

ANZCA BULLETIN

Special Report:

ANZCA SPEAKS TO HEALTH MINISTER, NICOLA ROXON

Plus:

ANZCA MEDICAL RESEARCH GRANTS
NATIONAL PAIN STRATEGY
SEXUAL HALLUCINATIONS AND ANAESTHESIA
MERCY SHIPS – MAKING A DIFFERENCE
COLLEGE OF INTENSIVE CARE MEDICINE



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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Cover: Australian Health Minister Nicola Roxon and ANZCA President Dr Leona Wilson at The Alfred Hospital, Melbourne.
Photo: Sarah Wood



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President's message



This is the last message for this year, and so I would like to extend to all of you, your families, whanau and friends the season's greetings, and hope that many of you will have a break and return re-energised for the new year. For those of you who are working over this time to allow your colleagues their breaks, I would like to thank you for continuing to serve our community so that they may have constant access to safe and high quality health care.

I would also like to thank all of our Fellows and trainees who have worked tirelessly to support the activities of our College. Our College depends on your support, and the skill and expertise that you bring to bear on all that you do for the College. This includes the members of the ANZCA and National and Regional Trainee Committees; the examiners for our examinations; those who have been involved with educating and training our trainees including the supervisors of training, module supervisors, specialists and provisional Fellows who have provided clinical supervision and examination revision; members of the National and Regional Committees and their sub committees; research grant reviewers; those who assess international medical graduates specialists; those who have represented us on countless external committees of government and other organisations and who have assisted with submissions to those bodies; those who organise and present at our CME meetings; and members of the Council and Council Committees, sub committees and working groups. In all of this we have been very ably supported by CEO Mike Richards and ANZCA staff who have worked enthusiastically and tirelessly.

2009, of course, is a watershed for the College as we are farewelling the Joint Faculty of Intensive Care. We respect the right of JFICM Fellows to make a decision to pursue the path of independence — just as anaesthetists did when we separated from the College of Surgeons 18 years ago. Importantly, the change has occurred in a spirit of goodwill. We wish the new College of Intensive Care Medicine well and we look forward to our good relationship continuing.

This is a time of potentially significant changes in the training of health professionals and in healthcare delivery in our two countries. It is important that we maintain our place in the conversation with government, so that we can bring our profession's knowledge and expertise to bear on the questions facing them. In this issue, we speak with the Australian Federal Minister for Health, Nicola Roxon, on a range of issues affecting both our specialty and, more broadly, the medical profession. It is two years since the Minister was appointed and her responses make interesting reading. In the March issue of the *ANZCA Bulletin* we hope to speak with Tony Ryall, Minister for Health, in New Zealand.

2010 will see the commencement of the national registration and accreditation scheme in Australia. It is pleasing that following representations from ANZCA and other medical colleges and organisations that the Australian Government listened to the genuine concerns expressed by the medical profession surrounding the initial draft legislation. The scheme does have important implications for anaesthetists including mandated continuing professional development and I would urge Fellows and affiliates of the College to reconsider your CPD standing now and register for the program.

More recently, Fellows and trainees would have noticed that we have taken steps to increase the profile and visibility of our profession in the media and wider community. Propofol, prescription drug abuse, allergic reactions, pain, conjoined twins, and some of our colleagues' fantastic volunteering work in disaster zones and the Third World, are just

some of the topics that have grabbed the media's attention and resulted in extensive interviews and media coverage. Increasing our profile is important in terms of communicating the critical role anaesthetists, intensivists and pain medicine specialists play in modern medicine, educating the community and governments. There is a thirst for information and I would encourage Fellows to contact our communications department if you think there is a story which may be of wider interest.

Wishing you a safe and Happy Christmas and a productive 2010.

Dr Leona Wilson
President

People & events



JFICM farewell dinner

A veritable who's who from the worlds of anaesthesia, intensive care medicine and pain medicine gathered at ANZCA House on Saturday, November 21 for the official farewell dinner of the Joint Faculty of Intensive Care Medicine, as they become the new College of Intensive Care Medicine in 2010.

In addition to the ANZCA Council and the boards of both faculties, previous Presidents, Deans and Heads of Section and other guests celebrated a historic occasion.

The President of ANZCA, Dr Leona Wilson, proposed the toast to the new College and introduced many of the past luminaries in the history of ANZCA. Professor Vernon van Heerden, the President of the new College responded by describing the events over the last 18 months that had culminated in this occasion, and thanked the ANZCA Council, in particular Dr Wilson and Associate Professor Kate Leslie for their part in the negotiations that had taken place. Excerpts of the speeches appear on pages 80-83.

One hundred guests enjoyed a wonderful evening and a fitting occasion to wish the new College of Intensive Care Medicine well for the future and an ongoing close relationship with ANZCA.

Top from left: ANZCA House foyer set for dinner; Professor Vernon van Heerden addresses the dinner guests; pre-dinner drinks in the marquee; CICM Vice President Professor John Myburgh makes a presentation to Associate Professor Kate Leslie; guests at pre-dinner drinks; guests at dinner; Dr Leona Wilson addresses dinner guests.







Byron Combined SIG Meeting 2009

What would you expect of a meeting held in Byron Bay in October? Great weather? Great social life? Great meeting?

While we had no control over the weather, the combined special interest group meeting held in Byron Bay from October 9-11 was a great success as both a meeting and networking opportunity. This meeting is always well attended by enthusiastic participants, but this year saw us achieve one of the largest numbers of attendees to date. Was it the location? We suspect so, but it was certainly aided by some very interesting and capable speakers and an exciting program.

There were lively sessions including "Selection of anaesthesia trainees", the "ANZCA curriculum review" and "Depression" amongst many others. The quality of the speakers was very high including Professor Gordon Parker, The Black Dog Institute, Dr Jillann Farmer, Queensland Health, Associate Professor Sandy Garden and ANZCA's Mary Lawson and Claire Byrne. Some of the presentations from the meeting are available on the medical education SIG website.

There are plans afoot for Port Douglas next year with bigger and better ideas coming from the SIG members. We look forward to seeing you there in 2010.

Dr Jodi Graham
Chair, Combined SIG Convenor

From top left: Healthcare industry exhibition area; Dr Kim Jamieson, Dr Debbie Goodall, Dr Karen Smith, Dr Nicole O'Brien, Dr Annick Depuydt; Laerdal team - Mr John McMurray, Mr Phil White, Ms Carylin Lenehan; Dr Amrat Chowdhary and his wife, Mrs Kulwant Chowdhary, Greg Baldwin and Dr Alka Singh; Dr Daryl Williams, Dr Michele Moore, Dr Vanessa Beavis and Dr Tracey Tay.





CVP SIG conference

The biennial Cardiothoracic, Vascular and Perfusion SIG conference was held at the Sheraton Noosa from October 4-7.

The invited overseas speaker was Professor David Reich, Chairman of the Department of Anesthesiology at the Mt Sinai School of Medicine in New York. Professor Reich gave excellent talks on management of cerebral protection during aortic surgery as well as transoesophageal echocardiography of the mitral valve.

The meeting also had a strong line-up of Australian and New Zealand speakers and feedback from the meeting was extremely positive with the session on adult congenital heart disease particularly well received.

Edwards, a major sponsor, kindly donated an audience response system that was very popular, permitting an exchange of ideas and knowledge of each other's clinical practice.

The conference social functions were well attended including the conference dinner at Bernardo's. The weather was balmy and the conference venue a popular one with delegates and their families taking advantage of the beaches, restaurants and shops that Noosa has to offer.

There were 190 registered delegates, a record number for a special interest group meeting. Thanks go to the speakers, the CVP SIG executive who arranged the program and Kate Briggs, the ANZCA SIG Coordinator.



Top from left: Welcome reception poolside at the Sheraton Noosa; Dr Justin Wong, Dr Warren Pavey and Dr Khairul Amir Zainuddin; Delegates enjoying morning tea with the healthcare industry; Dr Steve Same and Mrs Terri Same; Dr Mark Hurley, Ms Robyn Sutton and Dr Damon Sutton; "Anaesthesia in the cath lab" presented by Dr John Leyden.



People & events continued



Annual ANZCA/ ASA Combined CME Meeting of ACT

The 2009 Canberra Floriade “The Art of Anaesthesia” Meeting was held from September 19-20. The meeting was very lucky with beautiful Spring weather and the organisers are sure at least some of our delegates managed to get out and about and enjoy all that Canberra has to offer.

There were many distinguished speakers, and thanks go especially to those who travelled from overseas and interstate in order to make a presentation on our theme of Organ Protection and Immune System Modulation.

It was an honour to have the President of ANZCA, Dr Leona Wilson and the President of the ASA, Dr Elizabeth Feeney open the meeting and welcome delegates. The Vice President of ANZCA, Associate Professor Kate Leslie also gave a presentation.

Feedback received from this event has been tremendous, with many delegates remarking on the relevance and interest of the program. The Finkel Theatre at the John Curtin School of Medical Research was an excellent venue.

From top left: Inside the Finkel Theatre; Delegates visiting healthcare industry sponsors; Dr Stephen Brazenor; Professor Patrick Wouters discussing “Cardiac protection, volatiles and opioids”; Dr Pal Sivalingam making his presentation on “Starch and renal function”; Professor Thomas Bruessel; Delegates in the foyer of the John Curtin School of Medical Research.





National Pain Strategy launch

The launch of the initial draft of the National Pain Strategy was held on Sunday, October 18 to coincide with the final day of the Faculty of Pain Medicine's "Duelling with pain" Spring Meeting in Melbourne.

Speaking at the media conference were Professor Michael Cousins (Chair, National Pain Summit steering committee), Dr Penelope Briscoe (Deputy Chair, NPS and Dean, Faculty of Pain Medicine), Ms Coralie Wales (President, Chronic Pain Australia) and Professor Stephen Gibson (President, Australian Pain Society).

The strategy launch resulted in some 40 radio interviews, talkback calls and news items, 18 newspaper articles and three television reports.

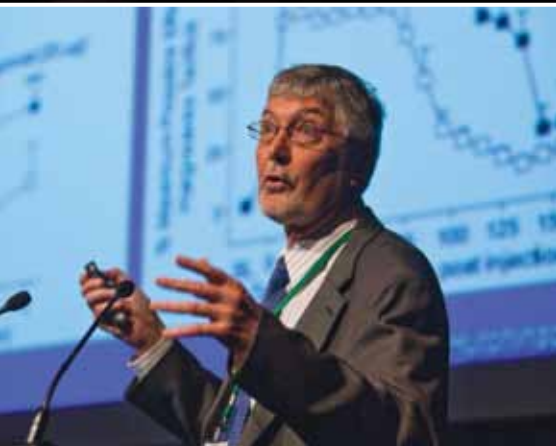
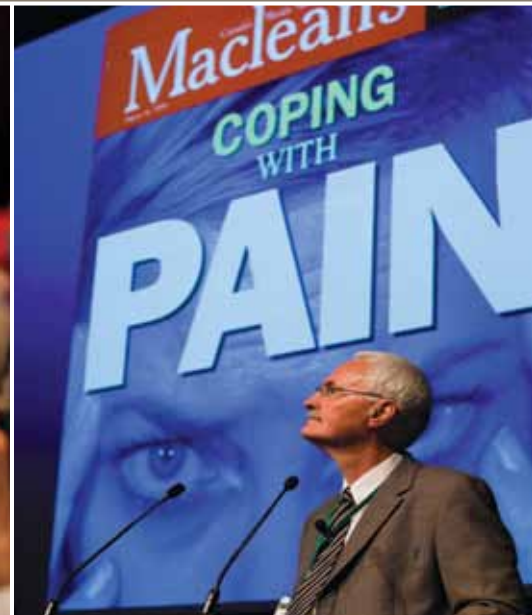
The strategy, which can be found on the National Pain Summit website – www.painsummit.org.au – is being regularly updated with feedback. It will be finalised at the National Pain Summit being held at Parliament House, Canberra on Thursday, March 11.



From top left: Professor Michael Cousins, right, and Professor Stephen Gibson at the media conference to launch the National Pain Strategy; Mr Rob Baveystock and Dr Stephen Leow; Dr Stephen Jensen and Dr Victor Wilk; Dr Penelope Briscoe, Professor Stephen Gibson, Professor Cousins, Ms Coralie Wales; Professor Cousins gives a television interview; Ms Wales speaks at the media conference; Dr Humphry and Professor Tess Cramond and Professor Julia Fleming at the National Pain Strategy launch.

People & events continued





FPM Spring Meeting “Duelling with pain”

Delegates attending the FPM Spring Meeting “Duelling with pain” in October at the Sofitel in Melbourne enjoyed a stimulating scientific program as well as practical sessions of relevance to the daily practice of pain medicine in acute, chronic and cancer pain settings.

The diversity of the sessions was a highlight of the meeting. They included the pharmacology of methadone, (Professor Andrew Somogyi, Adelaide), spinal magic bullets (Professor Colin Goodchild, Melbourne) and addiction controversies (Professor Jon Currie, Melbourne).

Dr Roman Jovey from Canada was a wonderful teacher, sharing his practical insights (for example, what to say in consultations) regarding the management of opioid use in chronic pain. Dr Suellen Walker (a locally born London expat!) spoke about research into spinal analgesics in babies and in laboratory research, giving glimpses of developing analgesic research.

There was opportunity to discuss and debate management with many experts, experienced clinicians and young clinicians. The audience included representatives from nursing and allied health, addiction medicine, rehabilitation medicine, psychiatry, anaesthesia, geriatric medicine and general practice, reflecting the potential for multidisciplinary approaches to pain management.

The smaller, problem-based learning sessions were interesting and practical. Feedback suggests the faculty should do more of these in future meetings.

The social program was excellent. Proud Melburnians were able to show off their “foodie” reputation with a delicious dinner in elegant surroundings at The Italian restaurant on Saturday evening. Informal networking with colleagues was a valuable part of the meeting. Such opportunities allowed our clinicians, who often work in challenging settings, to share their experiences and give clearer identity to their work treating and researching in pain medicine and related fields.

Thank you to everyone involved – speakers, health industry supporters, attendees, my committee and ANZCA and FPM staff for their contributions to a successful meeting. Thank you, and please consider coming to Newcastle in 2010.

Dr Carolyn Arnold
Convener

From top left: Dr Peter Cox, Dr Rebecca Martin and Dr Duncan Wood; Ms Julia Barton, Professor Ted Shipton and Dr Frances Beswick; Dr Graham Rice and Associate Professor Leigh Atkinson; Dr Roman Jovey; Professor Colin Goodchild, Dr Julia Fleming and Dr Jovey; Dr Charles Brooker, Dr Suellen Walker and Dr Chris Hayes; Professor Andrew Somogyi; Dr Graham Rice, Dr David Gronow and Dr Bruce Rounsfell; Dr Kerry Thomas and Dr David Lindholm; Dr Penelope Briscoe and Dr Carolyn Arnold; Dr Arnold; Mr Damien Finnis; Dr Paul Glover, Dr Nanda Bellum and Ms Claire Atkins; Dr Martine Holford and Dr Lewis Holford.

Letters to the editor



I read with interest the article “Training non-anaesthetist sedation practitioners – living with PS 9” (*ANZCA Bulletin*, September 2009). It raises a number of issues and it would be of help if the historical situation was reviewed.

Prior to 1990, there were no reports to the NSW Special Committee Investigating Deaths Under Anaesthesia (SCIDUA) of mortality associated with endoscopic diagnostic procedures, with the sole exception of bronchoscopy. Since then, a gradual increase has occurred, until deaths associated with endoscopy either under general anaesthesia or “sedation” now constitute more than 10% of notifications.

Many of these deaths go unreported because the Coroners Act does not include the term “sedation” in that section requiring deaths occurring within 24 hours of anaesthesia for a procedure. Those in which the person administering sedation is neither qualified as, nor training to become, a specialist anaesthetist are especially difficult to investigate.

Nevertheless, the table (right) shows results for cases classified as categories 1, 2 or 3 from 2005 through 2008, the last being that year for which data are complete.

Summarising the above, there were five gastroscopies, three colonoscopies, two ERCPs, two bronchoscopies, one oesophagoscopy and one PEG insertion for a total of 14 deaths in four years.

Specialists were involved in nine cases, although in four of these SCIDUA could not find any aspect of management that could have delivered a more favourable outcome. Non-anaesthetists were involved in four cases, in all of which SCIDUA criticised management issues, whilst in the one case involving a trainee, lack of appropriate supervision was a factor.

From a situation 20 years ago in which few, if any, deaths occurred with procedures such as the above, to one in which 10 per cent or more of reported cases are now the norm indicates a level of associated mortality which is considerable. Even though the denominator is unknown, it is fair to assume that the number of such procedures does not amount to more than 10% per cent of the total number of anaesthetics for surgical operations.

Under-reporting of deaths following sedation at the hands of non-anaesthetists is a problem, as is the fact that even when reported, follow-up sometimes yields

insufficient data on which SCIDUA can make a decision.

SCIDUA believes that irrespective of ASA status or severity of illness for which the procedure is being carried out, a patient’s best chance of survival is at the hands of an appropriately qualified and experienced specialist. It is therefore unfortunate that many departments of anaesthesia will not, or cannot, provide a service to endoscopy suites or radiology departments, irrespective of the seriousness of the patient’s condition. To their great credit, a number of departments do, and if they can, the rest could if they tried.

Training non-anaesthetists may be the next best thing but it remains second best. The College would do well to encourage departments which it approves for training to provide a service in this sometimes neglected area.

Professor R. Holland
Former chairman, SCIDUA

Table 1

Procedure	ASA class	GA/sedation	Anaesthetist	Classification	Factors/Suffix
Gastroscopy	unknown	Sedation	Other	3	Ai,ii,Bi,ii,iv Cii,Fii,iii
Gastroscopy	4E	Sedation	Specialist	3	GH
Gastroscopy and banding	4	GA	Specialist	2	GH
Gastroscopy	3	Sedation	Other	1	Ai,Bii
Gastroscopy	4E	GA	Specialist	3	Biv
Colonoscopy	4E	Sedation	Specialist	3	Ci,ii,H
Colonoscopy	3	GA	Specialist	2	GH
Colonoscopy	3	GA	Specialist	3	Ai,Bi,Cii,Fiii
ERCP	4	GA	Specialist	2	GH
ERCP	4E	GA	Trainee	3	Ai,iiFi,ii,iii H
Bronchoscopy	unknown	Sedation	Other	3	Ai,Ci,Fiii
Bronchoscopy	3	Sedation	Specialist	3	GH
Oesophagoscopy	4	GA	Specialist	1	Biv,Cii
PEG Insertion	4	Sedation	Other	1	Ai,Bii,Fiii



I would like to reply to the letter from Dr Guy Buchanan in the recent *ANZCA Bulletin*.

I am opposed to a change in name of the specialty and those practicing anaesthesia. In this country the expression “ology” is reserved for sub-specialties such as neurology, urology, cardiology, etc. Anaesthetists are not a sub-specialty of any other group.

The word anaesthesiologist has seventeen letters whereas anaesthetist has twelve letters.

I believe a change would create enormous confusion between the College, the ASA, our

Fellows, departments of anaesthesia and the general public.

The loss of the name anaesthetist for our specialty would leave this name free for any non-medical group that is allowed to practice some form of anaesthesia.

Although close to retirement I will continue to call myself an anaesthetist or retired anaesthetist, as the case may be.

Dr Ian Rechtman
FANZCA

Awards

Orton Medal

Professor Peter Kam (NSW) has been awarded an Orton Medal. This is the highest form of recognition the College can give one of its Fellows, and the award of the Orton Medal to Professor Kam is in recognition of his immense contribution to training and education across Australia, New Zealand and South East Asia over many years.

ANZCA Medal

Dr Robert Wong (WA) has been awarded an ANZCA Medal in recognition of his contribution to diving and hyperbaric medicine, his initiation of the formal qualification in this area in 2003, and his ongoing work to maintain the program at the highest possible standard.

Dr Diana Khursandi (Qld) has been awarded an ANZCA Medal in recognition of her long-term contribution to the specialty of anaesthesia. Dr Khursandi has made a significant and sustained contribution in a diverse number of areas including rural and regional practice, anaesthesia workforce challenges, gender issues in medicine, clinical indicators, CPD, education and training, and the health and welfare of doctors.

Professor Kam, Dr Wong and Dr Khursandi will be invited to receive their medals at the College Ceremony in Christchurch next year.

Council changes

Following the resignations from Council of Drs Richard Waldron and Peter Cook (as outlined in the report of ANZCA Council meeting on October 10 on page 100), casual vacancies have been filled by Dr Mark Reeves and Dr Patrick Farrell respectively. Dr Reeves and Dr Farrell have joined Council as co-opted members for an initial period to May 2010.



Dr Mark Reeves was elected Chair of the Tasmania Regional Committee in 2004 and has held this position since then. He gained his medical degree in London in 1989 before migrating to Australia for marriage and anaesthesia training.

Dr Reeves gained Fellowship in 1999 and moved to northern Tasmania for the lifestyle and the weather. He works in both public and private practice in Burnie. He is also the supervisor of training, a primary examiner and an enthusiastic research Fellow with the University of Tasmania.



Dr Patrick Farrell is Director of Anaesthesia of the Newcastle anaesthesia service based at John Hunter Hospital. He is a graduate of University of New South Wales. He commenced his anaesthetic training at the Royal Berkshire Hospital in Reading, UK and completed his Fellowship in Sydney in 1986. His clinical interests include paediatric and neonatal anaesthesia and he has contributed a chapter on paediatric thoracic anaesthesia to *Hatch and Sumner's Textbook of Paediatric Anaesthesia*. He was a final examiner for 12 years and a member of the Final Exam Committee. He is a past president of SPANZA.

Patrick is married, has four children and enjoys cycling and living near the Hunter Valley.



Special Report:

ANZCA speaks to Health Minister, Nicola Roxon

Australian health reform – issues and challenges

The past 12 months have been marked by a number of extensive reviews into Australia's healthcare system. It is expected that the Federal Government will announce its proposed changes to healthcare in the first half of 2010. Health Minister, Nicola Roxon, has been responsible for the health portfolio since December 2007.

ANZCA spoke to the Minister at a recent consultative forum at The Alfred Hospital in Melbourne and sought some answers to key questions facing anaesthetists, intensivists, pain medicine specialists and the wider medical profession.

Since being appointed as Minister for Health what has surprised you most about the portfolio or the health sector, more broadly – and what do you see as your biggest challenge?

We are about to embark on the biggest reforms of our health system since the introduction of Medicare – that's quite a challenge!

Reform agenda

You have consulted widely following the release of the Health and Hospitals Reform Commission Report with more than 70 forums around the country. Is there anything arising from these forums that you think deserves greater attention than you might otherwise have thought before you commenced the consultations? What issues have varied the most between the consultation sites?

The National Health and Hospitals Reform Commission report made recommendations for system-wide reform of the health system – and the Prime Minister, myself and other Ministers have held 76 consultations with health workers in communities across Australia.

Most consultations discussed health care reform in general, but we have also held consultations on specific reform areas, such as indigenous health, rural health, mental health, aged care, and preventative health.

Before we started, we expected many different topics would be raised – and this has happened – but there have also been strong common and consistent themes such as the importance of primary healthcare, preventative health, e-health reform and how we can take pressure off our hospitals.

We welcome everyone's feedback – and readers can find out more about it at www.yourhealth.gov.au.

When do you propose announcing the reforms?

A meeting of COAG this month will provide a forum to discuss health reform with the states and territories. The Commonwealth will put forward its National Health Reform Plan in the first part of 2010.

Where do you see the private health care system in 10 years, particularly its relationship with the public hospital sector? Can the two systems work more collaboratively and what is the role of the states/territories in the funding of specialist training posts in private settings?

I see an integrated healthcare system in Australia with the private and public systems working collaboratively to achieve optimal patient outcomes. The Rudd Government believes in a strong private and strong public system that work cooperatively.



“...there have also been strong common and consistent themes such as the importance of primary health care, preventative health, ehealth reform and how we can take pressure off our hospitals.”

Nicola Roxon,
Minister for Health



“The Government is well aware that medical specialist training numbers will have to increase to ensure that Australians will continue to enjoy world class health care in the future.”

**Nicola Roxon,
Minister for Health**



Collaborative arrangements will become a necessity in the coming years to cope with increasing demand for services – and to ensure there is an adequate supply of trained health professionals in the system into the future.

The Rudd Government’s \$171 million Specialist Training Program is aimed at working with the state and territory governments and the private sector to boost and target trainee places in expanded settings – the majority of which are in the private sector. Access to training in the private sector provides trainees with a broad range of experience. This can only occur with strong support and commitment from both the state and territory governments and the private sector.

We are seeing greater consumer representation and engagement in health issues, which we fully support. Do you think the level of engagement is sufficient and how can the colleges assist? Do you see consumers and community representatives as being more involved in decisions about healthcare interventions in the future?

Consumer representation and engagement in healthcare is essential and the effort made by the colleges to address this is a positive step forward.

There are a number of ways to help empower consumers, including through providing information and changing the way information is accessed.

The development of a national e-health system holds revolutionary potential – and will help empower consumers by providing access to patient-controlled information about their health.

Trainee positions – public and private

Output from medical schools will soon double. Our College’s workforce study shows that we need to produce more specialists for our growing and ageing population. (In fact, the study undertaken for us by Access Economics shows that – on current projections of supply and demand – there will be a shortfall of 2287 anaesthetists by the year 2028.) Our Fellows are willing and able to train more junior doctors. The missing link is funded positions for interns, prevocational doctors and specialist trainees in our public and private hospitals.

Accepting that funding training positions in the hospital system has historically been within the gift of state government departments of health, and having regard to the COAG process, what is the Commonwealth Government’s proposed solution to this issue?

The Government recognises that the provision of intern, pre-vocational and vocational training places is critical to the training pathway of doctors.



The Government will continue to work with the states and territories to increase medical training capacity. Australia is experiencing an unprecedented increase in the number of Australian and international medical school graduates and managing this effectively will be a significant challenge for all governments.

In regard to intern training places, at the July 2006 COAG meeting, the states and territories gave a guarantee to provide high quality medical intern training places for Commonwealth-funded medical graduates. This commitment is critical to ensuring the training of Australia's medical workforce. The allocation process for intern placements is the responsibility of state and territory governments. As the major employer in the sector, the states and territories determine how that process is managed.

I recently wrote to state and territory health ministers seeking advice on their planning for increasing intern training capacity and confirming their 2006 COAG commitments.

There will need to be an expansion of specialist training positions into the private sector to accommodate the increased numbers of trainees coming through the system and the changing nature of practice where some medical procedures are increasingly only performed in the private sector. A barrier to the implementation of full experience in the private sector is the requirement

for patients to be charged only for procedures that have been directly carried out by the specialist (except for surgical procedures by trainee surgeons who have a special exemption). Would the Government consider correcting this anomaly, which will prevent meaningful experience for all other trainees, and therefore inhibit the uptake of training in the private sphere ?

In the new environment, Australia may be less reliant on international medical graduates (IMGs). What is the Commonwealth Government's longer term plan with respect to the immigration of medical practitioners?

The Government is well aware that medical specialist training numbers will have to increase to ensure that Australians continue to enjoy world-class healthcare in the future.

Australia aims to be self-sufficient in the long term. However, in the short to medium term, increases in student numbers will not meet increasing demand. Other approaches, such as increased international recruitment, improving retention rates and workforce reform will also need to form part of any national and jurisdictional response.

As I've said previously, I am committed to working with state and territory governments through the COAG process, specialist medical colleges and the Australian Medical Council (AMC) to boost specialist trainee numbers.

The Government's Specialist Training Program will help to expand medical specialist training into non-traditional training settings. However this significant investment will only be successful if it is matched by states and territories increasing the number of public sector training posts and by medical specialist colleges agreeing to increase the number of medical graduates entering medical specialist training programs each year.

Rural/remote health

We understand there is a maldistribution of specialists between metropolitan and regional and rural areas and acknowledge there is a need to address this issue. Would the Government be in favour of creating special short-term rotational positions (3-6 months) in linkage with a teaching hospital to enable senior trainees to rotate to rural/remote or Area of Need (AON) regions where there is a need for specialists, but none are available? Such a scheme would allow these senior trainees to gain valuable independent experience, and also provide the community with medical cover by a practitioner who was close to full qualification as a specialist. By linking to a teaching hospital this would enable effective distant supervision to be provided. Are there any other options that the Government is considering that aim to improve recruitment and retention for the rural and remote specialist workforce?



“The Government is interested in considering any proposals that would increase specialist training outside of our major metropolitan centres and would welcome leadership from the colleges on this issue.”

Nicola Roxon,
Minister for Health

The Rudd Government knows that attracting and keeping doctors in rural and remote areas is about more than just overseas recruitment. That’s why the Rudd Government has developed a \$134.4 million package of measures to attract and reward doctors who practice in rural and remote Australia.

The package’s initiatives include:

- Higher relocation grants – for example, a doctor relocating from a major city to a regional centre will receive a \$15,000 grant, while a doctor relocating to a very remote area would receive \$120,000.
- Adjusting the rate of reimbursement of HECS payments to give more credit according to the remoteness of the location;
- Providing locum relief for doctors working in difficult locations to enable rural GPs to take a holiday or undertake further education and training; and
- Allowing more than 150 urban doctors to be up-skilled in exchange for undertaking four-week locum placements in rural and remote communities.

This package also includes some changes to the ten-year restriction on overseas trained doctors, reducing it in the most remote areas of Australia to five years. The ten-year restriction will also be reduced to seven years in places like Cairns and Townsville, six years in Burke and Cooktown and five years in Longreach and Tennant Creek.

The Government also aims to strengthen Australian’s investment in rural training through the Rural Health Continuing Education Sub-Program.

This program was announced in the 2009-10 Budget and is an amalgamation of three existing programs. The bringing together of these programs will encourage increased collaboration between stakeholder groups with the intent that this will foster multidisciplinary team based-training. The program will also provide a coordinated approach to issues of professional isolation and access to continuing professional development for health professionals in rural and remote areas.

These measures underline the Rudd Government’s ongoing determination to properly address the rural workforce shortages so Australians can access appropriate and timely healthcare when and where they need it.

The Government is interested in considering any proposals that would increase specialist training outside our major metropolitan centres and would welcome leadership from the colleges on this issue. This will be a vital part of providing the increased training capacity as well as providing much-needed services to those communities.

Supporting education and training

Does the Government support protected educational and administrative time for clinical supervisors of training and clinical teachers to carry out educational activities in clinical medicine?

In the new environment of an increased number of medical graduates and patient concerns about being “experimented on” by trainee doctors, we may rely more on medical simulation to prepare young doctors for emergency situations and to assess their progress. Do you see support for the development and maintenance of simulation centres as one way of addressing the issue of increased numbers of medical graduates where there are insufficient clinical training opportunities?

The Government is strongly committed to ensuring that clinical teaching and training is a key part of our future workforce planning.

That is why the November 2008 COAG package included the biggest investment in workforce made by any Government – a \$1.6 billion partnership. This includes \$1 billion for clinical training.

A \$175 million investment in capital infrastructure will support the training of the future medical workforce including funding for the simulated learning environments and an additional \$28 million will train and skill up supervisors across the disciplines.

The Commonwealth is working with all jurisdictions, the universities and private hospital sector to implement this component of the COAG health workforce reform package. Simulated learning will enhance the training experience across and within all disciplines, without compromise to patient safety or privacy. This will allow students to work in scenarios that they would otherwise receive little or no exposure.



ANZCA is undertaking a comprehensive review of its curriculum to ensure it is best practice and meets the needs of the health system and the population it serves in the 21st century. In addition, some time ago we mandated continuing professional development for all Fellows. In your view, what key elements does the new curriculum need to address in shaping the new training program?

With medical students, trainees and specialists dispersed across the country in the public and private sectors, we will be more reliant on distance education and web-based learning. Does the Commonwealth Government have a clear plan to support these educational activities?

The Rudd Government is strongly supportive of continuing professional development. This will be a requirement across all professions covered by the National Registration and Accreditation Scheme.

The Government supports education that will encourage best practice and quality care.

The Government is aware of the College accreditation processes undertaken by the AMC, in particular the assessment of standards that address curriculum content and delivery. My department,

through the work of the Expanded Medical Education Advisory Committee, is also aware of the importance of matching education and training with contemporary models of healthcare delivery.

Role of medical colleges

Australia's medical colleges such as ANZCA – which is self-funded with virtually no recourse to the taxpayer, and which relies predominantly on pro bono work by clinicians such as supervisors of training – have played an important, cost-effective role in educating and training medical specialists ensuring high clinical standards in Australian healthcare. Where do you see the medical colleges in your future plans for the health system, the future of specialist medicine and the increased demand for high-end services as the population gets older?

The Commonwealth acknowledges that professional medical specialist Colleges provide an important role and function in vocational training in Australia and appreciates the time dedicated by many professionals to training the next generation. As healthcare needs change over time – and the need for increased vocational training places grows – it

is important that the Commonwealth, states and territories and all education and training providers work together to address these important issues.

One of the more unfortunate events in Australia's health care system's history was the Patel case where a state health department employed someone without conducting due diligence regarding Patel's qualifications and experience under the "area of need" program. The department effectively bypassed well-established protocols involving Australia's medical colleges, which demand the highest clinical standards. What are your views on these certification processes and are you confident that these processes will minimise the risk of such cases being repeated?

A uniform national process for assessing International Medical Graduates (IMGs) was phased in across all jurisdictions from July 2008 to ensure that all IMGs meet the same minimum standards of medical education and clinical practice as Australian trained doctors. The new pathways are intended to reduce the possibilities for assessment error. The assessment pathways rely on the medical boards and colleges as essential elements in the assessment process.



“Pain management is one of a broad range of issues raised in the current consultation process on national health system reform and I look forward to considering innovative proposals that are being developed.”

**Nicola Roxon,
Minister for Health**

As part of these new standards all applicants have their qualifications independently verified, and in the case of specialists, the assessment process is administered by the Australian Medical Council. Currently, state and territory medical boards have the legislative responsibility to ensure that a medical practitioner is fit to practice. In the case of doctors recruited to hospital positions, the medical board must be satisfied that the applicant has been adequately assessed and is suitable for the position.

Further, the Commonwealth is acting with all states and territories to introduce a National Registration and Accreditation Scheme that will improve safety of our medical systems for the community.

Workforce

The National Health Workforce Agency will be responsible for the planning, coordinating and funding of pre-professional entry clinical training, workforce planning and policy development. How do you see this agency working and what are the implications for medical colleges' training programs? How can the medical colleges best work with the National Health Workforce Agency to ensure that in the future, the Australian public is served by a healthcare team of the same high standards as they are now?

In November 2008, COAG agreed to a significant package of health workforce initiatives through its \$1.6 billion commitment to the health workforce. The aim of that commitment is to improve health workforce capability and supply, recognising that against the backdrop of an ageing population and rising chronic disease, the already significant pressures on our existing health workforce will continue to increase.

The establishment of Health Workforce Australia will allow more effective, integrated clinical training arrangements and support the workforce policy and planning initiatives announced by COAG. Health Workforce Australia will be responsible for administering the majority of health workforce initiatives announced by COAG.

Australia has been at the forefront of utilising nurses as assistants as part of the anaesthesia care team – in the operating theatre and recovery room with more recent involvement in pre-anaesthesia clinics and acute pain services in the wards. Australian anaesthetists have also led investigations into the use of physician assistants within the anaesthesia care team. With Australia having one of the world's best safety records in this area, what changes, if any, do you envisage for the anaesthesia workforce?

Australia should be proud of its nurses. Often the skills and expertise of nurses go unrecognised, and the ability of many highly trained nurses makes them quite capable of taking on responsibilities such as those you've highlighted.

The Government acknowledges and supports a team-based healthcare model as practiced in anaesthesia. The Commonwealth will continue to engage heavily with key health professional stakeholders to assist in developing high quality and sustainable workforce models of healthcare delivery.

Pain

It is estimated that chronic pain (that is, constant daily pain for a period of three months or more) costs the Australian economy around \$34 billion per annum with 36.5 million working days lost – a huge productivity loss. Yet pain services seem to be unevenly spread with a small number of multidisciplinary pain clinics and only 26 funded specialist training places Australia-wide as well as a major shortage of trained GPs and other allied health professionals in this area. Do you see addressing the issue of pain as an important element in the government's health reforms and do you believe that the Commonwealth should be taking a lead role? Would the Commonwealth support an increase in funded positions for training in pain medicine?

The Government is aware of the significant burden on the community from acute and chronic pain, and has moved to address this issue through a range of national programs including the Pharmaceutical Benefits Scheme, the Medicare Benefits Schedule, the National Palliative Care Program and, through the National Health and Medical Research Council, research and acute pain guidelines.



The Government also acknowledges the work done within your College to address this particular area of health need. The Commonwealth through its Specialist Training Program will continue to work closely with training providers and Colleges to assist in producing a specialist workforce that meets emerging community's health needs.

Pain management is one of a broad range of issues raised in the current consultation process on national health system reform and I look forward to considering innovative proposals that are being developed.

Conclusion

What is your proudest achievement, or a decision to date, relating to our health system, that has given you most satisfaction since being elected?

The Rudd Government is taking concrete steps to improve Australia's health system after 12 years of neglect.

I am very proud that upon coming into office two years ago, the Government took swift action to deal with key pressure points in the health system and lay the foundations for longer term reform.

A landmark \$64 billion healthcare agreement was made to ease pressure on the health and hospital system – a funding increase of 50% on the last agreement.

This includes \$750 million for emergency departments, \$500 million for sub-acute care and the biggest investment in preventative health made by any government of \$872 million and \$1.6 billion on a workforce package.

The foundations for long term health reform are in place with the release of the comprehensive Health and Hospitals Reform Commission Report, the Preventative Health Taskforce and a draft of Australia's first National Primary Health Care Strategy.

But it is many of the smaller, practical initiatives that are also satisfying to see when they take off – our GO Superclinics opening, breast care nurses taking up their positions and kitchen gardens rolling into our primary schools, to name some examples.

What would you like Australia's health system to look like five years from now?

The Rudd Government wants health reform to ensure Australians have access to healthcare they can rely on – this means the right service in the right place at the right time – with the patient as the focus of the system.

We are at an exciting time in the health debate. Rarely does it happen that the urgent need for reform coincides with a Government determined to implement it.

In five years these major reforms will be well under way to ensuring we have a strong, agile and self-improving system for generations to come.

Dr Steven Cook: Operation Samoa – Tsunami aftermath



Steven Cook's original plan had been to become a surgeon. But it was while on deployment to East Timor in 2000 with the Royal Australian Air Force – which had awarded Dr Cook an undergraduate scholarship that had helped him through medical school – that his career plans took a marked turn.

From left: Dr Steve Cook with then Prime Minister, John Howard receiving the Conspicuous Service Cross; Dr Cook on arrival in Darwin on the first C-130 from Bali with a severely injured burns patient in 2002.

“You’re flying around in a helicopter bringing in burnt kids (from falling into oil cooking fires) and you realise how important retrieval and resuscitation skills are – I wanted to become a competent retriever,” said Dr Cook, an anaesthetist now based at the Royal Brisbane and Women’s Hospital and also working in private practice.

After seven months in East Timor, Dr Cook served for four months in Iraq in 2003 before he left the military and started his anaesthesia training in Sydney. He finished his training last year in Queensland.

In Iraq, Dr Cook was largely involved in transporting severely injured military casualties to Kuwait on C-130 transport planes.

“We were working pretty closely with the Americans and they were pretty amazing – I’m still using some of the stuff I saw back then, like their massive transfusion protocols that are still being introduced here,” he said.

Dr Cook is also a veteran of both Bali bombings – the first in October 2002 at

Kuta in which 202 people (including 88 Australians) died. The second attack in 2005 involved a series of three explosions in restaurants in which 26 people (four Australians) died.

In 2002, Dr Cook had been on-call in Sydney when initial reports indicated five people needed to be evacuated to Darwin. When he reached Darwin, the evacuation number had climbed to 40 and it rose again to about 80 by the time he landed amongst the chaos in Bali.

“I was involved in the initial response,” Dr Cook said. “When we rolled up 16 hours post the blast they were very much untreated, un-triaged patients.”

“We set up a field hospital at the airport in Denpasar and our job was the initial resuscitation – checking circulation, intubating patients, putting in drips, setting up monitoring - and then rapidly transferring them back to Darwin for definitive treatment.”

In all, 66 patients with major burns, traumatic amputations and severe burns were evacuated, with Dr Cook in charge of the first and third evacuations.

He recruited Australian surfers as stretcher bearers, some holidaying Australian nurses pitched in and helped and South African helicopter pilots were used as medics.

Dr Cook was awarded a Conspicuous Service Cross which “recognises outstanding commitment to duty or outstanding application of exceptional skills” for his efforts in 2002.

“We learned a lot of lessons after 2002,” Dr Cook said. “We upgraded our equipment and policies which meant the response to the second bombings in 2005 was pretty slick.”

In late September, Dr Cook was part of the rapid response team that went to Samoa following the tsunami in an operation coordinated by Queensland Health.

Dr Cook left for Samoa with just two hours notice, arriving the day after the tsunami.

“My wife’s very supportive and at least this one wasn’t dangerous. She’s had lots of phone calls like that,” Dr Cook said of

Dr Steven Cook: Operation Samoa – Tsunami aftermath

continued



“The whole Samoan trip was great because we had Samoan surgeons and Australian surgeons and Samoan anaesthetists and Australian anaesthetists working side by side,” he said. “You’re working as a team and sharing the skills.”

his wife, Nina, a psychiatrist who has had 10 years’ experience of her husband being called away at short notice. The couple has a three-year-old daughter Madeline and a one-and-a-half year old son, Alex.

“The whole Samoan trip was great because we had Samoan surgeons and Australian surgeons and Samoan anaesthetists and Australian anaesthetists working side by side,” he said. “You’re working as a team and sharing the skills and experience.”

Most of the work in Samoa was on adult patients. Sadly, many of the dead were children – “they couldn’t swim” – and he described the injuries they saw as being like what would happen if your patients had been “tossed around in a giant washing machine”. Many patients had severe limb injuries with infected wounds and fractures.

The teams were forced to rediscover the “lost art” of anaesthetising patients using ketamine, a drug that can be used without

the need for expensive equipment. “I think a lot of anaesthetists rely on their machines too much and don’t want to work without them - but it can be done and done safely,” said Dr Cook, who is an Officer in Charge for FAST (Fly Away Surgical Team) and an Early Management of Severe Trauma (EMST) instructor.

He is one of two Dr Cooks in the specialist reserve in Queensland – Steve Cook is a squadron leader and his uncle Peter Cook, a former ANZCA councilor, is a wing commander.

Last year he was involved in establishing the Trauma Service at the Royal Brisbane hospital (Queensland’s first) which manages trauma cases in a multi-disciplinary team. Anaesthetists can make an enormous contribution in the management of trauma patients - from initial resuscitation of critically injured patients through the operating theatre and intensive care and in acute and chronic pain management in the rehabilitation phase, he said.

Dr Cook is keen to see more anaesthetists working overseas in difficult conditions - in January he will be travelling with Interplast as part of a plastic and reconstructive surgical team to work in Papua New Guinea.

He has absolutely no regrets about the career he chose. “I love it,” he said.

Above: Dr Cook, left, with a patient who is undergoing hand surgery after being anaesthetised with ketamine.

Anaesthetists warned over patients and sexual hallucinations

Medical boards have reported an increasing number of complaints against anaesthetists concerning inappropriate sexual activity during or around the time of anaesthesia or sedation, particularly when propofol has been used. This article aims to alert anaesthetists to this potential problem that may lead to embarrassing legal investigations. The proceduralist may also be implicated, particularly if the procedure involves the pelvic or perineal regions.

Medical boards have reported an increasing number of complaints against anaesthetists concerning inappropriate sexual activity during or around the time of anaesthesia or sedation, particularly when propofol has been used. This article aims to alert anaesthetists to this potential problem that may lead to embarrassing legal investigations. The proceduralist may also be implicated, particularly if the procedure involves the pelvic or perineal regions.

Some definitions may be helpful. Patients who report hallucinations usually believe they were awake during the experience or at least aware of actual events occurring, and not in natural sleep or under anaesthesia or sedation. In contrast, patients who report dreaming usually believe that they were asleep and that the events were fanciful and not real.

However, patients and anaesthetists often confuse these phenomena. In addition, patients may start out believing they were dreaming, but change their minds when, for example, surgical or anaesthetic procedures have left bruising and/or swelling or there is pain or stiffness in certain anatomical areas such as perineum or mouth. There has been some research on dreaming

associated with anaesthesia but very little about hallucinations associated with anaesthesia where experience has mainly arisen from anecdotal reports or complaints.

There are a number of randomised trials investigating dreaming during anaesthesia, with a recent comprehensive review from Australia by Leslie and Skrzpek (1). Patients rarely spontaneously report dreams of a sexual nature. A study by Brandner et al. in 1997(2) appears to be the only one that has specifically sought these sexual aspects in dreams or recall following anaesthesia. There have, however, been a number of anecdotal reports of sexual dreams or recall in the literature concerning propofol (3-8), midazolam and other benzodiazepines (9, 10), thiopentone (and in former times methohexitone), and nitrous oxide when used as an analgesic and sedative (11). None of these anecdotal reports or research studies has included the more florid recall which tends to be reported in complaints.

With regard to anaesthetic agents, Brandner et al. (2) did not find any statistically significant difference when propofol-based anaesthesia was

compared with propofol induction and isoflurane anaesthesia or with thiopentone induction and isoflurane anaesthesia. There were, however, 19 patients of a total 119 patients (17%) who reported sexual emotions although only five patients had sexual dreams – only one of which was serious (level 4 out of 6 on the Ben-Horin overt sexuality scale).

This type of dreaming or personal experience of a sexual nature with anaesthetic drugs such as propofol may be more likely to occur in situations where the anaesthesia is “lighter”, or with “conscious” or “deep” sedation (12) and when the procedure is oral, gynaecological or urological. This raises the distinct possibility of an increasing incidence of such dreams or hallucinations, as propofol is increasingly used for sedation in a wide variety of settings. Dreams and/or hallucinations with propofol appear to be equally common in males and females (13), but the complaints of sexual assault or indiscretion are much more common from females. Practitioners who appear to be particularly at risk from complaints are dentists, anaesthetists and male recovery nurses. The incidence of sexual dreams or recall varies from



“Patients who report hallucinations usually believe they were awake during the experience or at least aware of actual events occurring, and not in natural sleep or under anaesthesia or sedation.”

43% (5) which reduced to 10% on later questioning, down to 0% (1). The incidence of “complaints” is not recorded in any study.

The only strategy that has been reported to reduce the incidence of dreaming during anaesthesia is intramuscular scopolamine (14). Scopolamine is also well known to be a good amnesic agent, which also may be useful at times of stressful procedures, though its main drawback for patients is a very dry mouth and rather prolonged sedation effects. Scopolamine is therefore not advocated for routine use to prevent dreaming. Opinion is divided as to whether warning patients preoperatively of the possibility of sexual dreams would limit (7, 10, 15) or exacerbate (2) the incidence of these dreams.

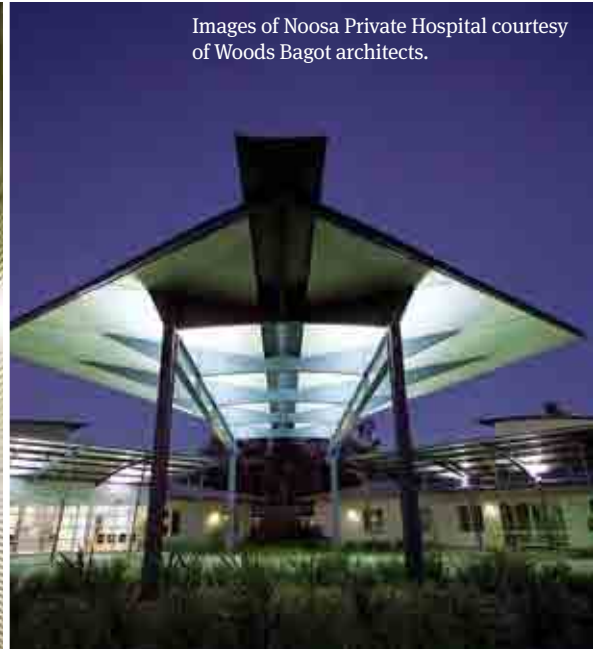
In conclusion, it would appear that protection is best achieved for both practitioners and patients if staff of both genders are present, to provide witness, whilst the patient is sedated or anaesthetised (7, 11, 16, 17).

Professor Barry Baker,
MB BS DPhil FANZCA FJFICM FRCA DHSA
Executive Director of Professional Affairs

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Anaesthesia training in the private sector



Images of Noosa Private Hospital courtesy of Woods Bagot architects.

ANZCA has responded to calls from public and private hospitals, from universities and from government, by accrediting a range of private hospitals for training in clinical anaesthesia.

Feedback from trainees and their supervisors has generally been positive, although some teething problems and cultural barriers have been encountered. In this article, we would like to highlight some of the advantages of training in private, outline some of the challenges that lie ahead and provide an example of one of the many successful public-private collaborations in our region (table 1). The College is undertaking a survey of training in private which will be published in a future edition of the *ANZCA Bulletin*.

The need to train anaesthetists in the private sector

With the increased number of medical graduates and demand for specialist anaesthesia services predicted for the next decade (“Australia’s looming anaesthetist shortage”, *ANZCA Bulletin*, March 2009), ANZCA needs to find additional training sites as a matter

of some urgency. Much of the surgical workload in Australia and New Zealand is undertaken in the private hospitals and already medical students, junior doctors and trainees of other medical colleges are receiving valuable training from enthusiastic teachers in this sector. The private sector is a valuable source of training sites for ANZCA as well.

In addition, the private sector provides a training experience that is not available in the public sector. For example, trainees can be exposed to cases that are hard to find in the public sector but are the “bread and butter” of many specialists in private practice (such as ophthalmic surgery, major joint surgery, endoscopic knee surgery and plastic/cosmetic surgery). They can also get experience and knowledge in the workings of a private hospital and the life of a private practice anaesthetist.

Finally, private hospitals provide a valuable source of sub-specialty surgery such as cardiothoracic surgery, neurosurgery and paediatric surgery. As there is significant demand for experience for these modules, many rotations are seeking to include in their schemes private hospitals with high volumes of these cases.

The process of accreditation

The process for accreditation of private hospitals is the same as the process for public hospitals, and is supervised by the ANZCA Training Accreditation Committee (TAC).

The department head at the private hospital completes detailed paperwork about the case-load, facilities, specialist staffing and qualifications, the CPD and QA activities at the hospital and the plans for the education and clinical supervision of the trainees. TAC seeks the support of the regional or national committee in the region before organising an on-site inspection.

Table 1: Accredited Private Hospitals

Private Hospital	Rotational Training Scheme
Noosa Private (Qld)	Queensland Anaesthesia Rotational Training Scheme
Mater Private Townsville (Qld)	Queensland Anaesthesia Rotational Training Scheme
Mater Private Brisbane (Qld)	Queensland Anaesthesia Rotational Training Scheme
Westmead Private (NSW)	Westmead Rotation
Brisbane Waters Private (NSW)	Newcastle Rotation
North Gosford Private (NSW)	Newcastle Rotation
Sydney Adventist (NSW)	Nepean Rotation
St Vincent's Private (Vic)	St Vincent's Rotation
Central Victorian Anaesthetic Service (Vic)	Stand alone (PF only)
Flinders Private (SA)	South Australian Rotational Training Scheme
Calvary-Wakefield (SA)	South Australian Rotational Training Scheme
Memorial (SA)	South Australian Rotational Training Scheme

“Trainees can be exposed to cases that are hard to find in the public sector but are the “bread and butter” of many specialists in private practice.”

During the visit, the inspectors are particularly keen to determine the amount of “hands-on” clinical work that will be possible, how the formal education and examination preparation of the trainees will be arranged, how the rotation to the hospital will work (daily allocation or more extended placements) and the arrangements for indemnity and pay. The inspectors’ report is considered by TAC with the final recommendations requiring the approval of ANZCA Council.

The challenges of training in private

While training in private hospitals has been firmly established in other countries and other specialties for many years, the concept is relatively new to the College and its Fellows and trainees.

Some private hospitals and their specialist anaesthetists have embraced training in private with enthusiasm. The specialists have reported that sharing techniques and ideas with the trainees is mutually beneficial and that patients

are very accepting of trainees - and the result has been happy trainees receiving outstanding training.

However, some significant and understandable hurdles to acceptance of trainees in private hospitals exist including:

- The concept of a private patient “paying” for higher expertise but being “exposed” to trainees.
- Concern about indemnity of the specialist and trainee in the event of a mishap.
- Concern about the ability of specialists to bill for procedures that are performed under their supervision.
- The possibility that the presence of a trainee may slow down “turnover”.
- The desire of specialists to “do their own thing” when working away from the public hospital.

The College is working with trainees, SOTs, private and public hospital specialists, hospitals management, the Australian Society of Anaesthetists and government to understand and address

these problems in order to provide more surety to specialists and trainees who participate in training in private.

Through frequent feedback, iterative changes and advocacy, the College hopes to demonstrate to specialists who participate in the training in private programs the benefits to their patients, to themselves and to the trainees.

Training in private has the potential to provide high quality training for trainees, continuing education opportunities for specialists and improvements in patient care that is too good to miss.

Associate Professor Kate Leslie
Chair, ANZCA Training
and Accreditation Committee

Anaesthesia training in the private sector

continued



The private experience

Training at Westmead Private Hospital

Westmead Private Hospital is a 140 bed private hospital located a few hundred metres from its larger sibling, Westmead public.

A wide range of surgical, obstetric and medical services is provided, including all the major surgical specialties bar transplant surgery. There is a 12 bed ICU which has 24-hour medical cover including an on-site consultant during the day. The obstetric unit is responsible for about 1500 deliveries each year.

The hospital was accredited by ANZCA for training in 2003 and is affiliated with the University of Sydney medical school.

One trainee from the Westmead rotational program is allocated to Westmead private for a three-month period. The trainee is rostered to work at the hospital during the day only with their overtime commitments and formal educational activities undertaken at the public facility.

Although the supervisor of training (SOT) keeps a watching brief, the trainees allocate their own time to the consultants or lists of most interest to their training needs or where a specific list requires a “second pair of hands”.

Occasionally the trainee is called upon to provide epidural analgesia for women in labour. This only occurs when no consultant is available within reasonable time, the woman declines the option of alternative analgesia until a consultant can come in and accepts the services

of the trainee. The Westmead Private rotation has proven to be a fantastic way for trainees to complete their cardiothoracic and neurosurgery modules and to find out more about private practice anaesthesia.

Despite a few early concerns about non-specialists “taking over” established areas of practice, in the seven years that the program has been running, there has been almost universal acceptance and enthusiasm from consultant anaesthetists at the hospital.

A recent trainee was asked for feedback for this article and wrote the following summary:

Benefit to Registrars

- It is a great opportunity to see cases that you would not normally see in the public or you would have minimal exposure to due to reduced number of cases and increased number of trainees.
- Specific examples of the lists that greatly benefit the trainees are: the laser ENT list, cardiac and neurosurgical lists, vascular list and the paediatric ENT list.
- It is a good opportunity to use the ultrasound for blocks as there are some consultants in the private hospital with a particular interest in that area who are happy to teach trainees.
- It provides the opportunity to see private practice and how it functions and the professional relationships with patients. This will be an integral part of our practice when we finish.
- There are smaller trainee-to-consultant ratios and better bedside teaching opportunity.

Benefit To Consultants

- There is always an extra pair of hands to assist with difficult cases and unexpected emergencies.
- Someone who can open a theatre for emergency obstetric cases until a consultant becomes available to take over.
- A trainee who can review post-operative patients with pain issues, as currently there is no acute pain service at the hospital.
- Opportunity to teach in a non teaching hospital setting.

The Westmead private experience has been very positive for both trainees and consultants. Some of the key aspects that seem to be important in making this collaboration successful include the following:

- A large enough overlap of specialists who work in both the co-located private and public facilities, but enough “new blood” to give trainees exposure to different ways of approaching clinical situations.
- A Department of Anaesthesia at the private hospital that embraces the concept of teaching in the private sector.
- A management team at the private hospital who value the collaboration beyond a mere service function.
- Management at both the private and public hospitals who work to overcome the administrative issues associated with pay and medical indemnity.

In summary, the Westmead private rotation is an integral part of the Westmead rotational program and provides benefits to the trainees, the anaesthetists and the patients at Westmead Private Hospital.

Dr David Elliott
Staff Specialist, Westmead Hospital

Dr Nicole Phillips
New Fellow, ANZCA Council
Supervisor of Training, Westmead Hospital

Above: Dr David Elliot, Specialist Anaesthetist and Dr Lindy Lowenstein, ATY1 trainee.

Dr Harry Venema: Mercy Ships – making a difference



Imagine a work environment where the prevailing atmosphere is one of cooperation rather than of competing agendas and where everyone is an enthusiastic, unpaid volunteer.

Imagine an anaesthetics department that includes medical specialists from all over the world, in addition to nurse anaesthetists from the US, but that generally has no dedicated anaesthetic assistants.

Imagine a week where one would expect to deal with several difficult airways (as a result of gross third-world pathology).

Imagine a hospital where there is no “luxury” surgery, and where the patients think nothing of having to gain access via a protective UN security cordon.

Imagine a work environment in which prayer is commonplace, divine assistance expected, but the surgeon does not believe that he is God!

You may say I’m a dreamer (with apologies...) but this is exactly the situation one experiences when volunteering for the global Christian charity Mercy Ships, which operates the largest non-government hospital ship in the world, the MV Africa Mercy. This ship has ward beds for 80 surgical patients and has six operating theatres. It is based in West Africa, moored in the port of a different country for 10 months of each year. The organisation’s stated aim is to provide “hope and healing to the world’s forgotten poorest”, and it does this by the provision of free medical care irrespective of tribe or religion.

The ship is staffed by more than 400 volunteers at any particular time. This revolving crew includes people involved with the running of the ship (by necessity a self-contained community), and those who specialise in shore-based community development projects in addition to the majority medical personnel. Volunteers serve for as little as two weeks or for as long as two decades.

Dr Harry Venema: Mercy Ships – making a difference

continued



In 2007-8 I volunteered for two rotations of about one month each, whilst the ship was in Liberia, a country brutalised by civil war, systemic poverty and government corruption (and by slavery in the more distant past). The experience for me was essentially one of first-world hospital care transported to patients with extreme third-world pathology. The hospital is well equipped with modern drugs, anaesthetic machines, fiberoptic scopes, a CT scanner and four ventilated beds.

The organisation attempts to complement rather than duplicate what is already available in the host country in terms of their own health system (often minimal and devastated by civil war) or that provided by other excellent NGOs (such as Red Cross and Mediciens Sans Frontieres). To this end, there is little acute or primary health care provided though there are exceptions - for example, the surgical drainage of Ludwig's angina as a life-saving measure (an anaesthetic challenge) or at the other end of the scale, the provision of a shore-based palliative care service to those patients

with malignancy (who are excluded from surgery). Rather, the ship's hospital is geared towards the provision of specialised elective surgery for conditions such as head and neck tumours (non-malignant but often slowly progressive and obstructing), clefts, goitres, meningo-encephaloceles, cataracts, vesico-vaginal fistulas, burns contractures, club feet and other bony malformations.

One of the most interesting conditions encountered is Noma ("to devour") or Cancrum Oris. It is an opportunistic, necrotising, ulcerative stomatitis. It progresses rapidly from an acute gingivitis to a catastrophic oro-facial gangrene, involving both soft and hard tissues. It is a disease of children living in extreme poverty, probably bacterial, often with underlying malnutrition, poor oral hygiene and an inter-current infection such as measles. The "fresh" phase carries with it a 70-90% mortality. Those who survive undergo a "healing" phase that can leave behind severe deformity. It is these survivors, often with severe physical, social and

emotional disability, who are offered restorative surgery by Mercy Ships, involving specialists in maxillo-facial and plastic surgery, some of whom have vast experience gained over decades with this condition. The surgery often stretches over multiple stages involving various full-thickness skin flaps and bony reconstructions. It is not unusual for several of these episodes to begin with the securing of a difficult airway when there is not already a tracheostomy in place.

Another condition with similar surgical ramifications and anaesthetic challenges is that of Ameloblastoma, an epithelial tumour of dental enamel origin, which, although benign, is nevertheless locally invasive into mandible and maxilla and can lead to slow obstructive death by suffocation and/or starvation.

It was a humbling experience to see the dedication and extraordinary skill of some of these surgeons who have given up many years of Western private practice, but it was even more of a highlight to witness the emotional and spiritual transformation of these kids over a few weeks. A similar transformation is



undergone by the women having repairs of their chronic vesico-vaginal fistulas.

I can honestly say that my interest in volunteering was not a purely altruistic one, since there was much to be gained personally! I found the experience valuable for its many challenges and rewards. I enjoyed the high paediatric case-load and frequent (anticipated) difficult airways. It was probably “good for the soul” to learn to cope without the help of dedicated anaesthetic assistants, and it made me return to Australia with a new appreciation for our own system in terms of ease and safety.

It was refreshing to work in a multi-national, multi-lingual environment of extraordinary unity of purpose. And it was a novel experience to work with other independent anaesthesia providers who were not medical practitioners.

It was immensely satisfying to be involved with surgery that was, in almost all cases, life-saving, if not literally, then certainly in social and emotional terms, because most patients had

conditions that led to their ostracism and exclusion from African society, and even their own families as a result (in part) of animistic religious values.

Since Liberia, the ship has been in Benin (for 2009) and is expected to operate in Togo for 2010, where I hope to join it for a further short tour of duty.

I would highly recommend Mercy Ships to any anaesthetist who is at consultant or senior registrar level, with a flexible work attitude being the key attribute, I believe.

Finally, my experience in this multi-national setting has made me appreciate that the training I have received in the Australasian setting is second to none.

To find out more about volunteering opportunities with Mercy Ships visit www.mercyships.org.au

Previous page: Dockside, West Africa; UK and Korean anaesthetists waiting for an infant to awake after repair of meningo-encephalocele.

Opposite page: This ship represents hope to thousands of West Africans; A case of meningo-encephalocele.

This page: Slums; A roadside billboard; Presentation of benign facial tumour at screening.

ANZCA Trials Group – Strategic Directions Workshop



Experts meet to discuss research priorities

One of the key aims of the ANZCA Trials Group is to develop new multi-centre trials to solve important problems in anaesthesia, perioperative medicine and pain medicine.

To this end, the trials group held its inaugural Strategic Directions Workshop on October 9, 2009 at the College's headquarters in Melbourne. The workshop was attended by researchers who are already collaborating in the group's multi-centre trials and Fellows who are interested in contributing in the future.

The workshop was led by David Story (Chair, Trials Group Executive) and was co-ordinated by Stephanie Poustie (Trials Group Research Co-ordinator).

The workshop included presentations from Associate Professor Kate Leslie on research at ANZCA, Associate Professor David Story and Professor Paul Myles on the current multicentre trials (ENIGMA-II, ATACAS) and audits (REASON) and Ms Jill Humphreys (Executive Officer, ANZCA Foundation) on research funding opportunities.

However, most of the day was spent discussing a series of proposed ANZCA Trials Group research projects that came from established and new researchers alike. Each project was presented and then vigorously discussed. Topics for new trials included:

- Deep anaesthesia and long-term mortality.
- Incidence and risk factors for persistent post-operative pain.
- Teaching and learning interdisciplinary teamwork.
- Aspirin/clonidine to prevent perioperative cardiac morbidity.
- Optimal sedation for colonoscopy.
- Echocardiography and perioperative mortality in #NOF.
- Low versus high volume fluid management.
- Restrictive or liberal blood transfusion and mortality (two proposals).
- Dexamethasone for antiemesis and postoperative infection.
- Predicting difficult intubation.
- TAP blocks and pain outcomes after abdominal surgery.
- Anaesthesia technique and outcomes from ERCP.
- Postoperative surveillance and intervention.
- Preoperative nutrition.

Subsequently, the proposed trials will be ranked in order of priority, detailed protocols will be developed and high-level funding will be sought. The Trials Group plans to conduct annual workshops to evaluate the progress of trials and to develop new projects.

The workshop proved to be an exciting and productive day. It was a great opportunity for old collaborators to meet up and for new collaborations to be fostered.

The future of research by ANZCA Fellows looks bright. Any interested Fellows are encouraged to contact the Trials Group Research Co-ordinator, Stephanie Poustie, via e-mail (spoustie@anzca.edu.au).

Attendees at ANZCA Trials Group Strategic Workshop

D Bramley (VIC)
T Brussell (ACT)
D Campbell (NZ)
D Canty (TAS)
M Chan (Hong Kong)
A Davidson (VIC)
E Hessian (VIC)
A Jeffries (VIC)
S Jenkins (SA)
R Kerridge (NSW)
K Leslie (VIC)
T McCulloch (NSW)
P Myles (VIC)
T Painter (SA)
P Peyton (VIC)
D Potgieter (ACT)
B Silbert (VIC)
P Sivalingam (QLD)
F Stapelberg (NZ)
D Story (VIC)
S Walker (NZ)
L Weinberg (VIC)
SJ Yap (NSW)
D Hannah (NSW)

Top, from left: Douglas Campbell, Matthew Chan and Pal Sivalingum; Su Jen Yap, David Bramley and Elizabeth Hessian; David Canty and workshop participants.

National registration and accreditation scheme – time to consider your CPD standing



A national scheme for the regulation of health practitioners within Australia is to be introduced from July 1, 2010. The scheme will incorporate a public national register for each medical profession and national boards have been set up to exercise regulatory functions, with the structure supported by state and territory boards.

Legislation to enable the implementation of the national scheme (Bill B) has been drafted and is being introduced for consideration into state and territory parliaments. Some of the key features of the scheme are mandatory reporting, criminal history and identity checks, simplified complaints arrangements, independent accreditation processes, privacy protections for practitioners and consumers, and **mandatory continuing professional development**.

In 2007, the ANZCA Council decided to replace the Maintenance of Professional Standards (MOPS) program with an updated Continuing Professional Development (CPD) program that would better reflect best practice in professional education.

The ANZCA CPD program was mandated from January 2009 for the following reasons:

- an ongoing need to demonstrate to government, key stakeholders and the community that anaesthetists are serious about maintaining the highest clinical standards and providing the best outcomes for patients.
- a mandatory CPD program is an important expression of that commitment to high standards.
- national registration being introduced in Australia, and participation in a formal CPD program being a compulsory element of registration.
- the need to place ANZCA on the same level as other medical Colleges, professional organisations and countries that have mandated continuing professional development programs.

CPD requirements for medical practitioners will be set by the relevant national board. Registered health practitioners (not students) will be required to demonstrate that they have participated in a CPD program as determined by their national board when they renew their registration annually. A health practitioner granted non-practising registration will not be subject to CPD requirements, as it is a standard condition that he/she not practise the profession.

With this scheme being introduced in July 2010, the College is encouraging all Fellows and affiliates of the College to reconsider their CPD standing now and register for the program either online or offline to meet the mandatory requirements needed for next year.

There are many benefits of the new CPD program and one is that you are able to access your online portfolio, add your CPD plan and activities then print off your own statement of participation whenever you need it. If you are participating offline you can still access an annual summary form online, complete it and send to the College for your statement or again print it yourself.

The CPD unit is able to help and advise you on the CPD program and help you enrol as soon as possible. The CPD Co-ordinator, Sara Habib can be contacted at the College at cpd@anzca.edu.au or on +61 3 9510 6299.

For further information on the National Registration and Accreditation Scheme visit www.nhwt.gov.au/natreg.asp.

Dr Frank Moloney
Chair, ANZCA CPD Committee

Dr Jamin Mulvey: Philippines floods – lending a hand



It was a week of unprecedented disaster in South-East Asia and the Pacific. On Saturday September 26, 2009, Typhoon Ketsana battered the coastline of the Philippines causing devastating flooding around Manila and killing about 200 people. Three days later, on Tuesday September 29, a tsunami destroyed countless villages and killed about 140 people in Samoa. Then the next day the Indonesian island of Sumatra was struck by earthquakes, killing more than 1100 people.



With such widespread destruction, it would take an unprecedented relief effort from volunteers and aid agencies to provide assistance to the people of these countries.

My understanding of such disasters – the destruction that goes hand in hand, and the international relief effort that follows – has increased dramatically since I first became involved in aid work in 2005. At that time, working for Australian Aid International (www.aai.org.au) a non-government, volunteer-based, relief organisation, I was deployed to Pakistani Kashmir for two months after earthquakes killed more than 80,000 people and injured more than 100,000.

This time, watching news reports about the flooding and displacement of about 750,000 people in the Philippines – prior to the Samoan and Indonesian crises – I was wondering whether AAI (for which I am on the volunteers list) would be involved in the humanitarian relief effort.

It wasn't long before I received my first phone call. The Samoan tsunami had hit the day before, and Queensland Health was preparing an aid response.

With my anaesthesia training and work commitments, I'm not usually in a situation to be readily deployed for aid work and you can't exactly arrange holidays in advance for these things. However, after talking to Dr Peter Moran, the Director of Anaesthesia at Princess Alexandra Hospital (who was incidentally on standby for deployment to Samoa) he kindly organised leave for the Philippines response.

Arriving in Manila a few days later, I hit the ground running.

The initial Disaster Assessment Response Team (DART) of AAI had arrived three days earlier; securing supplies, meeting governmental health officials, performing needs assessments, and devising a health care strategy in conjunction with the United Nations and World Health Organisation (WHO).

Our area of response was about 50km from the outskirts of Manila around Lake Laguna, the second-largest lake in South-East Asia, where the shoreline had shifted inland about 500m to 1km. As a consequence, with dense populations living around the lake, 125,000 families were displaced and the lack of clean water, sanitation, food supplies and electricity was having a huge impact.

We started clinics in the evacuation centres around Lake Laguna at San Pedro, seeing about 400 people a day. Our response team consisted of two AAI doctors, two AAI nurses, one local doctor and three local midwives.

Due to the nature of this disaster (compared with earthquakes and tsunamis which have high trauma loads) my anaesthesia skills were not required. However, my general medicine, primary healthcare, paediatric and infectious disease knowledge and skills were heavily tested.



Fearing outbreaks of infectious disease, we recorded all cases seen at the clinic, reporting back to WHO on a daily basis. With these disease surveillance methods, we were able to identify outbreaks of Leptospirosis-related acute gastroenteritis in our region. This enabled specific treatment and prevention programs to start, aiming to reduce morbidity and mortality.

Unfortunately, with flood waters not likely to subside for three months, outbreaks of vector-borne diseases, such as malaria and dengue, are almost unavoidable as mosquitoes re-establish themselves after the flooding.

Returning back to Australia after only nine days, I felt as though relatively little was achieved. It's easy to be overwhelmed in these mass disasters, but every little bit helps. It's not the individual effort that counts, but the combined, organised, collaborative effort of many that makes the difference.

AAI and other aid organisations are continuing their work in the Philippines, now focusing on medium- to long-term health care issues. As with all non-governmental aid agencies, they can only continue their work through donations and volunteer assistance.

Always challenging and rewarding, I would encourage ANZCA trainees and Fellows to enlist as volunteers for such relief missions.

AAI has programs in Timor, Indonesia, Philippines, and Burma; but keep your passport ready, as you never know where disaster will strike next.

Dr Jamin Mulvey,
MBBS(Hons) BSc(Hons)
Advanced Anaesthesia Trainee
Department of Anaesthesia, Princess
Alexandra Hospital, Brisbane

“Fearing outbreaks of infectious disease, we recorded all cases seen at the clinic, reporting back to WHO on a daily basis.”

From left: The medical relief team with members from AAI, the United Nations and local health officers; Extensive flooding to communities from typhoon Ketsana; Dr Jamin Mulvey reviewing patients at temporary clinics; Local children at San Pablo district evacuation centre.

ANZCA teachers: what's new in 2010?

WHY review and re-design the clinical teacher support and training activities?

The College is reviewing and redesigning the way in which it provides support and training for those involved in the delivery of clinical teaching to ANZCA trainees. This review is in parallel with the ANZCA Curriculum Review which is described on the following page.

WHO is conducting the review and re-design process?

A Clinical Teacher Development Working Group (CTDWG) has been appointed to oversee the review process and this group reports directly to the Education and Training Committee (ETC) of ANZCA Council. Chairing of the CTDWG and coordination of the overall review process is the responsibility of the ANZCA Education Development Unit (EDU).

WHERE is the review up to?

The CTDWG has provided the input and direction for the development of the new *ANZCA Teacher Course* to be delivered in 2010 throughout all ANZCA regions and nations. This exciting initiative will comprise two components:

1. ANZCA Teacher Course – Foundation Level

In 2010 the *ANZCA Teacher Course - Foundation Level* will be piloted in three locations - Victoria, New South Wales and New Zealand. The *ANZCA Teacher Course - Foundation Level* will be a 2 ½ day course and will equip participants with the fundamental skills, knowledge and professional behaviours to teach ANZCA trainees effectively.

WHO is the ANZCA Teacher Course – Foundation Level suitable for?

Anyone involved in teaching ANZCA trainees, in particular those who have received little or no formal training in teaching in the clinical environment.

Note: As 2010 will be a pilot year, numbers will be strictly limited. Regions will be asked to nominate a specified number of interested Fellows to attend.

2. ANZCA Teacher Course – Advanced Level

Two new Advanced Level options will be offered in 2010 in addition to the current suite of topics. The *ANZCA Teacher Course – Advanced Level* will be delivered face-to-face as a one-day workshop in all ANZCA regions, New Zealand, Malaysia, Singapore and Hong Kong.

WHO is the ANZCA Teacher Course – Advanced Level suitable for?

Fellows who have attended CTC Workshops previously, those who hold a formal ANZCA position of teaching responsibility, or anyone involved in teaching ANZCA trainees.

NB: The *ANZCA Teacher Course – Advanced Level* will supersede the current Clinical Teaching Course (CTC) workshops.

HOW can I find out more or register my interest?

For a full summary and up-to-date information visit the clinical teacher review homepage:
www.anzca.edu.au/edu/projects/teaching-review/clinical-teacher-development-anzca-training-programme.html

For ANZCA teacher course dates, locations and to register your interest visit: www.anzca.edu.au/edu/teacher-programme/teacher-course/anzca-clinical-teacher-course.html

For further information, e-mail the Education Training and Development Manager, Felicity Hutton:
fhutton@anzca.edu.au



ANZCA Curriculum Review: latest update

WHY is there a review?

The College initiated the review of the ANZCA training program in 2008, to ensure the curriculum remains contemporary, and that ANZCA trainees are experiencing the highest quality teaching and learning opportunities.

WHO is conducting this review?

A Curriculum Review Working Group (CRWG) was appointed to oversee the review process and this group reports directly to the Education and Training Committee (ETC) of ANZCA Council. Chairing of the CRWG and coordination of the overall review process is the responsibility of the ANZCA Education Development Unit (EDU).

WHERE is the review up to?

The Submissions

The CRWG had their first meeting in August 2008, where principles and plans for the review process were established. The ANZCA Curriculum Review Submissions Process was then undertaken by the CRWG from October 2008 to January 2009 (inclusive), with invitations sent to key stakeholders. The CRWG was pleased to receive a total of 132 submissions from a diverse range of stakeholders, including ANZCA committees, Fellows, trainees and staff; and a broad set of external stakeholders,

such as other colleges, anaesthetic associations, and various government/regulatory bodies.

The second meeting of the CRWG was held in March 2009, where analysis of the submissions commenced. The submissions were then made publically available on the ANZCA website in July 2009, to stimulate discussion and debate on the training program within the Fellowship and trainee body.

The Survey

The analysis of the submissions, and input from related subcommittees and working groups of the ANZCA ETC, were then used to create the ANZCA Curriculum Review Survey; which was designed as a further opportunity for ANZCA Fellows and Trainees to voice their opinion on the future of anaesthesia training. The survey was open for six week (from September 21 until October 31, 2009) and was available online and in hard-copy. ANZCA Fellows and trainees received the survey via post and e-mail, and the survey was also promoted through all College media (i.e. ANZCA Bulletin, E-Newsletter, Trainee Newsletter and on the ANZCA website homepage). More than 2000 survey responses were received, representing an overall response rate of over 35 percent.

WHAT will happen next?

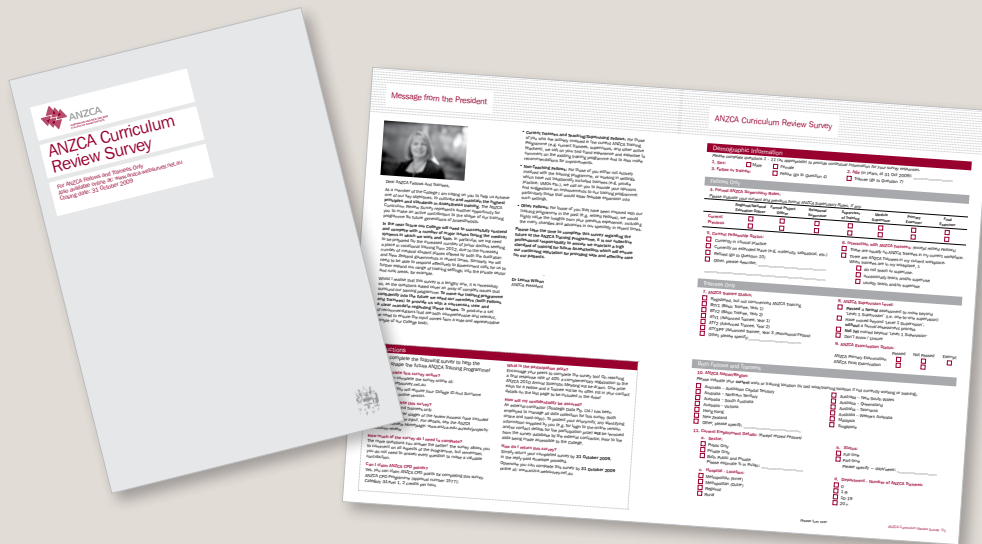
The next meeting of the CRWG was in November 2009, to analyse the survey responses and begin drafting outcomes of the review. The official dissemination of the ANZCA curriculum review outcomes will take place at the 2010 ANZCA Annual Scientific Meeting. The outcomes of this review are anticipated to include: a new ANZCA Curriculum Framework, and a set of recommendations for change to the ANZCA Training Program. Following the conclusion of the review, a process of redevelopment and implementation will need to be undertaken, with the future ANZCA training program expected to be launched in 2012; coinciding with an expected significant increase in vocational trainees.

HOW can I find out more?

For a full summary and up-to-date information on the curriculum review project, visit:

www.anzca.edu.au/edu/projects/curriculum-review

For further information, e-mail the Education Development Unit education@anzca.edu.au



Changes to the ANZCA in-training assessment (ITA) process in 2010

The purpose of the ANZCA in-training assessment (ITA) process is to help trainees to continue to learn effectively and progress successfully through their training program. It is intended to be a negotiated process in which the trainee and supervisor of training (SOT) agree goals or steps that are appropriate to the trainee's particular level of achievement.

The goals of the ITA have been summarised as follows:

- Discuss and set appropriate educational and clinical goals for the training term;
- Assess trainee progress towards obtaining these goals and assist the trainee in achieving these objectives;
- Provide the trainee with regular feedback; and
- Develop any remedial activities that may be required.

The College is engaged in a curriculum review project¹ and recommendations from the review are being formulated. A revised training program will be implemented from 2012. In the interim, a review of the ITA process has been conducted. The goal of this ITA review is to lay the foundation for further curriculum change, particularly in relation to ANZCA's curriculum framework and the implementation of a formal suite of workplace-based assessment tools.

The ITA review was initiated in response to feedback from SOTs and trainees. The planned changes have been developed by the Workplace-Based Assessment Subcommittee (WBASC) whose members include SOTs, a regional education officer (REO), and a trainee, in addition to other Fellows and College staff.

What is changing?

- The Approved Vocational Training (AVT) and ITA-2 Forms are being amalgamated into a single form (the ITA Form). This will reduce duplication for supervisors and trainees. The ITA Form will now include details of the trainee's training and thus **must** be submitted to the College so that this time can be counted towards training.
- The content of the ITA Form has been revised to include:
 - A criteria that allows a more comprehensive description of trainee performance. These have been designed to allow SOTs to provide more specific and detailed feedback to trainees on all areas of their clinical practice.

- Documentation of the initial, mid-term (where required) and end-of-term interviews with prompts for the SOT (e.g. modules completed/planned).
- A global assessment of trainee performance to indicate whether they are performing at a level consistent with their stage of training.

Feedback from SOTs indicates that the areas listed in the ITA Form are too "blunt" to provide a helpful description of trainee performance (particularly in non-technical areas such as communication and teamwork). The descriptors have been improved to make them more useful in describing trainee performance; hence allowing SOTs to give more helpful feedback to assist trainees to develop and improve.

As the new curriculum will be based on the CanMEDS framework², the descriptors in the new ITA Form are based on the CanMEDS roles. These roles have been developed into a revised curriculum framework that is tailored to the contemporary practice of anaesthesia. This is a first opportunity to apply this framework in a meaningful way.

- The ITA-1 Form has been redesigned and is now called the ITA-Short Form (ITA-SF).
- The use of the ITA Form for trainee self-assessment is no longer mandatory. The College supports the idea of trainees reflecting on and assessing their own performance. However, the implementation of this process has been variable and is not regarded as useful by many SOTs and trainees.
- The College will provide greater support for Supervisors of Training and regional/national education officers in the case of an unsatisfactory performance in the ITA process. The global assessment allows the SOT to indicate to the trainee whether his/her performance is at the level expected for the stage of training. If the answer is "no" or "borderline" then this acts as a trigger to ensure that the trainee's performance is being managed according to the TE18 *Guidelines for Assisting Trainees with Difficulties*³ process. The Training and Assessments Unit at the College will also monitor this global assessment and, if the trainee is not performing at the level expected, will contact the SOT and the REO/NEO to provide support to them in undertaking a remediation process to help the trainee improve.

- During 2010, the College will also develop an on-line process for completing and submitting the ITA Form.

What is not changing?

- The current end of term assessments (polling of three senior staff or a consensus meeting of senior staff) will continue. In addition, individual SOTs and departments may, if they wish, select additional methods for assessing trainees. This is in recognition that many SOTs already use tools like the Mini-Clinical Evaluation Exercise (Mini-CEX) or forms they have developed themselves. The College will provide examples of such forms and toolkits with practical information about how to use them. Ongoing educational development work will continue in 2010 and 2011 to investigate and agree a set of observation tools which will, in the future, be recommended for use for all trainees.
- TE18 *Guidelines for Assisting Trainees with Difficulties*³ and the trainee performance Review⁴ Processes will remain unchanged.
- Other aspects of the ITA Process will also remain unchanged.

More information about the changes will be posted on the College website, along with the new forms, frequently asked questions and toolkits for SOTs with practical tips to assist them with the revised process. Personalised communication will also be sent to all SOTs and trainees outlining the changes.

Feedback is welcome and further information can also be provided on request by contacting either **Dr Lindy Roberts** or **Greg Pain** at gpain@anzca.edu.au.

Lindy Roberts

Chair, ANZCA Workplace Based Assessment Subcommittee

Greg Pain

ANZCA Director, Training and Assessments

Mary Lawson

ANZCA Director of Education

1. Lawson M & Byrne C. ANZCA Curriculum Review: Your questions answered. ANZCA Bulletin September 2009, pp 54 - 56
2. What is meant by CanMEDS? G Goulding. ANZCA Bulletin June 2009, pp 56 - 57
3. College Professional Document TE18 Guidelines for Assisting Trainees with Difficulties www.anzca.edu.au/resources/professional-documents/training-educational/te18.html
4. College Regulation 33 Trainee Performance Review www.anzca.edu.au/resources/regulations/regulation-33.html



Professor Paul Myles and Dr Guy Haller

Using an incident reporting system to improve anaesthetic care: a study on undesirable events at the beginning of a new year

Patient safety is the avoidance, prevention, amelioration of adverse outcomes or injuries stemming from the processes of health care.¹ However, one can only manage what one can measure. The speciality of anaesthesia has been at the forefront of many developments in patient safety measurement and particularly in the use of incident reporting systems, an achievement originally developed in Australia.² These systems are widely used by anaesthesia departments around the world.

The Alfred Hospital (Melbourne, Australia) anaesthesia department developed a computerised reporting system as part of an ongoing quality assurance (QA) program in 1993. The system includes not only intraoperative incidents but all other patient information such as demographic characteristics, past medical history, current health status, medication usage, ASA score; type of procedure, timing, duration, and emergency status; as well as information on staff characteristics and level of supervision. A follow-up at 24 hours is routinely done for most inpatients and complication and patient satisfaction information are collected.

This system has proven to be very successful with a completion rate of 94% and a sensitivity/specificity for intraoperative incidents of 80% and 91%, respectively.³ It has allowed the investigation of several important clinical issues⁴⁻⁸ and more particularly the study of the impact on patient safety of introducing new trainees in hospitals at the beginning of the academic year.⁹

Common wisdom suggests an increase in the rate of undesirable events at the beginning of the academic year for anaesthesia trainees in teaching hospitals. This phenomenon is commonly termed the July phenomenon in the United States and the “killing season” in the United Kingdom^{1,11}. However, available data regarding this phenomenon have been equivocal.¹²⁻¹⁴

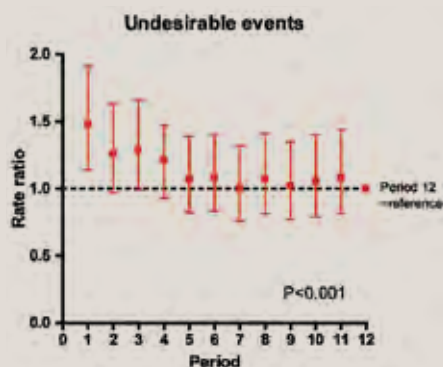
We recently published a study on this subject in the *British Medical Journal*,⁹ utilising our existing QA database. We compared the rate of undesirable events during or after procedures performed by new trainees at the beginning of the academic year with the rest of the year. This was a retrospective cohort study of 19,560 patients over a five-year period. All patients having an anaesthetic procedure carried out by first to fifth year trainees starting work for the first time at the Alfred Hospital were assessed.

We found that the rate of undesirable events was higher at the beginning of the academic year compared with the rest of the year (absolute event rate 137 v 107 per 1000 patient hours, relative rate reduction 28%, $P < 0.001$). The overall adjusted rate ratio for undesirable events was increased by 40%:

Training year	Rate/1000 patient hours (no. of events)		Rate ratios of undesirable events with first period compared with rest of year
	First period	Rest of year	Adjusted rate ratio† (95% CI)
year 1	130 (288)	108 (1130)	1.31 (1.11 to 1.55)
year 2	134 (35)	89 (46)	1.69 (0.94 to 3.04)
year 3	198 (13)	168 (71)	1.19 (0.53 to 2.71)
year 4	128 (89)	111 (467)	1.25 (0.92 to 1.68)
year 5	152 (168)	92 (365)	1.78 (1.39 to 2.29)
All years	137 (593)	107 (2079)	1.40 (1.24 to 1.58)

†Adjusted for case mix of patients (age, sex, ASA physical status score, comorbidities), type of surgery, and characteristics of anaesthetic procedure (type, duration, emergency status, time of day, and mode of supervision)

This excess risk was seen for all levels of training ($p < 0.03$). The excess risk decreased progressively after the first month, and the trend disappeared fully after the fourth month of the year:



It should be emphasised that some of the reported undesirable incidents were near misses or otherwise well-managed by trainees or their supervising consultants, and so did not result in patient harm. This does not however detract from the key findings of the study.

Not only was the suspected increased rate of undesirable events at the beginning of the academic year confirmed, but it was also found that the phenomenon was present regardless of trainees' level of clinical experience. This challenges the common view that professional expertise relies solely on medical knowledge, technical skills, and clinical judgment.¹⁵ Adequate (new) staff orientation, knowledge of the specifics of the working environment, and awareness of teamwork-related factors may also contribute strongly to trainee performance and patient outcome.

These results imply that improving trainees' orientation and integration, regardless of their level of clinical expertise, during their first weeks of employment is crucial. Advanced trainees should benefit from the same level of close supervision (1:1) usually reserved for first year trainees. Crew resource management programs such as those developed in aviation could also be used to improve team coordination and interprofessional collaboration early in the academic year.¹⁶⁻

¹⁸ Simulator training may also enhance improvements in junior trainees' technical and teamwork skills.

Indeed, since the study data were collected, the Alfred hospital's Department of Anaesthesia and Perioperative Medicine has made several changes to improve orientation and supervision of its new trainees. We provide 24 hour in-house consultant cover at all times, and minimise consultant leave through February. All incoming trainees are provided with a full-day orientation program before starting their clinical work. Trainees also are given information about intranet-based protocols and guidelines, and important procedures as to what they should do in case of any emergency. Airway workshops and other high-fidelity simulation days are offered early in the academic year. Further studies are planned to assess the overall impact of these initiatives.

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The propofol controversy

Since the untimely death of Michael Jackson, the use, as a sedative, of the anaesthetic agent propofol with its narrow therapeutic margin of safety is being reviewed, certainly in the USA. It is agreed that specialist anaesthetists are unable to service the large volume of endoscopic procedures and that other members of the medical workforce need to be trained to ensure proper assessment, safe clinical practice and the ability to handle crises. An article in the recent *ANZCA Bulletin*, "Training non-anaesthetist sedation practitioners-living with PS9" by Joanna Sutherland and Cate McIntosh¹ describe a program undertaken to address these issues. Although it is specifically stated in the College document that the proceduralist must not also administer the sedative drugs, what is not clarified is whether these "grandfather" gastroenterologists are in fact "operator anaesthetists" when propofol is employed, irrespective of whether "conscious sedation" can ever be assured with this drug.

In the news section of the *British Medical Journal*² Fred Charatan of Florida raises the issue of the increase in propofol addiction among health professionals associated with its wide use in "sedation" as well as anaesthesia; this point is supported by the American Association of Nurse Anaesthetists who have raised concerns

over the easy access. Consideration is being given to applying the same level of control as with opiates. Paul E Wischmeyer et al³ undertook a survey of 126 academic anaesthesiology training programs in the US and found a fivefold increase in propofol abuse over previous surveys. Trainees were the most vulnerable and one explanation may be (as with Michael Jackson) that, for a person under stress, an apparently normal sleep can be rapidly induced along with an awakening relatively devoid of after effects.

Restriction of the use of propofol is not suggested but all procedural areas including endoscopy suites with their rapid turnover will increasingly need to have in place adequate strategies for the control of the drug, particularly in view of the now extensive use by non anaesthetists.

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ECRI Alerts

October – Normal Priority

Physio-Control-LIFEPAK 15 Biphasic Monitor/Defibrillator

A recent alert from the ECRI Institute (www.ecri.org/Pages/default.aspx) concerns the Physio-Control-LIFEPAK 15 Biphasic Monitor/Defibrillators where the non invasive blood pressure may be disabled if there is bumping or squeezing of the cuff resulting in a display of XXX instead of a valid reading of the NIBP. In this situation the device must be powered off and back on. The problem does not affect defibrillation or other functions of the monitor. Physio-Control have upgraded all units in the US but it is not clear whether this has yet occurred in Australia or New Zealand.

November 6 – Critical Priority

BD/Acacia-Q-Syte Luer Access Split-Septum Needleless Intravenous Connectors: May Allow Air Bubbles to Enter Infusion System, Potentially Resulting in Air Embolism

This alert concerns the BD/Acacia-Q-Syte Luer Access split-septum needleless intravenous connectors. BD states that it has received complaints of air bubbles leaking into the infusion system through the above connectors. This problem may result in an air embolism in a patient with a central venous catheter. The manufacturer has not confirmed the geographich



distribution of the affected product. ECRI Institute recommends that you check your inventory for this product regardless of where you are located, and isolate the affected product from your inventory.

November 13 – High priority

ZOLL—M Series Defibrillators: Unsecure Connection between Paddles and Cables May Delay Therapy

This alert concerns the Zoll-M series defibrillators. In rare cases, Zoll-M Series multifunction cable (MFC) connectors may fail to securely attach to M Series external defibrillator paddles, potentially permitting inadvertent disconnections that could delay treatment. Currently, ECRI Institute has no reason to believe that this is a widespread problem. Nevertheless, given the risk that the problem may go unnoticed before clinical use, ECRI Institute believes that users should verify proper connections between cables and paddles during the manufacturer-recommended shift check.

Philips—IntelliVue Monitors and Multi-Measurement Server (MMS) Monitoring Modules: Module to Monitor Connector Damage May Impede Monitoring

This alert concerns the Philips—IntelliVue Monitors and Multi-Measurement Server (MMS) Monitoring Modules. The connector pins of Philips multi-measurement server (MMS) monitoring modules or Philips IntelliVue physiologic monitors may become bent when the modules

are attached to or removed from the monitors, potentially interrupting patient monitoring. In some facilities, such damage is frequent. Philips has indicated its intention to implement design changes to reduce the likelihood of such damage. In the meantime, if clinicians experience problems such as a lack of or intermittent communication between the MMS and monitor, facilities should examine connectors for damage and immediately replace them if required.

GE/Baxter—Tec 6 Plus Desflurane Vaporizers: Internal Rotary Valve May Fail Prematurely, Potentially Causing Over- or Underdelivery of Anaesthesia

This alert concerns the Philips the GE/Baxter—Tec 6 Plus Desflurane Vaporizers. The UK Medicines and Healthcare Products Regulatory Agency (MHRA) has issued a Medical Device Alert (MDA/2009/072) warning healthcare workers that the internal rotary valve of the above vaporisers may fail prematurely. While the failure rate is low, it is higher compared to other types of vaporisers. MHRA states that because many perceive that anaesthetic vaporisers are extremely reliable, anaesthetists may mistakenly believe that the anaesthetic agent monitor failed and continue to use faulty vaporisers. This problem may result in over- or under-delivery of anaesthetic agents. MHRA recommends that you identify any affected vaporisers in your inventory. Ensure that users are aware of

the increased failure rate of the affected vaporisers. MHRA also recommends that you have procedures in place to ensure that the vaporiser's performance is closely monitored, the vaporiser is replaced immediately if any problem is suspected, and that the vaporiser's performance is checked regularly.

To view ECRI's full alerts please contact the ANZCA library at library@anzca.edu.au

Managing acute pain safely

Part 1: Opioid-induced respiratory depression

The first in a two-part series, Associate Professor Pam Macintyre and Associate Professor David Scott discuss how to manage acute pain safely.

Surveys published over the last few decades have consistently shown that acute pain management is often suboptimal.

This has led to an increasing use of more sophisticated methods of pain relief in general hospital wards and in ambulatory settings, as well as an increasing emphasis placed on the need to assess pain on a regular basis. Assessment of pain as the “fifth vital sign”¹ has been promoted as an essential component of acute pain management and one that should be routinely recorded in conjunction with measurements of respiratory rate, blood pressure, pulse and temperature.

Much less emphasis, however, has been placed on the need to monitor for the early onset of significant side effects related to treatment – in particular, opioid-induced respiratory depression.

Without such monitoring, safe management of acute pain using opioids is not possible. Use of an unbalanced strategy for pain management, which emphasises the need for better pain management and lower pain scores without stressing the need for appropriate patient monitoring, can and will lead to an increase in adverse events².

As well as appropriate monitoring, there must also be suitable lines of communication whereby nursing staff can relay their concerns, as well as proper and timely responses to any abnormalities detected.

If problems are detected at an early stage it will increase the chance of avoiding significant and permanent patient harm. The information below therefore aims to summarise current knowledge relating to the assessment of opioid-induced respiratory depression.

Opioid-induced central nervous system depression

Opioids administered by any route have central nervous system depressant effects as well as analgesic effects. The focus of attention has tended to be on respiratory depression (altered response of the respiratory centre to carbon dioxide) although as is discussed below, the effects on conscious state are tightly linked to this and are equally important.

There remains significant confusion about the best method of monitoring for respiratory depression related to administration of opioids. While measurement of arterial PCO₂ levels is the most sensitive and accurate, it is not possible in most patients, particularly on a regular basis.

Over recent years, the question of how best to monitor for opioid-induced respiratory depression has been debated in a number of publications including in newsletters of the Anesthesia Patient Safety Foundation (APSF) from the US.

Detecting respiratory depression

One article³ summarised the conclusions of a workshop convened by the APSF to look at improved recognition of postoperative opioid-induced respiratory depression.

Included was a summary of the sensitivity, specificity, reliability, response times and costs of a number of methods of monitoring ventilation and/or oxygenation: respiratory rate, tidal volume, continuous measurement of oxygen saturation and end-tidal CO₂, blood gas analysis, minute ventilation and chest wall impedance.

Despite recognising the limitations of available monitors, and despite the low sensitivity of continuous pulse oximetry in patients given supplemental oxygen (common in many countries), the recommendation of the APSF was for “the use of continuous monitoring of oxygenation (generally pulse oximetry)

and ventilation in non-ventilated patients receiving PCA, neuraxial opioids or serial doses of parenteral opioids”³.

An editorial in a more recent APSF newsletter by Stoelting & Weinger, 2009⁴ reiterated the APSF stance and stated that continuous use of pulse oximetry should be “the routine rather than the exception”.

They suggested this only for patients receiving PCA or neuraxial opioids. However, there is no evidence to suggest that respiratory depression following these methods of opioid administration is any greater than following opioids given by other routes of administration⁵.

Reliability of oxygen saturation monitoring

But just how reliable is oxygen saturation (as measured by pulse oximetry) as an indicator of respiratory depression?

Although it is an easy and non-invasive measure of blood oxygen levels, care must be taken in the interpretation of any readings because these may not reflect respiratory drive. If the patient is receiving supplemental oxygen, the added oxygen may mask deterioration in respiratory function (i.e. “normal” oxygen saturation levels may still be seen in the presence of significant respiratory depression). However, if supplemental oxygen is not used, is it any more reliable? The answer may be “no” as there can be reasons other than opioids for hypoxaemia, especially in the postoperative setting⁶.

Cashman and Dolin reviewed published cohort studies, case-controlled studies and audit reports as well as randomised-controlled trials and used the data to compare patient-controlled analgesia (PCA), epidural analgesia and intramuscular (IM) opioid analgesia in terms of pain relief⁷, nausea, vomiting, sedation, pruritus, and urinary retention⁸ and respiratory and haemodynamic effects⁵.

In the latter paper, the incidence of respiratory depression for the various techniques was reported using a variety of measures – as used by the authors of the studies included in the review. These measures were a decrease in respiratory rate, elevated PaCO₂ levels, the need for administration of naloxone, or decreases in oxygen saturation.

There appeared to be little difference between the analgesic techniques unless pulse oximetry was used – a far greater proportion of patients given IM opioids were reported to have low oxygen saturation levels – 37% of patients given IM opioids compared with 11.5% in patients with PCA. Could IM opioid analgesia really be more likely than PCA to cause respiratory depression?

If the data from the paper on effectiveness of pain relief using these techniques is examined⁷, it can be seen that patients given IM opioids reported significantly more pain (moderate-severe pain in 67.2% and severe pain in 29.1% compared with 35.8% and 10.4% respectively in PCA patients), suggesting that these patients may have received much lower doses of opioids. It is therefore probably unlikely that these patients would have a greater risk of respiratory depression than patients using PCA.

Could hypoxia therefore have arisen for other reasons such as an inability to cough or take deep breaths after surgery, obesity, or fluid overload? Patients can be hypoxaemic and in pain without significant respiratory depression⁶.

So, despite APSF recommendations that have been made suggesting that the use of oxygen saturation monitoring should be mandatory in all patients given opioids, it may not always be a good or reliable indicator of respiratory depression.

Furthermore, it is unlikely that continuous pulse oximetry would be made available (too costly) to all patients receiving opioids – neither as inpatients nor when opioids are required for acute

pain management at home. False positive alarms from overuse would also decrease confidence in the technique.

It is possible that transcutaneous CO₂ measurement may become more common^{9,10} but the same problems that would arise from a requirement for routine use in every patient, including patients at home, would remain.

Therefore, reliance must be placed on other clinical measures.

Respiratory rate or level of sedation?

CNS depression from opioids can lead to respiratory depression, for which respiratory rate can be an unreliable guide, as well as a decreased conscious state manifest by drowsiness, loss of airway tone and ultimately upper airway obstruction.

In 1988, Ready et al¹¹ published their landmark paper on the development of an anaesthesiology-based Acute Pain Service (APS). In the text of that article was a description of four patients who developed respiratory depression after administration of epidural morphine. Two patients were noted to have “marked sedation”; their PCO₂ levels were 63 and 66 mm Hg and the lowest recorded respiratory rates were 11 and 8 breaths/min respectively.

The other two patients were unconscious; PCO₂ levels were 85 and 95 mm Hg and their respective lowest recorded respiratory rates were eight and 12 breaths/min. Note that the patient with the highest PCO₂ also had the highest respiratory rate! Thus their APS developed and used sedation scores (similar to the table below) to routinely monitor all patients given opioids.

The importance of increasing sedation as a clinical sign of early respiratory depression was also highlighted by Vila et al².

This group reported on the introduction and use of a numerical pain treatment algorithm (NPTA) which aimed to improve pain scores in cancer patients – opioid administration was

guided by a patient’s numerical (0 to 10) pain score. As a consequence of this push for lower pain scores, there was a doubling in the incidence of over-sedation or respiratory failure – which was not usually accompanied by a decrease in respiratory rate.

Of the 29 patients who developed respiratory depression (either before or after the introduction of the NPTA), only three had recorded respiratory rates of less than 12 breaths/min; however 27 were noted to have a decrease in their level of consciousness during the 12 hours before the event.

The authors concluded that there was not a predictable decrease in respiratory rate associated with respiratory depression and also noted “an inherent patient safety concern when titrating opioid analgesia to a one-dimensional pain rating scale”.

In another paper reporting on an audit of patients given PCA for pain relief after surgery, respiratory depression was defined as a respiratory rate of less than 10 breaths/min *and/or* a sedation score of two (defined as “asleep but easily roused”) or more.

Of the 13 patients who developed respiratory depression, 11 had sedation scores of two or more. In contrast to the study by Vila et al above, all were reported to have respiratory rates of less than 10 breaths/min¹².

There are other examples of cases where an over-reliance on the use of respiratory rate as an indicator of respiratory depression may have led to problems and where increasing sedation may have been missed.

Reports of life threatening respiratory depression have been published following opioid administration via a number of routes (but especially using IV PCA) and are often used to “demonstrate” the potential danger of opioid administration in patients with obstructive sleep apnoea (OSA).

Managing acute pain safely

Part 1: Opioid-induced respiratory depression

continued

Four of these reports involved the use of PCA: one patient given PCA set to deliver (inappropriately) a background infusion of morphine of 2mg/hr was found unconscious with a PaCO₂ of 94 mm Hg;¹³ another was ‘found to be unrousable’ with a PaCO₂ of 76 mm Hg¹⁴; and yet another was “heavily sedated and hypercapnic”¹⁵.

Respiratory arrest leading to the death of three patients receiving postoperative bupivacaine and fentanyl epidural infusions has also been reported¹⁶. The “usual” sign of respiratory depression was stated, in the discussion, to be a decrease in ventilatory frequency. In another report a patient died after being given IM morphine; over the two hours after IM injection he was noted to be “sleeping” and then “unresponsive”, and an order was given to continue monitoring of “vital signs”¹⁷.

Checking a patient’s level of sedation was considered by the American Society of Anesthesiologists (ASA) Task Force on Neuraxial Opioids to be important in the detection of respiratory depression in patients given neuraxial opioids, as well as assessments of adequacy of ventilation and oxygenation¹⁸. However, it was noted only that “in cases with other concerning signs, it is acceptable to awaken a sleeping patient to assess level of consciousness”.

If a patient is not woken, it would be possible for increasing sedation and respiratory depression to be missed unless the patient was at least roused – see below. This paper also stated, in contrast to the APSF position, that both the taskforce members and consultants “disagree that pulse oximetry is more likely to detect respiratory depression than are clinical signs”.

In the cases mentioned above, would the same outcomes have been seen had sedation been monitored and had excessive sedation (a sedation score of two – see below) triggered some action?

Sedation scores

A number of different sedation scoring systems are available. Whichever is used, it must represent a sensible progression – that is, increasing sedation (i.e. decreasing rousability) and not necessarily things such as cognitive function (e.g. whether or not the patient is confused).

One common sedation scoring system used is that in Table 1. Note that it indicates patients should be roused to assess their level of sedation. If this is not done, the early onset of respiratory depression can be missed, sometimes with fatal results¹⁹. Anecdotally, when arterial PCO₂ measurements have been done on patients with a sedation score of 2 (as defined in Table 1), the levels tend to be higher than 55mm Hg.

Furthermore, the assessment of patients at night when they are “asleep” should be undertaken by simply evaluating their ability to “stir” in response to mild stimulation (e.g. taking a pulse or blood pressure reading) rather than vigorously waking them up (which leads to sleep deprivation and dissatisfaction).

Other monitors

Bedside capnometry devices are available but not in widespread use. They generally work by sampling expired carbon-dioxide through modified nasal prongs and may be used whilst administering supplemental oxygen.

Patient tolerance, expense and reliability beyond a research environment limit their utility. Transcutaneous carbon-dioxide measurements are also not in widespread use and are generally not suited for long-term application.

Summary

In summary, when clinical indicators are used to monitor for opioid-induced respiratory depression, increasing sedation is a more reliable indicator than a decrease in respiratory rate – although both should be measured.

It is recognised that, as with the other potential monitors of respiratory depression discussed by the APSF above, increasing sedation suffers from a lack of specificity and sensitivity. However, is it any worse than the other suggestions?

Monitoring for opioid-induced respiratory depression needs to be available to all patients receiving opioids by any route and in all acute pain settings in both hospitals and at home. Clinical practice would suggest that, in the absence of better clinical monitor, sedation should become the “sixth vital sign”.

It is recognised that there may be a number of other reasons for sedation – including administration of sedatives such as benzodiazepines and some antihistamines (e.g. promethazine). It follows that concurrent administration of sedatives will interfere with the use of sedation scoring as an indicator of respiratory depression but, as they also increase the risk of respiratory depression, they should be avoided where possible.

If a sedation score of two or more is reported, a reduction in opioid dose is mandated, regardless of the patient's pain score. If the patient is uncomfortable, alternative and less sedating forms of pain relief will need to be added to the analgesic regimen.

Table 1: Sedation Scores

0	awake, alert
1	mild sedation, easy to rouse
1.5*	asleep, easy to rouse
2	moderate sedation, easy to rouse, unable to remain awake
3	difficult to rouse

* may not be used in some centres where a score of 1 is used whether or not the patient is asleep

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Medical research boosted by \$600,000



ANZCA has allocated more than \$600,000 to important and exciting research initiatives to commence in 2010. It is hoped that these projects will lead to significant improvements in patient safety and contribute to medical research worldwide. More than 40 applications were received from Australia, New Zealand, Hong Kong, Singapore and Malaysia, and ANZCA was especially pleased to support a Scholarship Grant for a PhD student among the 16 successful applications. Two continuing PhD students were also supported. ANZCA acknowledges and appreciates the many generous contributions made to the ANZCA Foundation that facilitate this important process.

Research award recommendations

The **Harry Daly Research Award** was awarded to **Professor Matthew Chan** for his project “Re-defining the Warning Criteria for Intraoperative Neurophysiologic Monitoring”.

The **Mundipharma ANZCA Research Fellowship** was awarded to **Dr Paul Wrigley** for his project “Regional changes in cerebral perfusion associated with persistent spinal cord injury neuropathic pain”.

The **Pfizer ANZCA Research Fellowship** was awarded to **Professor Alan Merry** for his project “Validation of the ‘WHO Surgical Safety Checklist’ to reduce postoperative morbidity and mortality – The Check WHO Study”.

The **ANS ANZCA Research Fellowship** was awarded to **Professor James Sleigh** for his project “The genetics of the analgesic response to opioids in the post anaesthesia care unit”.

The **JB Craig Research Award** was awarded to **Dr Phillip Finch** for his project “Adrenergic receptor involvement in an animal model of complex regional pain syndrome type I”.

Project Grants

A reappraisal of the sniffing position and the Three Axes Alignment Theory for direct laryngoscopy

What is the best position for the head and neck to manage a patient’s airway? Anaesthetists commonly use the “sniffing position” for tracheal intubation which aligns the oral, pharyngeal and laryngeal axes and produces a line of sight from the anaesthetist’s eye to the patient’s vocal cords. This position has been taught and written in textbooks since its proposal by Magill in 1936 yet there has been little research since to support its current usage until it was contested by Adnet and co-workers in 2001, who concluded using an MRI study that alignment of the three axes was impossible. The current study will repeat Adnet’s paper but substitute two curves – 1) primary curve which is formed when the previously described oral and pharyngeal axes are joined and 2) the secondary curve which is produced from the pharyngeal and laryngeal axes. The researchers expect that the radius of curvatures will increase with the sniffing position and therefore show that there is alignment of these curves with the line of sight proving the sniffing position actually works.

Dr Keith Greenland, Dr Michael Edwards, Royal Brisbane and Women’s Hospital, Australia.

\$15,000

Above from left: Professor Jamie Sleigh; Dr Phillip Finch; Dr Keith Greenland.

Medical research boosted by \$600,000

continued



The genetics of the analgesic response to opioids in the post anaesthesia care unit

After surgery: (i) some patients have little pain, (ii) some patients have a lot of pain but analgesic drugs work well to reduce the pain, and (iii) some patients have a lot of pain but the analgesic drugs don't work very well. Whilst some of this variation can be explained by clinical factors, it is likely a significant proportion of the variation is caused by intrinsic genetic factors. In this study, the researchers will determine whether or not EEG monitoring can predict the requirements for analgesics in the early post-operative period. They are collecting a large quantity of clinical data about pain scores and the effect of drug treatment as well as samples for genetic analysis. Previous work shows that a particular genetic variant of the morphine receptor (A118G) occurs in about 16% of the population and is probably associated with the poor response to morphine. Using the results from this study, the researchers would hope to pursue pre-operative genetic tests to predict exactly who is likely to experience severe – or alternatively little – postoperative pain.

Professor James Sleigh, University of Waikaito, Hamilton, New Zealand.

\$50,000

Evaluation of exercise rehabilitation for survivors of intensive care

Patients who survive ICU commonly suffer from weakness and debilitation. International literature has reported that these patients have reduced physical function and a poor quality of life up to six years following discharge. In this study, all ICU survivors with >5 days ICU stay will be randomised to either a comprehensive physiotherapy rehabilitation program or standard care. Physical outcome measures along with validated quality of life questionnaires will be used to evaluate the rehabilitation program at baseline, three, six and 12 months post discharge from ICU. Cost utility and cost effectiveness of providing a rehabilitation program to survivors of ICU also will be assessed. It is hoped the introduction of a rehabilitation program will improve function and quality of life. This will potentially reduce the burden to patients, their family/carers and the community, allowing better utilisation of resources and an improved quality of life.

Dr Stephen Warrillow, Associate Professor Linda Denehy, Ms Sue Berney, Austin Health, Melbourne, Australia.

\$20,000

Determination of equivalent dose rates of metaraminol and phenylephrine to prevent hypotension during elective Caesarean section under spinal anaesthesia

Vasopressors are frequently given to maintain maternal blood pressure during caesarean section under spinal anaesthesia. Two vasopressors, phenylephrine and metaraminol, are considered the most suitable and effective drugs for maintaining the blood pressure in this setting, however we do not know which is more effective or even by how much exactly their potency differs. In this study, the investigators will randomly assign women to receive either phenylephrine or metaraminol infusion during planned caesarean section. By varying the concentrations given during an infusion over a fixed period, and measuring the effectiveness in maintaining normal maternal blood pressure, dose rates of equivalent potency will be determined. This information is required before a larger well-controlled comparison of the two drugs, powered to detect differences in important clinical outcomes, can be conducted.

Dr Nolan McDonnell, Professor Mike Paech, University of WA, Perth, Australia.

\$10,000

Above from left: Professor Paul Myles; Professor Matthew Chan.

Regional changes in cerebral perfusion associated with persistent spinal cord injury neuropathic pain

Around 50% of patients with spinal cord injury continue to suffer from persistent pain that cannot be relieved by currently available treatments. Improvements in treatment continue to be held back by our lack of understanding as to why some people with spinal cord injury develop pain and others do not. Recent research suggests that changes in the brain are crucial to the problem. This study will examine the long-term changes occurring in the brains of those people that develop neuropathic pain following spinal cord injury. The study will involve 70 people and use a new brain imaging technique called quantitative arterial spin labelling (QASL) to measure brain blood flow as an indicator of brain function. People with spinal cord injury and no pain, spinal cord injury and neuropathic pain and people without spinal cord injury or pain will undergo a single brain scanning session and comparisons will be made between the three groups to determine differences in long-term brain function.

Dr Paul Wrigley, Dr Luke Henderson, Clinical Assoc Prof Philip Siddall, Pain Management Research Institute, Royal North Shore Hospital, Sydney, Australia.
\$45,645

ENIGMA-II trial long-term follow-up study

Nitrous oxide is very widely used internationally. The ENIGMA-II trial is a five-year study of 7000 patients in about 40 hospitals around the world, and is already underway. Patients are randomly allocated to one or two routinely used anaesthetics: either (i) general anaesthesia that includes nitrous oxide, or (ii) general anaesthesia that does not include nitrous oxide. The aim of the follow-up study is to investigate the long term effects of nitrous oxide in these patients. Six thousand patients who are participating in the ENIGMA-II trial will be followed up at 12 months after surgery, to compare the incidence of cardiac complications (including myocardial infarction) and death in those who did and did not receive nitrous oxide as part of the anaesthetic.

Prof Paul Myles, Alfred Hospital, Melbourne, Australia; Associate Professor Kate Leslie, Royal Melbourne Hospital, Melbourne, Australia; Professor Matthew Chan, Chinese University of Hong Kong, PRC.
\$60,000

Validation of the “WHO Surgical Safety Checklist” to reduce postoperative morbidity and mortality - The Check WHO Study

The World Health Organization (WHO) has developed a checklist to make surgery safer by reducing errors and improving team work. A study from eight centres world-wide showed that the checklist reduced patient harm and actually saved lives. Auckland City Hospital was one of the centres, but only four operating rooms were involved, so there were not enough patients to see a significant benefit locally. Furthermore the standard of medical care in New Zealand is already higher than in some of the centres in the WHO study. This new study, using the same measures as before, will compare patient outcomes for 2006-2007 (before the checklist was introduced) with those in 2009-2010 (after its modification and adoption) at the Auckland City Hospital. The research will include enough patients to see whether the benefits of in the international WHO study can in fact be gained with the modified checklist in New Zealand.

Professor Alan Merry, Dr Simon Mitchell, Associate Professor Papaarangi Reid, University of Auckland, New Zealand.
\$51,751

Adrenergic receptor involvement in an animal model of complex regional pain syndrome type I

Complex regional pain syndrome (CRPS) starts after various types of injury, sometimes quite minor, with or without obvious injury to nerves. One explanation for the persistence of CRPS is that an abnormal connection develops between the pain processing system and the sympathetic nervous system. Indeed, research findings support the idea that sympathetic nerves contribute to pain after peripheral nerve injury, has shown that pain-signalling nerves contain adrenergic receptors, and that the density of these receptors increases greatly after peripheral nerve injury. The investigators wish to determine whether the density of adrenergic receptors also increases after injuries that spare major peripheral nerves and will collaborate with researchers from Stanford University to test their hypothesis using an animal model. This research may explain why so many different forms of environmental stimulation aggravate pain and distress in patients with CRPS, and why current forms of treatment are often ineffective.

Dr Philip Finch, Professor Peter Drummond, Professor Jacqueline Phillips, Murdoch University, WA, Australia.
\$47,000

The Australian and New Zealand Registry of Regional Anaesthesia (AURORA Study) (PhD Fellowship)

Many anaesthetists are now undertaking peripheral nerve blocks guided by ultrasound. Identifying problems after regional anaesthesia is challenging because they occur rarely and identifying the root cause of a complication can be difficult. Because ultrasound imaging allows the anaesthetist to image the needle, nerve and surrounding structures it is possible that it may both improve the safety and quality of regional anaesthesia. To determine if this is true, the investigators will collect crucial information describing contemporary practice from a very large number of patients. The internet will be used to facilitate this with an online interface (www.Regional.anaesthesia.org.au) used to collect data into a central database. The investigators plan to determine accurately risks associated with nerve blocks and also factors that influence an individual patient having a complication. Such information has hitherto not been available and will critically inform clinical practice in addition to having public health and health policy relevance.

Dr Michael Barrington, Associate Professor Danny Liew, Dr Rowan Thomas, St Vincent's Hospital, Melbourne, Australia.

\$70,000 per annum for three years

Re-defining the warning criteria for intraoperative neurophysiologic monitoring

Spinal cord monitoring is an established technique to provide real time information on the functional status of the nervous system during spine surgery. This monitoring can detect impending injury so that timely intervention can be applied before permanent damage occurs. Clearly, this requires early recognition of the “warning signals”. Unfortunately, the current recommendation for these critical thresholds has not been validated. The researchers plan to perform a systematic study to determine the threshold changes of monitoring signals, beyond which neurologic deficit occurs in a pig model of spinal cord injury. Appropriate interpretation of these signals will be important to avoid inadvertent spinal cord injury. The impact on patients, their families, and the society as a whole in terms of decreasing the number of patients who become paraplegic after spine surgery will be socially and economically significant.

Professor Matthew Chan, Professor Tony Gin, Chinese University of Hong Kong, PRC.
\$59,438

Medical research boosted by \$600,000

continued

Perfusion levels and correlation of pain processing regions in the brains of chronic pain patients and healthy people

People with chronic pain can experience low mood and are less active. This study will use magnetic resonance imaging (MRI) to look for brain regions that are involved in emotional and behavioural responses to pain. The objective of the study is to identify new options for the management of the negative impact of pain. The project is a collaboration between Melbourne Health, the University of Melbourne and the Florey Neuroscience Institutes.

*Dr Malcolm Hogg, Dr Michael Farrell
The Royal Melbourne Hospital, Australia.*

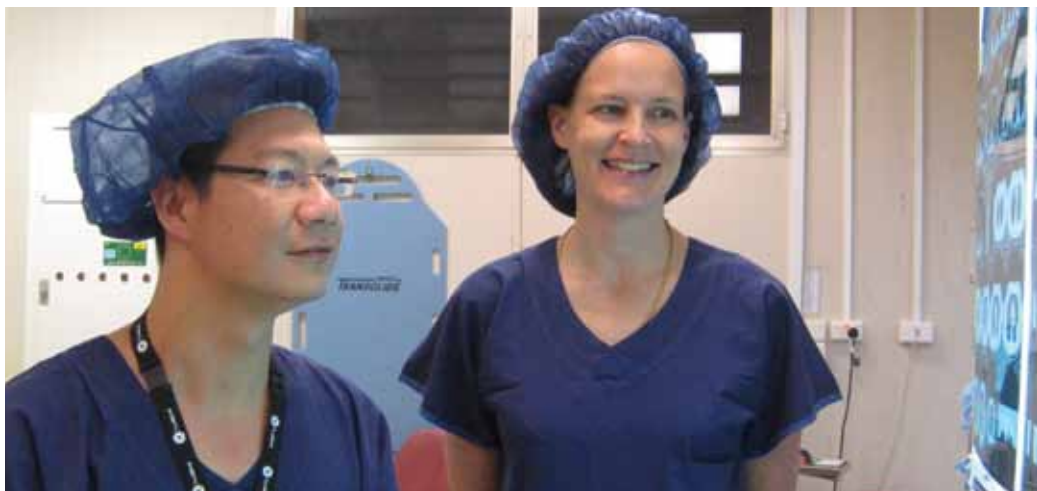
\$40,000

Does remote ischemic post-conditioning reduce ischaemia reperfusion injury in patients undergoing lung transplantation?

Lung transplantation is the treatment of choice for a number of incurable lung diseases, but after new lungs are implanted, a significant number of these lungs will experience primary graft dysfunction (PGD). PGD is caused by a number of factors including the period when the donor lungs are ischaemic and the unstable period when the new lungs are first reperfused. The aim of this study is to discover if short periods of ischaemia to muscle using a thigh tourniquet before lung transplantation protects the new lungs from injury and improves lung function. This phenomenon is called remote ischaemic preconditioning. The investigators will randomly assign patients requiring lung transplantation to receive 3 short periods of thigh ischaemia or no treatment before the new lungs are implanted and perfused with blood again. Oxygen levels and oxygen requirement will be measured at various time points in both groups to see if our simple intervention improves the function of transplanted lungs.

*Dr Enjarn Lin, The Alfred Hospital,
Melbourne, Australia.*

\$20,000



Novice investigator grants

The use of mechanically skinned muscle fibres for the diagnosis of MH: a pilot study

Malignant hyperthermia (MH) is an inherited disease that can be triggered by common anaesthetics. It can potentially be fatal and it is therefore important to diagnose the disease in patients who are at risk. Current testing involves taking a sample of muscle from the outer thigh of a patient and exposing that tissue to anaesthetic agents which trigger an MH episode. The sample of muscle taken is approximately 4cm by 3cm and recovery can be painful. This study will look at a new test to see whether the muscle sample can be smaller and therefore less painful for patients being tested. We need to make sure that the new test is as accurate and reliable as the original one and we are trying to establish this with our study.

*Dr Brad Hockey, Supervisor: Dr Robyn Gillies, Royal Melbourne Hospital,
Australia.*

\$18,570

Comparison of oesophageal doppler with arterial pressure waveform derived cardiac output and stroke volume variation

The aim of this project is to compare devices that can measure cardiac output non-invasively (the CardioQ™ device from Deltex Medical, the Edwards Lifesciences FloTrac/Vigileo™ system and the LidcoRapid system). In the past, cardiac output could only be measured invasively using a pulmonary artery catheter (PAC). This device had some potentially serious adverse effects. A new generation of non-invasive cardiac output monitors is emerging in clinical medicine that are safe and can be used routinely. This study is primarily aimed at comparing how consistently the devices demonstrate changes in cardiac output during surgery. To do this, the study plans to monitor patients having major surgery using both devices at the same time by accurately recording the times and the events that affect the heart and circulation. The investigators will also evaluate each device's ease of use and check their accuracy by comparing them with the more invasive PAC device in a smaller group of patients, who already require this for their operation.

*Dr Tuong Phan, Supervisor: Dr Roman Kluger, St Vincent's Hospital, Melbourne,
Australia.*

\$15,000

Above from left: Dr Enjarn Lin and Dr Silvana Marasco.

Simulation/ education grant

Training for debriefing after simulation of anaesthetic crises: current practices

A program of research in Australia and New Zealand is currently examining the key role of debriefing after simulation experiences that have been designed to increase anaesthetist's skills in crisis management. Existing research, with professionals such as doctors and pilots, indicates that the debriefing discussion that follows a simulation is a key element for learning. Effective debriefing enables trainees to investigate and reflect on their actions and the actions of others, integrating their current knowledge and beliefs with the perspectives of expert professionals and with theories of best practice. This study will investigate what happens during the debriefing that follows simulated crises that are managed by trainee anaesthetists. The results of this study will be used to help with the future design of simulation-based training, particularly the training of instructors.

Associate Professor Sandy Garden, Dr Deidre Le Fevre, Associate Professor Jenny Weller, Massey University, Wellington.

\$32,226

Grant review process

Each year many willing members of the ANZCA community invaluablely contribute to the process of selecting the best research grants for support by thoroughly reviewing and rating each grant application. The process is dependent upon this support. Each application is reviewed by three independent reviewers who are carefully chosen for their relevance to the particular grant application. The table below lists this year's reviewers for the 2010 grant round. ANZCA is sincerely grateful to these reviewers for their assistance. Many of the reviewers review many more than one grant.

The ANZCA Research Committee members each read all of the grants, select the reviewers, read the reviews, collate the information and act as overall spokesperson for each grant, and attend meetings at which the final recommendations to Council are made. They also contribute as reviewers of grants.

The process is rigorous and transparent. Conflicts of interest are recorded and committee members are excluded from consideration of any grants for which they have conflicts. An independent community representative, Dr Angela Watt, has been appointed to the Research Committee to contribute to the impartiality and appropriateness of the process.

The Research Committee members are:

Professor Alan Merry, Chair

Associate Professor Kate Leslie, Deputy Chair

Professor Andrew Bersten

Associate Professor David Cottee

Professor Tony Gin

Dr Chris Hayes

Mr Ian Higgins, Director, ANZCA Foundation

Professor Paul Myles

Professor Mike Paech

Associate Professor Tony Quail

Professor Stephan Schug

Associate Professor David Scott

Associate Professor Tim Short

Associate Professor Phil Siddall

Associate Professor Dave Story

Dr Angela Watt, Community representative

Dr Steve Webb

Dr Dan Wheeler

Grant reviewers for the 2010 grant round

Dr Christopher Acott

Dr Leanne Aitken

Associate Professor David Baines

Dr Paul Baker

Dr Michael Barrington

Professor Rinaldo Bellomo

Professor Duncan Blake

Dr Simon Body

Associate Professor Robert Boots

Dr Andrew Buettner

Associate Professor Marianne Chapman

Dr Jeremy Cooper

Professor Michael Cousins

Dr Dean Cowie

Dr Andrew Davidson

Dr Andrew Davies

Professor Doug Elliott

Dr Michael Fink

Dr Steven Fowler

Dr Michael Fredrickson

Dr Craig French

Associate Professor Sandy Garden

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Dr Neville Gibbs

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Dr Dan Wheeler

The ANZCA Foundation

An initiative of the Australian and
New Zealand College of Anaesthetists



Back row from left: Associate Professor Kate Leslie, Mr Kieren Perkins, Mr John Astbury, Mr Neil Batt
Centre row from left: Mr James Strong, Professor Michael Cousins, Mr Geoff Linton, Mr Michael Gorton
Front: Professor Alan Merry
Absent: Dr Leona Wilson and Ms Yvonne Kenny.

Meet the ANZCA Foundation board

Mr Michael Gorton, AM, is a principal with solicitors Russell Kennedy with experience in corporate and commercial law and a special interest in health law. He has qualifications in law and commerce and has an extensive background in the community sector. Michael has honorary fellowships with the Royal Australasian College of Surgeons and ANZCA.

Mr Geoff Linton was an audit partner with Ernst & Young in the financial services industry for 25 years. Upon his retirement from Ernst & Young he became secretary of the Collier Charitable Fund. He is a company director and Audit Committee member.

Mr Neil Batt, AO, is Executive Director of the Australian Centre for Health Research Limited. He had a substantial career in politics having held Tasmanian ministerial portfolios for transport, education, economic development and forestry and concluding his political career as Tasmanian Deputy Premier and Treasurer. In addition, he was the national President of the Australian Labor Party. Neil has been active in charitable activities including Chair of the International Diabetes Institute.

Mr John Astbury is a director of Woolworths and is a member of the Audit, Risk Management and Compliance Committee and the Corporate Governance Committee. He was previously a director of AMP and of Insurance Australia Group (IAG). Previous roles include Finance Director of Lend Lease Corporation and chief general manager, National Australian Bank.

Mr James Strong, AO, is the Chairman of Insurance Australia Group (IAG), Woolworths Limited, the Australia Council for the Arts and Kathmandu. He is also a director of Qantas Airways Limited and the Australian Grand Prix Corporation. James was the chief executive and managing director of Qantas Airways Limited from 1993 to 2001. James has been admitted as a barrister and/or solicitor in various state jurisdictions in Australia. In 2006, James was made an Officer of the Order of Australia.

Associate Professor Kate Leslie, FANZCA, FAICD, is the vice-president of ANZCA and Chair of the College's Training Accreditation Committee. She has served as Chair of the College's Annual Scientific Meeting Committee (2002-2004) the Communications and Fellowship Affairs Committee (2002-2004) the Research Committee (2004-2008) and was the Honorary Treasurer for four years (2004-2008).

The Foundation is grateful to the following people and organisations who have supported our programs in 2009:

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	Professor Tess Cramond	QLD
	Dr Ying Hung Mok	HK

The John Snow Society

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Associate Professor Kate Leslie	VIC
Professor Michael Cousins and Mrs Michelle Cousins	NSW
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Dr Leona Wilson, FANZCA, FAICD, is the President of ANZCA. As a Fellow of the College and a member of Council, Dr Wilson has contributed to a wide range of College activities including Chair of the Education and Training Committee and the Hospital Accreditation Committee. Dr Wilson is the first female anaesthetist to be elected President of ANZCA and the first New Zealander to hold the position.

Mr Kieren Perkins, OAM, is a former professional swimmer. One of the world's best long distance swimmers, he won two Olympic gold medals in 1992 and 1996, and a silver medal in 1992 and 2000. Since his retirement from professional swimming he has worked in the broadcast media. He is a board member of Swimming Australia and the Starlight Foundation. In the Australia Day Honours of 1992 he was awarded the Medal of the Order of Australia (OAM). He is an Australian Living Treasure.

Professor Alan Merry, ONZM, FANZCA, FFPMANZCA, FRCA, is head of the Department of Anaesthesiology, University of Auckland, an ANZCA councillor and Chair of the College's Quality and Safety and Research Committee. He is also Chair of the Quality and Safety of Practice Committee of the World Federation of Societies of Anaesthesiologists. Professor Merry is co-author of the publication *Errors, Medicine and the Law* (CUP, 2001).

Professor Michael Cousins, AM, FANZCA, FFPMANZCA, is a past president of the College and is Chair of the ANZCA Foundation. He was the founding dean of the Faculty of Pain Medicine and has also served as Chair of the Committee of Presidents of Medical Colleges. He is a councillor of the Australian Medical Council and is Chair of the Steering Committee of the National Pain Summit.

Ms Yvonne Kenny AM is one of the most distinguished sopranos of her generation. She was born in Sydney and after achieving a BSc in Biochemistry, went to London to study voice. She made her operatic debut in 1975 after which she joined the Royal Opera House, Covent Garden where she remained a member of the company until 1994. She was made a Member of the Order of Australia in 1989 for services to music and also conferred an Honorary Doctorate in Music by the University of Sydney in 1999.

To make a bequest, become a patron and for all other inquiries please contact:

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Fax: +61 3 9510 6786
E-mail: ihiggins@anzca.edu.au

Howard's unusual way

A SEVERE reaction to anaesthetic that struck down former prime minister John Howard was "very rare", a group of doctors said. Mr Howard (below) was taken by ambulance to Sydney's Royal North Shore Private Hospital, where he was monitored over the weekend, after suffering an anaphylactic reaction during routine dental work on Friday.

The Australian and New Zealand College of Anaesthetists said these reactions could be "life-threatening", but anaesthetists were trained to deal with such extremely infrequent cases.

An anaphylactic reaction occurs when the body's immune system over-reacts to ingestion of a foreign material, such as a drug.

Mr Howard was released from hospital yesterday and was reportedly recovering well.



"When the tidal wave struck they obviously got thrown around like in a washing machine and so there were a lot of limb fractures and severe cuts." Brisbane anaesthetist Steve Wood tells ABC radio about his experiences as part of the rapid response team that went to Samoa after the tsunami struck on September 29.

Celebrity's deaths cited in call for action on prescription drug abuse

The deaths of Heath Ledger and Michael Jackson have thrown a spotlight on the growing problem of prescription drug abuse in Australia, says a senior specialist.

Dr Penelope Briscoe, dean of the faculty of pain medicine at Australia and New Zealand College of Anaesthetists (ANZCA), says reform is needed to curb the illicit use and sale of powerful prescription medicines.

Dr Briscoe says US figures show that seven million Americans abuse prescription drugs — more than the number abusing cocaine, heroin, hallucinogens, ecstasy and inhalants combined.

"Australia is heading down a similar path with the rate of oxycodone and morphine prescriptions similar to those in the US," Dr Briscoe says in an article published in the quarterly *ANZCA Bulletin*.

"This aligns with reports that oxycodone — nicknamed 'hully-hully heroin' — is the drug of choice in the injecting room in Kings Cross."



DRUG VICTIM: Heath Ledger.

ence was emerging. "The use of oral morphine [tablets] in Australia has increased 40 times since 1990, and we have seen a four times increase in the oxycodone supply."

Clarifying these figures, however, was a research-based change in practices as doctors eroded their resistance to prescribing opiates to people with chronic pain.

Dr Briscoe said a new oversight mechanism for pain management was needed to ensure people in need need help, but it should be sensitive enough to raise a red flag in cases of abuse.

This would ease pressure on doctors who had been "traumatized all our lives to believe our patients... and take things at face value."

"We're now being asked to become suspicious."

Perth-born Ledger died in his New York apartment last year from an accidental overdose of prescription drugs, while forensic tests on Jackson show a mix of prescription and other drugs caused his death in June.

Pain, Propofol and an ex-PM. These are just three of the diverse subjects involving anaesthetists, pain medicine specialists and intensivists that have drawn media attention in recent months.

The launch of the National Pain Strategy on Sunday, October 18 generated more than 40 interviews, talkback calls and news reports on radio and resulted in 18 newspaper articles and three television reports.

Also popular was the report by Dr Penelope Briscoe (Dean, Faculty of Pain Medicine) in the September *ANZCA Bulletin* that discussed the growing prescription drug abuse problem. The references to celebrity (Heath Ledger and Michael Jackson) in Dr Briscoe's article helped spark media attention.

Similarly, former Prime Minister, John Howard's anaphylactic reaction to anaesthesia and Michael Jackson's death linked to Propofol abuse were taken up by the media. In both cases, ANZCA spokespeople were able to reassure the public of their safety when in the hands of qualified anaesthetists.

Another very big story in recent weeks has been the separation of conjoined Bangladeshi twins Trishna and Krishna at Melbourne's Royal Children's Hospital. The hospital's head of anaesthesia, Dr Ian McKenzie, played a major role in keeping an enthralled public up to date with the twins' progress.

Also part of a major news event were Brisbane's Steven Cook and Adelaide's Gerry Neumeister who went to Samoa soon after the tsunami and told their stories on local radio on return.

ANZCA put out a statement when a *British Medical Journal* published a study in October that showed a spike in adverse events when trainees begin their hospital rotations and a media release to announce the launch of the Surgical Safety Checklist in Australia and New Zealand in August.

In November, 3AW's Talking Health presenter, Dr Sally Cockburn, had three

guests including Associate Professor David Scott on her two-hour program from the Department of Anaesthesia at Melbourne's St Vincent's Hospital.

A Media Contacts Guide that lists Fellows with expertise in particular areas is being prepared and the search for good stories is ongoing — generally, there is a thirst for health-related issues.

The communications unit can approach the media and also advise Fellows on what to expect when they are to be interviewed.

SURGERY CHECKLIST TO HELP PREVENT INJURY IN HOSPITALS

EMBARGOED TO 10.30AM
 Wellington, Aug 27 NZPA - A surgery checklist to help ensure doctors operate on the correct part of the right person was announced today.
 Every hospital in New Zealand and Australia will receive the checklist, part of a World Health Organisation initiative to reduce mortality rates and complications during surgery.
 The 21-item checklist will take just two minutes to complete and will be done in three phases – before, during and after surgery.
 It will include checking the patient's identity, operation site, availability of equipment and labelling specimens for testing.
 Speaking at its launch, Health Minister Tony Ryall said while "most" patients received good care a Ministerial Review Group report found 44,000 people suffered unintended injury in hospital caused by the management of their injury.
 Healthcare workers "suffer perpetual information overload" and it was hard for one person to remember everything.
 The checklist was a "simple improvement, yet it has such a significant effect", Mr Ryall said.
 "I strongly encourage all clinicians with the support of their managers to adopt the Surgical Safety Checklist in their hospitals."
 The Royal Australasian College of Surgeons censor in chief Ian Civi said the list had "real potential to save lives, reduce operating room errors, and improve patient safety."
 "We want to see it displayed in every operating theatre in every hospital in New Zealand and Australia."
 The Australian and New Zealand College of Anaesthetists Quality and Safety Committee chairman Professor Alan Merry said the checklist involved no additional expense to the hospital or patient.
 A global trial of the list, part of which was carried out in Auckland, found death rates for surgical patients fell from 1.5 percent to 0.8 percent after its introduction.
 Inpatient complications fell from 11 percent to 7 percent.
 Prof Merry, who was the principal investigator at Auckland City Hospital for the trial, said the checklist was a very simple clinical tool that would have an enormous impact on preventing mishaps and associated complications.
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 27/08/09 09:42NZ



Doctors hope national strategy will improve treatment for people with chronic pain
 Alan Connell
 Health editor
 Pain specialists Michael Cousins said it was "rather shocking" that less than half of patients with acute pain and cancer pain were receiving effective treatment, but "with chronic long-term cancer pain it's much worse – less than 10 percent of people" were getting proper relief.
 "That's clearly a situation that can't continue from a humanitarian point of view," said Professor Cousins, a former president of the Australian and New Zealand College of Anaesthetists.
 Two years ago an Access Economics report found pain cost the Australian economy \$34 billion a year and caused more than 30 trillion lost work days with one in five Australians affected.
 Professor Cousins said the situation was caused by factors such as poor training and inappropriate attitudes among doctors and nurses, and a social stigma affecting people particularly with non-cancer chronic pain.
 "Not only did this lower outcomes, it also lowered patients' own expectations of what could or should be done to help them," he said.
 The strategy will roll out the federal government, universities and colleges and other organisations to improve pain treatment, including increasing the understanding of health workers through improved training.
 But he said better education of patients was also needed, given the widespread belief in a large number of myths about pain – such as the idea that a severe pain indicated a severe injury or disease, or that strong pain required strong drugs.



Media releases distributed by ANZCA (August – November)

Since August, ANZCA has generated...

- “World-first National Pain Strategy launched” (Sunday October 18, 2009)
- “Leading pain specialists gather for Melbourne meeting” (Friday October 16, 2009)
- “College welcomes study on trainee doctors” (Wednesday October 14, 2009)
- “Rural lives saved by new mobile heart-lung machine service” (Monday October 5, 2009)
- Anaesthetists Steve Cook, Gerry Neumeister in Samoa (Monday October 5, 2009 and Tuesday October 6)
- “Bulletin: New registry providing vital flu information” (Tuesday September 22, 2009 in New Zealand)
- “ANZCA Bulletin out today: Australia’s prescription drug abuse problem/ New registry providing vital flu information” (Monday September 21, 2009)
- “John Howard story: anaphylactic shock and anaesthesia” (Monday September 7, 2009)
- “Surgical Safety Checklist will save lives” (Thursday August 27, 2009 in New Zealand)
- “Michael Jackson story – use of Propofol” (Tuesday August 25, 2009)
- “Simple tool will save lives” (Wednesday August 19, 2009 in Australia)

- 77 print and online stories
- 83 radio interviews
- 19 radio news stories
- 5 television reports

ANZCA’s communications unit is always looking for good news or general interest stories that can be promoted in the media. If you have an idea, please contact media manager, Clea Hincks, at ANZCA via e-mail chincks@anzca.edu.au or by phone (03) 9093 4917 or 0418 583 276.

Library update

Health and safety alerts - ECRI Institute notices



The ANZCA Library subscribes to ECRI publications on operating room risk management and health device alerts and information. Check this space regularly for updates on the latest information produced by ECRI.

Recent notices include:

Top 10 technology hazards for 2010

The top five are:

1. Cross-contamination from flexible endoscopes
2. Alarm hazards
3. Surgical fires
4. CT radiation dose
5. Retained devices and unretrieved fragments

Health Devices, Vol. 38, No. 9, September 2009

- Real-time locating systems
- The Basics of benchmarking

Health Devices, Vol. 38, No. 10, October 2009

- Surgical fire prevention guide
- Integrating your OR for less

Operating Room Risk Management Executive Summaries

- Obstetric liability: an overview
- Event reporting
- Use of reprocessed single-use medical devices.

Pain medicine book collection

The ANZCA Library has created a direct link to pain-related books held in the collection via the library catalogue.

Log-in to the ANZCA/FPM website and link to the library catalogue to view the large range of books in the pain area.

<http://www.anzca.edu.au/resources/library/book-catalogue.html>

New EBP website launched

Centre For Evidence Based Practice Australasia

The (virtual) Centre for Evidence Based Practice Australasia (CEBPA) is not a typical website but an evolving “cloud” (or collection) of EBP resources from across Australia and New Zealand, with particular emphasis on Australasian content. <http://www.cebpa.info/>

New research in anaesthesia, pain medicine and intensive care medicine

Recent Cochrane Library Reviews

The Cochrane Pain, Palliative and Supportive Care Group has recently published a number of systematic reviews on interventions for acute postoperative pain in adults. Browse by review group in the Cochrane Library to view the new publications.

http://www.mrw.interscience.wiley.com/cochrane/cochrane_clsystev_crglist_fs.html

“Hypothermia for neuroprotection in adults after cardiopulmonary resuscitation”

Arrich J, Holzer M, Herkner H, Müllner M. Cochrane Database of Systematic Reviews 2009, Issue 4. Art. No.: CD004128. DOI: 10.1002/14651858.CD004128.pub2.

“Local anaesthetic wound infiltration and abdominal nerves block during caesarean section for postoperative pain relief”

Bamigboye AA, Hofmeyr GJ. Cochrane Database of Systematic Reviews 2009, Issue 3. Art. No.: CD006954. DOI: 10.1002/14651858.CD006954.pub2.

<http://mrw.interscience.wiley.com/cochrane/clsystev/articles/CD006954/frame.html>

“Non-pharmacological interventions for assisting the induction of anaesthesia in children”

Yip P, Middleton P, Cyna AM, Carlyle AV. Cochrane Database of Systematic Reviews 2009, Issue 3. Art. No.: CD006447. DOI: 10.1002/14651858.CD006447.pub2.

<http://mrw.interscience.wiley.com/cochrane/clsystev/articles/CD006447/frame.html>

“Anaesthesia for fast track cardiac surgery”

Varadarajan B. NHS Evidence - surgery, anaesthesia, perioperative and critical care (published September 2009; downloaded 19 November 2009).

Available from: <http://www.library.nhs.uk/theatres/viewResource.aspx?resid=324726>

“Anticoagulants and antiplatelet agents: regional anaesthesia”

Available from: <http://www.library.nhs.uk/theatres/viewResource.aspx?resid=320359&code=04c3c808065251347f5b4c578182427f>

“Does regional anaesthesia improve outcome after total hip arthroplasty? A systematic review”

Macfarlane AJ, et al *British Journal of Anaesthesia* Vol. 103, Issue 3, Pages 335-45, 2009

“Perioperative peripheral nerve injuries: a retrospective study of 380,680 cases during a 10-year period at a single institution”

Welch, MB., et al. *Anesthesiology*. Volume 111, Issue 3, Pages 490-497, 2009

“Should dosing of rocuronium in obese patients be based on ideal or corrected body weight?”

Meyhoff, Christian S., et al. *Anesthesia & Analgesia*, Volume 109, Issue 3, Pages 787-792, 2009

“Anaesthesia and deep brain stimulation”

Dobbs, P., Hoyle, J and Rowe, J. Continuing Education in Anaesthesia, Critical Care & Pain, Volume 9, Issue 5, Pages 157-161, 2009

“Safe Management of Anaesthetic Related Equipment”

New AAGBI Guideline

http://www.aagbi.org/publications/guidelines/docs/safe_management_2009.pdf

Library update

continued

New Titles

Chronic pain for dummies Kassan, Stuart S; Vierck, Charles J; Vierck, Elizabeth. (Hoboken, NJ: Wiley, 2008).



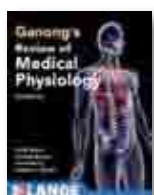
Diagnostic imaging in critical care: a problem based approach Joyce, Chris; Saad, Nivene; Kruger, Peter; Foot, Carole; Blackwell, Nicki. (Sydney: Churchill Livingstone Elsevier, 2010).



Effective writing for health professional: A practical guide to getting published Johnstone, Megan-Jane. (Crows Nest, NSW: Allen & Unwin, 2004).



Ganong's review of medical physiology Barrett, Kim E. (ed); Barman, Susan M. (ed); Boitano, Scott (ed); Brooks, Heddwen L. (ed); Ganong, WF (23rd ed New York: McGraw-Hill Medical, 2010).



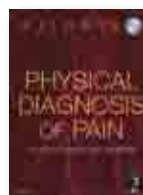
Manage your pain: Practical and positive ways of adapting to chronic pain Nicolas, M; Molloy, A; Tonkin, L; Beeston, L. (Australian Broadcasting Corporation - Sydney, Australia: HarperCollins Publishers, Inc, 2006).



Manual of intensive care medicine Irwin, Richard S (ed); Rippe, James M (ed). (5th ed - Baltimore: Lippincott Williams and Wilkins, 2010).



Physical diagnosis of pain: an atlas of signs and symptoms Waldman, Steven D. (2nd ed - Philadelphia, PA: Saunders Elsevier, 2010).



A practical guide for medical teachers Dent, JA (ed); Harden, RM (ed) (3rd ed - Edinburgh: Churchill Livingstone, 2009).



Safer surgery: analysing behaviour in the operating theatre Flin, Rhona (ed); Mitchell, Lucy (ed). (Surrey, England: Ashgate, 2009).



War surgery in Afghanistan and Iraq: a series of cases, 2003-2007 Woodruff, Bob (foreword by). (Falls Church, Va.: Office of the Surgeon General, United States Army, 2008).



Books can be requested via the ANZCA Library catalogue

www.anzca.edu.au/resources/library/book-catalogue.html

ANZCA members can borrow a maximum of five books at once from the ANZCA Library. Loans are for three weeks and can be renewed on request.

Members can also reserve items that are out on loan. Melbourne-based members are encouraged to visit the ANZCA Library to collect requested books.

Items will be sent to other library users within Australia. A core collection of the anaesthetic syllabus textbooks is available for loan from the New Zealand office of the College. A list of the New Zealand books can be accessed by selecting "New Zealand" from the "Location" drop-down box of the catalogue.

When requesting an item from the catalogue, please remember to include your name, ID number and postal address to ensure prompt delivery.

Contact the Library

www.anzca.edu.au/resources/library

Phone: +61 3 8517 5305

Fax: +61 3 8517 5381

E-mail: library@anzca.edu.au

Regions

New South Wales



The Novotel Wollongong hosted the spring CME in November on the theme of “Risky business”, looking at aspects of risk management and mitigation in contemporary anaesthetic practice. The lectures, small group discussions and workshops to tailor CPD needs were attended by 130 delegates. The meeting started with a keynote talk by Professor Ross Kerridge on what and how preoperative assessments should be done. This was complemented by Roger Truill and John Ellingham talking about how they do it in the public and the private systems. The weekend heard from invited obstetricians, cardiologists, respiratory physicians, intensivists, endocrinologists, radiologists and anaesthetists, and then there was time to swim, exercise or just relax. Positive feedback was received on the theme, the talks, the format and the venue, and we look forward to doing it all again next year in Port Macquarie.

Above: Delegates from the NSW CME participating in a workshop.

Right from top: Delegates in a workshop; Dr Alan Rubinstein with the “Harvey” simulator; Dr Richard Connolly and Dr Ross Kerridge at dinner.



Queensland



There have been two combined ANZCA/ASA Continuing Medical Education dinner meetings in the past three months. Dr Mark Warner spoke in September on the topic of “How new technologies and practices will influence perioperative safety”. Dr Warner is the Professor of Anesthesiology at the Mayo Clinic College of Medicine.

The second meeting was held in November at Victoria Park Golf Course. Professor André Van Zundert, M.D., Ph.D., F.R.C.A. spoke on “Videolaryngoscopy – the end of the classic laryngoscope” which was followed by a practical workshop in videolaryngoscopy for participants. Professor Van Zundert is from the Department of Anaesthesiology, ICU & Pain Therapy at the Catharina Hospital-Brabant Medical School, Eindhoven, Netherlands.

A Faculty of Pain Medicine dinner meeting was held in October. Dr Suellen Walker, a senior clinical lecturer and consultant in paediatric anaesthesia and pain management at UCL Institute of Child Health and Great Ormond Street Hospital, London, UK, joined us and spoke on the topic “Pain in children”.

Queensland has almost completed the primary lecture program for semester two which has been held on the second Saturday of each month. We’ve also held the primary practice and the final practice vivas evenings. Thank you to all Fellows for their support and, in particular, lecturers: Dr Paul Frank, Dr Ros Purcell, Dr Matt Kelso, Dr Gamini Wijerathne, Dr David Trappett, Dr Bruce Hammonds, Dr Peter Watt, Dr Mark Lai, Dr Cameron Hastie, Dr Kim Vidhani, Dr Justine McCarthy and Dr Gabe Mar Fan.

Australian Capital Territory



2009 Canberra Floriade Meeting

The ACT ANZCA/ASA Combined CME Meeting was held in September. The meeting was well supported with more than 120 local, interstate and overseas delegates and 22 healthcare industry representatives attending. The two-day event included international speakers, Professor Patrick Wouters of the University Hospital Ghent, Belgium, who gave a presentation on “Cardiac protection, volatiles and opioids” and Dr Matthias Jacob of the Ludwig-Maximilians University Munich, Germany who presented the topic “Protection of the vascular barrier”. Professor Thomas Bruessel did an outstanding job in organising this meeting. (See People & events on page 8 for photos).

ANZCA ACT Regional Committee AGM

The ACT Regional Committee held its annual general meeting in the ACT regional offices on November 12. Local issues discussed included progress on work being done by an ACT Mortality and Morbidity Committee, the development of an ACT regional committee orientation manual, how the relationship with local Fellows was progressing and how the ACT was benefiting from improved relations with various health groups.

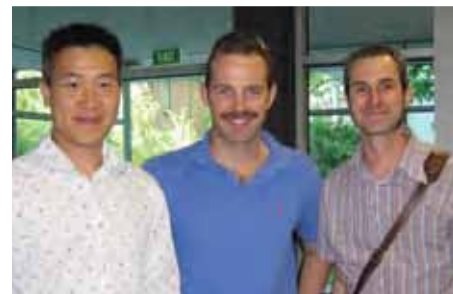
Victoria



The Victorian Regional Committee primary full-time course was held from November 16-27 at ANZCA House. The course was essentially for trainees preparing to sit the primary examination early in 2010. A record number of 61 attendees were registered and included trainees from interstate and New Zealand. The course was very successful and this was due to the valuable time and hard work of the lecturers and mock examiners, and the organisational skills of the course coordinator.

The final session was comprised of mock viva examinations. This year, 17 Fellows attended the College to give the candidates a mixture of examination practice, top tips and reassurance.

From top right: Interstate trainees; mock viva examiners; Dr Fred Rosewarne (right), a foundation lecturer of the primary full-time course presented “Physics for Anaesthetists” with one of the participants of the course; Dr Ian McKenzie (second from the right) with trainees.



Western Australia



Updates in Anaesthesia meeting

In early November, Western Australia held its annual Country Meeting at the Quay West Resort Bunker Bay which is about a three-hour drive south of Perth. The weekend began with a welcome BBQ and drinks for sponsors, delegates and their families.

The annual Updates in Anaesthesia meeting attended by 116 delegates was entitled “Trauma and the anaesthetist”. The academic program opened with the invited speaker, Professor Ross Baker who is Director of the Haemophilia Centre of Western Australia, giving an informative presentation on coagulation and trauma including bleeding and clotting and everything in between. Dr Lucy Kilshaw, a consultant geriatrician and the second invited speaker then gave an excellent presentation on the peri-operative care of ortho-geriatric patients.

Dr Alex Swann spoke about the anaesthetists’ role and principles of management in major trauma and disasters in remote and rural Australia;

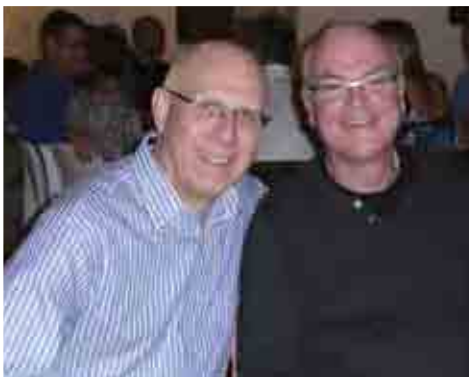
Dr Rob Radici, a retrieval specialist with the Royal Flying Doctors Service in WA, presented a trauma case of a difficult airway encountered in a rural location and Dr Andy Heard presented an algorithm for the management of a crisis situation where a patient cannot be intubated or ventilated.

On Saturday afternoon the airway workshops and PBLDs were offered concurrently. The demonstrated techniques in the airway workshops were a sample of the adaptations of advanced skills which are being taught in the “wet” and “dry” lab unique airway teaching program at Royal Perth Hospital. The workshop presenters were Drs Catherine Fuller, Shannon Matzelle, Patrick Eakins, Jim English, Andy Heard, Nick Brown and Gavin Teague. The airway PBLDs were presented by Dr Roger Browning, Dr Alex Swann, Dr Claire McTernan and Dr Wim Smithies.

The Sunday morning session included presentations from Dr Lars Wang on anaesthesia for the head-injured patient; Dr Chris Cokis spoke about anaesthesia for patients with thoracic trauma with a

focus on aortic injury; Dr Harmmeet Aneja discussed some of the common extremity trauma scenarios faced by the modern anaesthetist and the pros and cons of using regional anaesthesia in these situations; and Professor Stephan Schug spoke about pain management for the trauma patient.

Thanks go to the invited speakers Professor Ross Baker and Dr Lucy Kilshaw, the sponsors, presenters and the organising committee from Royal Perth Hospital including the convenors, Associate Professor Tomas Corcoran and Dr Denise Yim who put together an interesting scientific program and an enjoyable weekend in the south-west of Western Australia which included an excellent social program and a fantastic evening at Vasse Felix Winery.



South Australia/ Northern Territory



The South Australia/Northern Territory Regional Committee had its local CME meeting on December 2 at the Women's and Children's Hospital in Adelaide. The meeting, sponsored by the ASA, was teleconferenced to both Darwin and Alice Springs. ASA President, Dr Liz Feeney, gave an introductory talk on the ASA. The College CME committee would like to thank the ASA for their continued support of academic meetings. The guest speaker was Professor Annette Braunack-Mayer, an associate professor in ethics who is involved in the department of health sciences. Professor Braunack-Mayer presented two clinical scenarios involving various ethical issues that involved anaesthesia and the relationship with surgeons. A very valuable interactive session followed.

Photographs from the "Updates in anaesthesia" meeting from Bunker Bay, clockwise from left: Bunker Bay, Western Australia; Dr Lucy Kilshaw; Dr Alex Swann, Mrs O'Loughlin and Dr Ed O'Loughlin; Delegates at the meeting; Dr Leigh Coombs and Professor Ross Baker; Dr Mark Williams (back), from left: Associate Professor Tomas Corcoran, Dr Denise Yim, Ms Sandra Box, Ms Bree Toussaint; Dinner at the Vasse Felix Winery.

WA Part III Course

The 2009 Part III Course entitled "Life Beyond Training – Making the Transition" was held on Saturday, November 14 at the University Club of Western Australia. The course was convened by the GASACT Senior Chair, Dr Ana Licina.

The course was aimed at fourth and fifth year anaesthetic registrars who will soon be completing their training and obtaining their FANZCA. Topics included: "Starting out in private practice", "Paperwork and practicalities of the transition", "Life as a new consultant in public practice", "Insurance and medico-legal matters", "Getting paid – billing 101", "Full-time public and private practice and a combination of both".

Thank you to Dr Sharon Smedley, Dr Markus Schmidt, Dr Angela Palumbo, Dr Rob Storer, Dr Jamie Knuckey, Dr Ian Forsyth, Dr Alex Swann and Dr Paul Rodreda for their support.

Tasmania



The Tasmanian combined ASA/ANZCA meeting will be held from February 19-21, 2010 at The Old Woolstore in Hobart. The theme is "A disaster of a conference" and the invited speaker is Dr Robyn Gilles (Head of Malignant Hyperthermia Diagnostic Unit, Royal Melbourne Hospital). The meeting will look at various emergency and difficult situations ranging from difficult airways, trauma, obstetrics, as well as malignant hyperthermia. There will also be a workshop on ultrasound and regional anaesthesia of the upper and lower limbs. Please contact Di Cornish in the regional office via e-mail – tas@anzca.edu.au – for more information.



NZ Anaesthesia ASM 2009, Rotorua, November 4-7, 2009

The 2009 NZ Anaesthesia ASM (NZA ASM) organising committee provided a program of great interest and attendee numbers exceeded expectations. The keynote speakers, Ivan Joubert (Cape Town), Hans-Joachim Priebe (Freiberg), Peter Marhofer (Vienna) and John Barnard (Waikato) won accolades for their presentations and for their participation in all the sessions.

The Waikato Hospital Department of Anaesthesia ASM organising committee is to be congratulated for all the hard work undertaken to create this successful conference. Dr Cam Buchanan was the convenor and Dr David Kibblewhite, scientific convenor. Other members of the organising committee were Drs Kevin Arthur, Tom Watson, Arthur Rudman, Lucas Sikiotis, Andrew Miller and Gary Hopgood and Amanda Graham from Six Hats Conference Management.

The New Zealand Anaesthesia Education Committee (NZAEC) oversees this joint NZNC/NZSA conference. Thanks are extended to Dr Brian Lewer, the NZAEC Chair who has now completed his two years as Chair. Rose Chadwick, the NZAEC Administrative Officer provided valuable support for the NZA ASM, including organising two NZAEC meetings at the ASM (for trade personnel and convenors). The trade meeting was attended by more than 40 representatives who appreciated the opportunity to discuss issues of common interest.

Clockwise from top left: Dr Hayley Bennett, Dr Hugh Douglas (IV) and Dr Cam Buchanan, convenor of the NZ Anaesthesia ASM; NZ Anaesthesia ASM conference dinner at the Blue Baths, Rotorua; workplace-based assessments workshop: front row (seated) Dr Richard Willis, Professor Garry Phillips, Dr Leona Wilson, and Dr Genevieve Goulding; middle row, Dr Vaughan Laurenson, Dr Vanessa Beavis, Dr Paul Smeele, Dr Brian Lewer; back row, Dr David Kibblewhite; Dr Gary Hopgood, Dr Stuart Henderson, Dr Nigel Robertson, Dr Malcolm Stuart, NZNC; The NZ Anaesthesia ASM conference dinner from left: Dr Vanessa Beavis, Mrs Wendy Warmington, Dr Andrew Warmington, Mrs Thompson, Dr Wally Thompson, Dr Leona Wilson.

International Medical Graduates

NZNC vocational registration panel

The ANZCA New Zealand Panel for Vocational Registration (NZPVR) has conducted a number of International Medical Graduates (IMGs) preliminary assessments and interviews on behalf of the medical council over the last 12 months.

Workplace-based assessments for Fellowship

An assessors' workshop and the first assessments in New Zealand occurred in October.

ANZCA New Zealand Trainees' Committee

This committee, under the chairmanship of Dr Kathryn Hagan has been actively developing resources to assist New Zealand trainees. These include a part zero course and a trainees' handbook.

Policy submissions and representations to government

The New Zealand National Committee has considered a wide range of discussion documents and requests for nominations from the Ministry of Health and the Medical Council of New Zealand over the past few months:

- The establishment of a New Zealand Perioperative Mortality Review Committee and nomination of a Fellow to serve on the committee - Minister of Health.
- New Zealand anaesthesia workforce and training including the Government's electives initiative – Minister of Health and Director General of Health.
- ANZCA/RACS WHO Surgical Safety Checklist launch – Minister of Health.
- Acute services in provincial hospitals roundtable – Ministry of Health.
- Clinical Training Agency Board nominations (the one national agency for workforce training, funding and planning) – Ministry of Health.
- Use of locum work by District Health Boards – Ministry of Health.
- MCNZ and ANZCA International Medical Graduates (IMGs) assessment processes and the new MCNZ framework for supervision of IMGs – Medical Council of New Zealand (MCNZ).
- Medical Council periodic assessment of performance as part of CPD.
- The Faculty of Pain Medicine's application to MCNZ for recognition of pain medicine as a vocational branch of practice in New Zealand.
- Division of Rural Hospital Doctors Board of Studies regarding anaesthesia training.
- Accident Compensation Corporation "Evaluation of Treatment Injury Legislation".
- Nursing Council – Registered Nurse Scope of Practice under the Health Practitioners Competence Assurance Act (2003).

New Zealand National Committee (NZNC) meetings

The New Zealand National Committee (NZNC) of ANZCA met on November 20. A wide variety of issues were discussed, including the establishment of a New Zealand Perioperative Mortality Review Committee by the Minister of Health with an invitation to ANZCA to nominate a Fellow to serve on this committee; Medical Council of New Zealand (MCNZ) and ANZCA assessment processes for international medical graduates; the interim report to MCNZ for the reaccreditation of ANZCA as a branch advisory body; New Zealand workforce survey and report; acute services in provincial hospitals; Rural Hospital Doctors Training Program; and the Faculty of Pain Medicine's application to MCNZ for recognition of pain medicine as a vocational branch of practice in New Zealand.

Future CPD events in New Zealand

ANZCA ASM - May 1-5, 2010.

2011 NZA ASM – Dr Michal Kluger and the team from Northshore are organizing this conference to tie in with the Rugby World Cup 2011.

International Congress of Cardiothoracic and Vascular Anaesthesia (ICCVA) 2012

Considerable time, effort and diplomacy have been directed towards securing and preliminary planning of the ICCVA meeting (under the auspices of the Society of Cardiovascular Anesthesiologists from the States). At this stage, it is expected that the meeting will run alongside the NZA NZ ASM in Auckland in 2012. The event will be a joint undertaking between NZSA and ANZCA.

ANZCA/NZSA Workforce Report 2009

There was a 75% response rate to the College's workforce survey to measure the supply and demand for anaesthesia services (652 out of 873 recipients) which was a truly exceptional response. Respondents who completed the survey were entered into a prize draw for a dinner up to the value of \$500. The winner was **Dr Pamela Meyer** of Rotorua, who shared her prize with colleagues during the NZA ASM. Results of the survey are being analysed. The final report will be made available in early 2010.

ANZCA New Zealand Trainees' Committee

This committee, under the chairmanship of Dr Kathryn Hagan, has been actively developing resources to help New Zealand trainees. These include a part zero course and a trainees' handbook *Anaesthesia Training in NZ made easy*. The committee members, who reside in various parts of New Zealand, usually meet by teleconference but met for the first time face-to-face in Wellington on November 28. The ANZCA President, Dr Leona Wilson, and NZ National Committee Chair, Dr Vanessa Beavis, joined the meeting.



Front row from left: Drs Rachel Dempsey, Nicola Broadbent, Kathryn Hagen (Chair) and Nathan Kershaw (NZSA representative)
Back row from left: Dr Leona Wilson (ANZCA President), Juliette Adlam (Administrative Officer, NZ Office), Drs Thimali Rajapaksa, Sheila Hart, Erica Dibb-Fuller, Geoff Long (National Education Officer) and Sabine Pecher.

New College of Intensive Care Medicine



The following are remarks made by Professor PV van Heerden, Dean of the Joint Faculty of Intensive Care Medicine, at a dinner at ANZCA House, Melbourne, on November 21 to celebrate the creation of a new College of Intensive Care Medicine.

“ At this time we celebrate the successful culmination of a process commenced some 18 months ago. This process began with a vote by the fellowship of the Joint Faculty of Intensive Care Medicine in favour of the formation of a separate body for training and certification in intensive care medicine in Australia and New Zealand. Such a body would be the first of its kind in the world – this is not unusual, as intensive care medicine in Australia and New Zealand has led the way internationally since the 1970s.

Following the vote by the JFICM fellowship, the board of the Joint Faculty then entered into negotiations with the Council of ANZCA about how to bring about the reality of a new College of Intensive Care Medicine. With the support of the ANZCA Council and the JFICM Board a working party, consisting of Leona Wilson and Kate Leslie from ANZCA and John Myburgh and myself from the joint faculty, was established to steer the process. Negotiations took place under a heads of agreement drawn up between JFICM, ANZCA and the RACP. I must pay special tribute to Leona Wilson who provided strong guidance to counterbalance the sometimes unbridled enthusiasm of the JFICM approach. As an example, I think we had a six-month timeline in mind, while Leona promoted a more realistic 12-18 month timeline.

Somewhat uniquely in these types of negotiations, talks were always courteous, and indeed, fruitful. Even the potentially difficult negotiations regarding financial settlement, proved not to be so. Perhaps we all had the advantage of having the formation of ANZCA not too long ago to look to as an example.

A constitution was written for the new College of Intensive Care Medicine and operations commenced in February 2009, when the inaugural board of the CICM was established. These board members were also the first foundation Fellows of CICM. Since that time the boards of the joint faculty and the CICM have

run in parallel, allowing the transfer of processes and functions from one to the other. This has been a smooth transition process and we are confident that the infrastructure and processes to allow seamless commencement of activities by CICM on January 1, 2010 are in place. A new College for a new decade!

In preparation for January 2010, most foundation Fellows of the new College were admitted at the November 2009 board meeting of the CICM. New diplomas will be reaching these Fellows shortly.

It would be remiss of me to neglect mentioning the proud heritage we take with us to the new College. Intensive care medicine is a relatively new specialty – with its genesis in the polio epidemics of the 1950s – a time so well described by Dr Ron Trubuhovich in his historical papers published in our journal, *Critical Care and Resuscitation* and elsewhere. The early 1970s saw the specialty becoming more organised, resulting in the formation of the Section of Intensive Care of the RACS – an enterprise of some far-sighted people, Barry Baker, Ron Trubuhovich, Felicity Hawker, David McCleave, Dennis Kerr and Ken Hillman.

The first examination in intensive care medicine was held in 1979 – one candidate presented. Compare this to the more than 100 that present each year now. At about the same time our physician colleagues started a training scheme for intensive care medicine.

The Section of Intensive Care evolved into the Faculty of Intensive Care after the



establishment of ANZCA in 1992. There were still two training schemes available at the time - those run by the Faculty of Intensive Care and the RACP. A single training scheme was formalised with the formation of the Joint Faculty of Intensive Care in 2002. The past deans of the faculty and joint faculty read like a “who’s who” of famous intensive care physicians – Clarke, Duncan, Hawker, Matthews, Havill and Lee. They, the board members who supported them and the excellent executive officers and their staff have made great contributions to the speciality over the years.

Special mention should also be made of representatives on the JFICM board from ANZCA and the RACP – in particular I’d like to thank Professor Nip Thomson and Professor Barry Baker for their wise counsel.

At this point I’d also like to point out some of the special and unique strengths of the speciality of intensive care medicine in Australia and New Zealand. These include –

- Firstly, the unity of purpose of intensive care physicians, regardless of primary speciality. We have not seen the bickering between primary specialities about who “owns” intensive care medicine that has hampered the development and caused the fragmentation of the speciality in other countries. Australasian intensive care medicine has always enjoyed the support of the primary specialities, particularly anaesthesia and internal medicine.

- Secondly, the concept of closed intensive care units and general intensive care units has recognised the skills that intensive care physicians bring to patients – as opposed to open and super-specialised units.
- Thirdly, the support of our society, ANZICS, has been instrumental in enabling long and fruitful careers in intensive care medicine for its practitioners by taking care of industrial matters.
- Fourthly, the bi-national nature of our organisations has provided strength and diversity to our speciality.

The 18-month process I began describing has seen the new College of Intensive Care Medicine on the threshold of a new era of intensive care medicine in Australia and New Zealand. It is the leading body of its type in the world and is proud to oversee training in hospitals in Australia, New Zealand, Hong Kong, Singapore, Canada, the UK and Ireland and soon in India. We have 700 Fellows and honorary Fellows all over the world who take special pride in the formation of the new College.

The new College owes a great debt of gratitude to all those who have contributed to the process in the 30 years leading up to this final 18-month process. May the fact that the new College has been born through a process of evolution, rather than revolution only add to its strength in the future. I’d also like to wish

the Faculty of Pain Medicine well and look forward to watching the evolution of your speciality over time. ”

Professor PV van Heerden
Dean, JFICM
President, CICM

“This has been a smooth transition process and we are confident that the infrastructure and processes to allow seamless commencement of activities by CICM on January 1, 2010 are in place.”

Below from left: The presidents and vice presidents of ANZCA and CICM, Professor Kate Leslie, Professor PV van Heerden, Dr Leona Wilson and Professor John Myburgh; The ANZCA House foyer set for dinner; Professor van Heerden with previous JFICM deans, Dr Geoff Clarke, Dr Alan Duncan, Dr Neil Matthews and Dr Jack Havill; Professor van Heerden addresses the guests.



New College of Intensive Care Medicine

continued



The following is an edited excerpt of remarks made by the President of ANZCA, Dr Leona Wilson, at a dinner on Saturday, November 21, at ANZCA House to celebrate the new College of Intensive Care Medicine of Australia and New Zealand.

“ Mr President, Vice-President, CEO and Council of CICM, and guests, on behalf of ANZCA it is my great pleasure to propose the toast to the new College of Intensive Care Medicine of Australia and New Zealand and, of course, sadly, to farewell the JFICM from our College and the RACP. Tonight is a wonderful occasion in that we are celebrating the birth of a new College, but at the same time sad in that we are farewelling a faculty.

I would like to welcome our guests to this celebratory dinner. Vernon is going to tell us about the history of intensive care medicine, so I'd like to talk about the people in this room – here we have the

people who made and lived this story of the history of our College and intensive care medicine.

Barry Baker, the obvious first place to start. He was the first head of the section of intensive care medicine of the Faculty of Anaesthetists, RACS, Australian by birth, New Zealand by adoption, intensivists and anaesthetist. When we came to the separation of the JFICM from ANZCA, we had Barry Baker, now a Director of Professional Affairs for ANZCA helping us. Barry was the Dean of the Faculty of Anaesthetists at the time of negotiation of separation from the college of surgeons, and a font of knowledge on the separation of a faculty from a college and the establishment of a new college.

Ron Trubohovich worked at DCC in Auckland, the first unit accredited by the section for training for intensive care medicine in New Zealand (and Australia).

And then in 1992 we (the Faculty of Anaesthetists, RACS) formed the new college of anaesthetists. This is a good time to reflect on our formation as a College and our separation from the college of surgeons and we have here our surgical representative on Council, **Graeme Campbell**. The RACS provided us with safe conditions for our birth, providing us with administrative and financial infrastructure, so that we were able to grow as a specialty and we are grateful to them for that. We (that is the Faculty of Anaesthetists, RACS) had to negotiate our separation, especially the finances, with the College of Surgeons.

“The process of separation had the potential to destroy our good relationship with the new College, and instead it’s my view that it’s strengthened it.”

This proceeded very amiably and collegially, and served us as a model to follow in our negotiations with JFICM.

I remember separation being an item of discussion through the 1980s, and hearing vehement opinions on each side, and of course taking part vigorously. The main issues were that we were a separate specialty, and thus should have a separate College. The contrary view was that separation would entail the loss of influence that we would sustain by no longer being part of a College that was perceived as having the ear of governments, and the dangers of increasing fragmentation of the profession. But, the decision to separate proceeded, and ANZCA came into being.

Our inaugural scientific meeting as a College was held in Canberra in 1992. **Tess Cramond** proposed the toast to the new College of Anaesthetists at the College’s inaugural dinner at that meeting. She noted the atmosphere of goodwill and continuing support from the President of RACS that attended our separation from RACS. **Peter Livingstone**, the last Dean of our faculty and the first President of our College, responded to Tess’s toast at



that dinner. He spoke of our 40 years as a faculty, a long “growing up” period. Your College, Mr President, has spent less time as a faculty – as I calculate it, 18 years. **Michael Davies** chaired a scientific session opening the ANZCA inaugural meeting in Canberra. And then, of course, once we became a College in our own right, then the section of intensive care became a faculty, with **Geoff Clarke**, being the first Dean. The faculty then became joint with ANZCA and RACP, and we have **John Wilson** representing Geoffrey Metz, President of RACP. **Felicity Hawker** was the inaugural Dean of the JFICM, and then stayed on to assist the faculty as the first DPA. We are also joined by the other Deans, **Alan Duncan**, **Neil Matthews** and **Jack Havill**.

The process of separation had the potential to destroy our good relationship with the new College, and instead it's my view that it's strengthened it. The negotiating team from JFICM, **Vernon van Heerden**, **John Myburgh** and **Phil Hart** were absolutely professional in their approach, and made what could have been extremely difficult discussions incredibly collegial. I'm very grateful for that, and the support from ANZCA Vice President, **Kate Leslie**, and CEO **Mike Richards**.

Mr President, intensive care medicine has transformed the way in which medicine is practiced in the last half of the 20th century and the first decade of this century. This has benefited our

patients and their families enormously. As anaesthetists, pain medicine practitioners (and surgeons) we need to acknowledge how the standard of intensive care medicine has expanded the scope and complexity of the work we do. This has provided tremendous professional satisfaction, personal fulfilment, not to mention back-up when things do not go according to plan.

And so, in proposing the toast, I'll use the same words that **Tess Cramond** used in her toast to the new College of Anaesthetists: “the College of Intensive Care Medicine of Australia and New Zealand – may it flourish and extend its influence”. ”

Dr Leona Wilson
ANZCA President

“Intensive care medicine has transformed the way in which medicine is practiced in the last half of the 20th century and the first decade of this century. This has benefited our patients and their families enormously. As anaesthetists, pain medicine practitioners (and surgeons) we need to acknowledge how the standard of intensive care medicine has expanded the scope and complexity of the work we do.”

Below from left: **Dr Kerry Brandis**, ANZCA Councillor and **Dr Amod Karnik**, CICM Board member with guests in the marquee; Background music at the dinner was provided by the **Soundwood Strings**; **Dr Humphry Cramond**, **Mrs Elule Goucke**, **Professor Tess Cramond** and **Dr Roger Goucke** with the **Dean of the Faculty of Pain Medicine**, **Dr Penelope Briscoe**; **Professor John Myburgh**, **Dr Jane Baker** and **Professor Barry Baker** applaud the President's speech.



News from the College of Intensive Care Medicine

Location of the new College premises

The College has leased office space at 168 Greville Street, Prahran, which is just over a kilometre from ANZCA House in Melbourne. The building is the old Prahran Post Office, which is being extensively renovated and converted into a three storey office building. Building works are not yet completed, but all being well the move from ANZCA House will take place in early January and the College will then be fully operational as an independent entity.

The College's new website www.cicm.org.au will be ready to be launched by the start of next year and will take over from the temporary web page that is at that address. The member database, finance system, insurance coverage, human resources arrangements, etc, are all in the final stages of preparation and will all be in place ready for the move.

Associate membership

The College constitution has provision for a class of membership other than Fellow (and Honorary Fellow). The board discussed whether or not to enact this provision and create regulations governing admission to the College as an associate member, to be available to medical practitioners who work in the area of intensive care medicine but are not eligible for Fellowship. Following debate over the merits and potential drawbacks of broadening the criteria for membership, the board resolved to not create a category of membership for non-Fellows.

Foundation fellowship

There has been an excellent response to the call for foundation fellowship, with over 90% of the joint faculty fellowship now having completed their application and paid the fee. These foundation Fellows were all formally admitted to the College at the board meeting. In addition to the fellowship fee, a number of Fellows also very generously made additional voluntary donations to the College. The certificates of Fellowship will now be prepared, but with more than 600 names to be written, it will take the calligrapher some time to complete his task.

All remaining Fellows of the joint faculty who have not yet completed their application for foundation fellowship are encouraged to do so as soon as possible. After January 1 the joint faculty will cease to exist and fellowship of the college (FCICM) will in future be the recognised qualification for specialist practice in intensive care medicine, by both the Australian Medical Council and the Medical Council of New Zealand.

The board recognises the additional financial imposition that the fee for foundation fellowship has meant for many Fellows. The money received will help to ensure that the College has some financial reserve and can begin to establish an asset base with a view to one day purchasing a permanent home for the College.

Fees for 2010

In considering the fee for the annual fellowship subscription for 2010, the board was mindful of ensuring that the College could meet its financial commitments while at the same time recognising that foundation fellows had recently made an additional contribution of \$1000. It was ultimately decided to keep the annual subscription for 2010 the same as 2009. The annual subscription notice will be posted to Fellows early in the new year.

Support for regional Committees

The matter of ongoing support to the regional (and New Zealand national) committees was discussed at some length in the board meeting. ANZCA has agreed that their offices in New Zealand and Queensland will, for a limited period (up to two years), continue to provide administrative support to those CICM regional committees. In the other regions it will be necessary for other arrangements to be put in place. Board member Amod Karnik has been appointed regional officer and given the task of liaising with the chairmen of the regional committees to ensure that there is continuity of support in those regions.

Joint training with RACP

An education committee has been established to supervise the ongoing joint training program between RACP and the College. The CICM representatives on the committee are Peter Morley and Charlie Corke. The purpose of the committee is to ensure that the existing pathway to fellowship for RACP trainees who complete all of the requirements for advanced training in intensive care medicine remains available.

Farewell gift from ANZCA

The ANZCA Council have generously decided to give the College a substantial and lasting memento. After some discussion it was decided that a boardroom table and chairs would be a much appreciated and practical gift. These are being constructed by a Melbourne furniture maker and will be ready by the time we move to our new office.

Report from the JFICM Board Meeting

The final meeting of the JFICM Board was held on November 5 at ANZCA House, with the CIM Board meeting held the following day. In attendance were Dr Michael O'Leary, the new President of ANZICS and Dr Anthony McLean from the JFICM New Zealand National Committee.

Organ donation

Dr Gerry O'Callaghan, National Medical Director of the Australian Organ and Tissue Donation and Transplantation Authority presented to the board a summary of the work of the authority and, in particular, the development of a set of clinical triggers for use in all relevant hospital departments where consideration of organ and tissue donation is appropriate.

Education and training

Rural training rotations

The board approved a proposal to allow a three-month rotation to a rural or regional ICU which has been approved for basic training, as part of the non-continuous year of advanced training in a C12 or C24 unit. The rotation must be prospectively approved by the Censor and will not count towards the senior registrar time.

Examinations

General intensive care fellowship examination

The second General Fellowship Examination for 2009 was held on August 28 (written component) and October 22-23 (oral component). Fifty candidates sat the written exam, with 36 (72%) being successful. A further 18 candidates carried over success at a previous written, so 54 presented for the oral in Sydney. On day one, the hot cases were held at the Prince of Wales, Royal Prince Alfred, Royal North Shore and St George hospitals. On day two, the viva section was held at the Novotel Hotel, Brighton Le Sands. For the oral section 46 candidates were successful, a pass rate of 85%.

The year 2009 marks the 30th anniversary of the first intensive care fellowship examination. To mark the occasion, a celebratory dinner was held to coincide with the exam in Sydney. The previous chairmen of the Examination Committee were all in attendance and regaled the audience with tales of the early years of the exam.

Paediatric intensive care fellowship examination

The 2009 exam in paediatric intensive care was held on August 28 (written component) and October 20 (oral component). Six candidates sat the written component, with five being successful and progressing to the oral component, held at The Children's Hospital, Westmead. All five candidates were successful.

Congratulations to all the successful candidates from both exams, and a huge vote of thanks to all the examiners who contribute their time and expertise and also to the staff for ensuring that the week went so smoothly.

Intensive care examination dates for 2010

Primary examination 1

Written component	March 1
Oral component (Melbourne)	April 5

Primary examination 2

Written component	September 13
Oral component (Melbourne)	November 12

General fellowship examination 1

Written component	March 26
Oral component (Melbourne)	May 27-28

General fellowship examination 2

Written component	August 30
Oral component (Sydney)	October 28-29

Paediatric fellowship examination

Written component	August 30
Oral component (Auckland)	November 5

2009 Annual Scientific Meeting – Brisbane, June 12-14.

The 2009 ASM attracted just over 300 registrants in total, and with good support from the healthcare industry (two major sponsors and 19 trade exhibitors) was able to generate a good surplus. The board is most grateful to the organising committee, in particular the convener Rob Boots, for the huge amount of time devoted to enduring the success of the meeting.

Fellowship Affairs

Admission to fellowship by examination

The Board noted admission to fellowship of the Joint Faculty of Intensive Care Medicine by examination:

Edward Litton	NT
Matthew Holland	UK
Seamus Crowley	WA
Geoffrey McCracken	NZ
Gopal Taori	VIC
Vikram Patil	NZ
John McCaffrey	UK
Gordon Flynn	NSW
John Mackle	UK
Rohit D'Costa	VIC
Nicola Willis	QLD
Andrew Cheng	NSW
Grant Cave	NZ
Koon Lam	HK
Sayek Khan	NSW
Poongundran Namachivayam (Paediatric Intensive Care Medicine)	VIC

Honorary fellowship

A nomination was received for the award of honorary fellowship to Dr Sheila Willatts, an eminent (now retired) physician and a pioneer of intensive care medicine in the UK. The board voted unanimously in favour of the award.

Fellowship statistics

At October 14, 2009, the joint faculty had 688 Fellows. 542 in Australia, 59 in New Zealand, 22 in Hong Kong, 19 in the UK, 20 in Ireland and 26 in other countries.

Critical care and resuscitation

The journal of the joint faculty, *Critical Care and Resuscitation*, continues to grow and thrive under the leadership of chief editor Rinaldo Bellomo. Now in its 10th year, the journal is receiving increasing numbers of articles submitted for publication. Allocation of an impact factor is now an important next step in the journal's evolution. Publication costs are rising steeply and will need to be allowed for by the College's budget.

Dean's Message



Pain medicine has been receiving a lot of publicity in the last couple of months with the previous Dean's report highlighting problems with inappropriate management of chronic pain in our communities, and then the launch of the National Pain Summit, where more than 50 organisations have joined together aiming to raise the awareness that our patients deserve readily available and appropriate pain management.

I was involved in a number of radio talkback shows and was extremely disappointed when I spoke with one individual in a major Australian capital city where, even in this day and age, he is receiving inappropriate management of his cancer pain. The caller had pancreatic cancer (which is known to be a particularly severe form of cancer pain) and was being managed by his GP and gastroenterologist with four oxycodone per day. His pain relief was so inadequate that he was taking far more than prescribed (up to 20 per day). The radio host "suggested" that this individual was exhibiting signs of addiction. This is a classic case of "pseudo addiction" which is an iatrogenic syndrome resulting from inadequate pain management. As a result of this inadequate management, patients engage in behaviours seeking more medication and are often misdiagnosed as having addiction problems.

When the World Health Organization ladder was first published in 1986, it was predicted that over 90% of cancer patients could obtain reasonable relief from their pain by using a combination of opioid and adjuvant medication. In the small group that did not respond to either oral or parenteral medication, invasive procedures are appropriate.

Pancreatic cancer is one of those conditions where I believe invasive procedures are appropriate.

These patients respond poorly to opioids and are often on high doses when referred.

In my centre we still perform coeliac plexus blocks, which give good pain relief in up to 80% of patients, and improve appetite; if that is not available, intrathecal pain management strategies are appropriate.⁽¹⁾

Pain specialists have for a long time believed that if we give patients with cancer good pain management they live longer. PS Staats in the *Anaesthesiology Clinics of North America* comments: "... untreated pain can take on a life of its own. Ongoing pain can increase - physically damaging stress and psychologically damaging depression each of which can, like all negative emotions, intensify the pain experience".

Clinicians have long understood that unremitting pain can shorten life by causing the patient to choose suicide (or euthanasia) but we are now beginning to realise that, for reasons not yet understood, pain can hasten unassisted death.⁽²⁾

Thus, we have a situation where we are trying to raise the profile of pain medicine throughout Australasia, while patients with cancer are not even being referred on for opinions and treatment.

Part of this relates to the ignorance of doctors that cancer pain can be treated successfully in almost all cases. However, there is also a belief by both patients and their doctors that cancer pain is inevitable, fear that if strong analgesics are used now there will be nothing left when the disease progresses and that using morphine will lead to addiction. There is also lack of understanding of what is available and accessible. I still hear it stated that there is no point referring some patients on to a pain clinic as the waiting period is up to 12 months. However, most pain clinics throughout Australasia have a triaging system where patients with cancer pain are seen quickly.

One of the strategies of the National Pain Summit is to chart pain as a fifth vital sign in all health facilities in Australia. Therefore, along with taking blood pressure, pulse, respiratory rate and temperature, the health professional should also ask the patient about their pain.

I believe anaesthetists are in a unique position, in that they often see patients when they present for surgery who may have recently had a diagnosis of cancer. Anaesthetists have the capacity to enquire about the patient's pain - not just in the peri-operative period - and make recommendations to the patient and the surgeon that the patient may well benefit from referral to a pain or palliative care specialist.

Anaesthetists should be well aware of the procedures that can assist patients with cancer pain and must also be aware that patients who present to surgery with significant pre-operative pain are at much higher risk of having severe pain in the peri-operative period.

Therefore, as we are moving towards a pain summit in Canberra in March next year, I would suggest that all practitioners talk to patients about the pain they suffer on an ongoing basis and make the appropriate recommendations about referral.

In almost all circumstances cancer pain can be managed using a combination of medication via numerous routes of administration, or therapeutic nerve blocks and also addressing pain management using both psychology and physiotherapy where appropriate.

Patients with pancreatic cancer often have a very short prognosis of months. However, in my experience, with coeliac plexus blocks these patients can have fantastic quality of life. They often come back for two or three blocks suggesting that their longevity has been prolonged.

So to all my colleagues who practise medicine in whatever branch, make sure that when you are taking a history and examining your patient, along with other vital signs, you always ask about their pain, the duration, the intensity and make appropriate referrals.

Dr Penelope Briscoe
Dean

References:

1. Staats PS, Pain: Effects of Alcohol Celiac Plexus Blocks, Pain, and Mood on Longevity of Patients with Unresectable Pancreatic Cancer, *Pain Medicine* (2001) Vol 2 No.1 p 28
2. Staats PS, The Effect of Pain on Survival, *Anaesthesiology Clinics of North America* No.21 (2003) 825-833

New Zealand application for specialty recognition

An application for specialty recognition in New Zealand has been submitted and the consultation process has commenced with the Medical Council of New Zealand seeking sector feedback in advance of the next meeting of their Education Committee on January 11, 2010. The two-stage application process is expected to take about 18 months.

International Medical Graduates

The board has resolved to establish a qualification of "Associate Fellowship" as a form of recognition for those who have completed the training and examination requirements of the Faculty of Pain Medicine but who are not eligible for Fellowship as they do not hold Fellowship of an approved Australian or New Zealand primary specialty. Associate Fellows will become eligible for Fellowship of the Faculty of Pain Medicine upon confirmation of "Substantially Comparability" of their Specialist Qualification by the corresponding Australasian College. Processes are being finalised with a view to introduction of this qualification in 2010.

2010 ASM – Christchurch

Plans are well advanced for the refresher course day and ASM program including Dr Jeffrey Mogil (Canada) as the FPM ASM visitor and Dr Richard Rosenquist (US) as the FPM New Zealand visitor. The programs for both the refresher course day and ASM are now available on the website. Registration brochures will be circulated in January.

National Prescribing Service (NPS) Acute Post-operative Pain (APOP) Toolkit

The National Prescribing Service (NPS) quality improvement toolkit on Acute Post-operative Pain (APOP) management is now available. The APOP toolkit comprises a downloadable software application (audit tool) and educational resources. The APOP toolkit will assist anaesthetic, surgical and nursing staff in post-operative units and acute pain service teams to conduct reviews of patient care in the area of acute post-operative pain. The audit tool measures pain assessment and sedation scores, post-operative analgesic use and safety of prescribing and administration, patient perspectives on effective pain management and adverse effects and discharge management.

Access the free toolkit at http://www.nps.org.au/due_apop

Supervisor of training (SOT) workshop

FPM supervisors of training met at the NSW Regional Office to participate in a workshop facilitated by the Manager, ANZCA Education and Development Unit. The focus of the workshop was on assisting trainees in difficulty and nine supervisors of training (SOTs) participated enthusiastically.

SOTs explored the types of problems that trainees may experience and used a framework to analyse and define these problems. An overview of relevant ANZCA/FPM policies and procedures was provided and participants had the opportunity to refine their communication skills through the use of role play. SOTs valued greatly the opportunity to work through problems they commonly faced as a collective group and learn from each other's experiences. As a result of the workshop, attendees developed a range of remediation strategies to address problems encountered by trainees at a local level.

The next workshop is planned in conjunction with the 2010 ASM in Christchurch.

ANZCA submission: Medical Specialist Outreach Assistance Program-Indigenous Chronic Disease Guidelines

The Faculty recently made a submission to the Department of Health and Aging in relation to the Medical Specialist Outreach Assistance Program-Indigenous Chronic Disease Guidelines. These guidelines will focus on the improving the range of health services available to rural and remote indigenous communities. To read this submission please visit <http://www.anzca.edu.au/news/submissions-to-government/>

ANZCA Library online collection of pain medicine books

The ANZCA Library has created a direct link to pain-related books held in the collection via the library catalogue. Log in to the ANZCA/FPM website and link to the Library catalogue to view the large range of books in the pain area. <http://www.anzca.edu.au/resources/library/book-catalogue.html>



2009 Faculty of Pain Medicine examinations

The 2009 Faculty of Pain Medicine examination was held November 25-27 in the Pain Management and Research Centre at the Royal North Shore Hospital. Twenty of the 24 candidates were successful, representing a broad range of specialty backgrounds including anaesthesia, surgery and, for the first time, general practice. Merit awards went to Dr Kerry Thompson (Vic), Dr Clifton Timmins (Qld) and Dr Max Sarma (Tas).

Admission to Fellowship of the Faculty of Pain Medicine

By training and examination:
Dr Donald Johnson UK

By training and examination:
Dr Stephanie Oak NSW

From top: 2009 Court of Examiners and Observers; from left: Dr Kerry Thompson and Chair of Examiners Dr Ray Garrick; Dr Max Sarma and Dr Ray Garrick; Successful candidates for 2009; Dr Ray Garrick congratulates Dr Clifton Timmins.



National Pain Strategy – priorities

The draft National Pain Strategy (NPS) sets out a number of strategies aimed at minimising the burden of pain on individuals, families and the community.

A key first step will be to have pain management recognised as a national health priority and recommendations incorporated in to the current health reform program. The strategy which addresses acute, chronic and cancer pain, makes recommendations covering improvements in standards and access to treatment, consumer empowerment and the need for state of the art research that translates into the clinical setting. There is an emphasis on strategies aimed at preventing the progression of acute pain episodes, to chronic pain. Some of the priority strategies are:

- ✓ Implement a strategy of charting pain as the fifth vital sign in all health facilities in the nation.
- ✓ Recognise chronic pain as a disease entity with a diagnostic code (as for other chronic diseases) in order to document its prevalence, outcomes and costs.
- ✓ Develop and evaluate a service delivery model for pain management in the community which provides interdisciplinary assessment, care and support as a part of comprehensive primary health care centres and services, linked to tertiary interdisciplinary pain centres.
- ✓ Increase the number of trainee positions in pain medicine to facilitate access to appropriate pain management services throughout Australia, including regional and remote areas which are currently very poorly serviced.

- ✓ Secure funding and provide resources for existing accredited specialist inter-disciplinary pain clinics to continue to provide care for people with complex needs, and to support health professionals in community care settings by providing education, training and advice, participating in clinical networks, and researching and evaluating new treatments.

- ✓ Develop a funding model for interdisciplinary pain management in the community, including pain management Medicare item numbers for accredited advanced-skill practitioners, and funding for self-management programs (including group programs).

- ✓ Recognise the critical role of adequate management of acute pain to minimise the rate of progression of acute pain to chronic pain.

- ✓ Develop systems, including e-health records, to facilitate improved communication and information sharing between multiple care providers, and to improve transitions between care settings.

- ✓ De-stigmatise the predicament of people with pain, especially chronic non-cancer pain, through development of a community awareness campaign and training for health professionals and insurers.

- ✓ Ensure consumers and their carers have the knowledge, tools and confidence to seek appropriate advice, education and/or treatment to enable them to better manage their pain.

- ✓ Ensure the social, economic and regulatory environment (i.e. employers, legal systems, compensation systems, insurance bodies, and government agencies) provides a compassionate, empathic and well-informed framework to support people in pain.

- ✓ Develop and standardise education materials for consumers, health professionals, insurers, rehabilitation providers to improve understanding of the nature of chronic pain and best practice management, including management of pain medicines.

- ✓ Support key consumer groups to provide resources, advice and community-based support for people with chronic pain.

- ✓ Establish a national body with clinical, consumer and government involvement to identify the partnerships, framework and resources required to build capacity and deliver proposed outcomes.

- ✓ Establish a virtual Centre of Excellence in Pain Medicine to provide clinical, research and education leadership for Australia and to develop and maintain an accreditation and quality improvement framework for pain services in collaboration with consumers.

- ✓ Recognise pain as a discrete research area in NHMRC research categories and an NHMRC Research Priority.

The draft National Pain Strategy, aimed at acute, chronic and cancer-related pain, is a result of the collaborative work of health professionals and consumers. It has been developed in the lead-up to the National Pain Summit to be held in March 2010. The National Pain Summit is led by ANZCA, Faculty of Pain Medicine, the Australian Pain Society, and consumer group Chronic Pain Australia, in collaboration with inaugural supporters, MBF Foundation and the Pain Management Research Institute.

To read the draft National Pain Strategy visit www.painsummit.org.au

Depression and suicide: what can you do?



There is no question that anaesthetists, like everyone else in society, suffer from depression. The difference perhaps, is that most doctors find it difficult to disclose the fact to themselves or their colleagues, or to seek medical help for it. It has also been estimated that 10 per cent of deaths of anaesthetists are due to suicide, yet the cause of these deaths is rarely acknowledged as such other than locally at the time. Many suicide deaths in the anaesthetic community are trainees.

Depression may often manifest itself in a fashion that is insidious, and can be described by the sufferer as stress, burnout or anxiety. It may present as physical symptoms, such as headaches, fatigue and insomnia, and will very often be denied or trivialised. Depression in anaesthetists may also be recognised by colleagues or supervisors as diminished performance, mood changes or withdrawal.

Depression and suicide may be triggered by such incidents as work problems, adverse events, litigation, substance abuse or relationship problems. Suicide may be more common in the presence of mental illness, medical illness, and in those who have had a prior attempt or verbalised suicidal ideation; it may also occur in those who use psycho-active and/or recreational drugs. Critically, however, even where there are “good reasons”, anxiety and depression must be identified and treated formally.

So what can be done to identify depression and prevent suicide, particularly by the untrained anaesthetist? The first strategy is that we all need to take responsibility for our own health, have our own GP and seek help if we notice signs of depression in ourselves.

The next sounds trite, but is probably the strongest strategy we have. That is to care for your colleagues as conscientiously as you do for your patients and your families. When the surface is scratched, most communities of anaesthetists, be they in hospitals, private practices, regions, study groups or cohorts, actually care deeply about the well-being of their colleagues and friends. Unfortunately, however, we tend to be more vigilant of others’ well-being at times of crisis, rather than being proactive or observing them on a day-to-day basis.

Once we identify a colleague in trouble, what next? Share the concerns with others – they too may have noticed, or wondered about the person in question. Consult an expert; psychiatrists and Doctors’ Health Advisory Services are the obvious places to start. There are also a number of psychologists in several states who have active interests in helping doctors pass exams. The members of the Welfare of Anaesthetists Special Interest Group are not experts but can suggest avenues for help or referral.

Someone must then make the approach with a firm plan for what to do if the person refuses or avoids help. It may help if the person who does so is not an authority figure or one with implications for career progression and when the approach is made, it should be done in a timely and sensitive manner. If it doesn’t work the first time, it should be repeated until it does. And remember, asking someone directly whether he/she feels hopeless, depressed or suicidal will not provoke these feelings.

Finally, if it all fails and someone does take his/her own life, we, as a professional community, have an obligation to recognise the grief, guilt and even anger of those left behind and to ensure that these people are supported, either directly or by referral.

Dr Tim Porter
MBBS, BEC, FANZCA

Acknowledgements:
Welfare of Anaesthetists Special Interest Group: - RDO3 Recognising Depression and Anxiety Private communication and editing: Dr D Khursandi.

For help or information, visit beyondblue.org.au or spinz.org.nz or call Lifeline (Australia) on 13 11 14 or Lifeline (New Zealand) on 0800 543 354.

Members of the Welfare of Anaesthetists Special Interest Group can be found at www.anzca.edu.au/fellows/sig/welfare/introduction.html.

Dr Linda Rose Dadds

January 23, 1972 – November 11, 2009



Linda Dadds was born on January 23, 1972 at Memorial Hospital in Adelaide. She was educated at Colonel Light Gardens Primary School and later Kingscote Area School on Kangaroo Island, where she matriculated in 1988. After leaving school, she spent a year in Guatemala on an AFS exchange, during which time she became fluent in Spanish.

On her return, she completed a Bachelor of Medical Laboratory Science degree through the University of South Australia, graduating with honours after studying the role of blood in rejection after organ transplant. She was recognised for her work with a Queen Elizabeth Hospital Research Day Award.

She initially worked as a research scientist at Daws Road Repatriation Hospital contributing to laboratory work and papers on the science of bladder tumours, before being accepted in 1998 into the Flinders University post-graduate medical degree. As a medical student she rotated to Barmera, Greymouth New Zealand, Alice Springs and Thursday Island.

She completed her internship and residency at the Queen Elizabeth Hospital in South Australia, and commenced anaesthesia training there in 2004. On the South Australian regional training scheme she also worked at the Royal Adelaide Hospital, Flinders Medical Centre, Daws Road Repatriation Hospital, Women's and Children's Hospital and the Darwin Hospital.

Linda took a particular interest in teaching junior registrars, and as one of many registrars who struggled with our college exams, she had a special concern for those who, like her, had difficulty passing them. She was a very giving person and generous to a fault. When friends from her parent's Barossa Valley community were ill she took time to help them and their families understand and cope with the foreign medical world. Similarly her patients felt that Linda had time for them and understood them as people rather than just patients. Some of her patients went so far as to write to Linda's parents after her death to express their sympathy and their gratitude for Linda's care.

While Linda found the ANZCA examination process very difficult, she had completed the primary exam, all her modules and training time and was a highly valued, well-regarded and trusted senior registrar at Modbury Hospital. Linda was often the most senior doctor in the hospital after hours, and the Anaesthetic Department hoped to keep her as a consultant as soon as she passed the elusive fellowship examination.

Outside work, Linda was a prolific and passionate reader and an ardent lover of animals, particularly cats and horses. She rode from the age of five and became a very accomplished rider and show jumper. She owned two beautiful cats, and had just bought a new puppy. Linda loved music and was an accomplished flautist. She also loved going to musicals

and the ballet. Sport, too, played a huge role in her life and included netball, skiing, badminton, tennis, sailing, table tennis, volleyball and, of course, horse riding. She was a keen gardener and a loyal friend with an infectious laugh.

Tragically, Linda took her own life at Modbury Hospital on Remembrance Day, November 11, 2009.

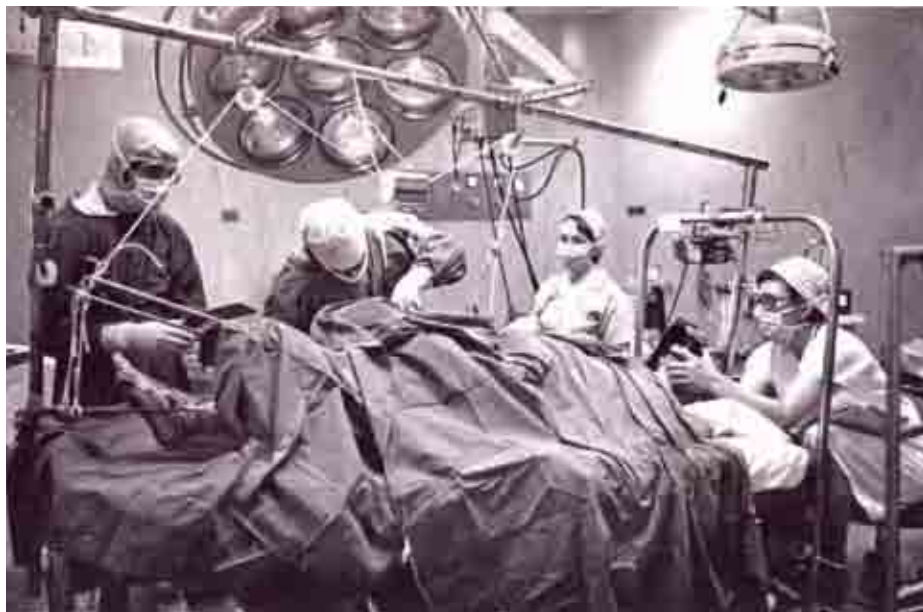
Linda is survived by her parents Rose and Ken Dadds who were incredibly and justifiably proud of their daughter, her brother Andrew, sister-in-law Carol, beloved nephews Owen and Theodore, and her partner Chris Beamond. They have kindly agreed and contributed to the publication of this obituary in the hope that it will lead to a wider recognition of suicide as an issue in our profession, and possibly help prevent another family having to experience a similar senseless loss.

Farewell, Linda, you will be deeply missed by many.

**Dr Kate Drummond and
Dr Monica Korecki**

Jean Reid Oakes

June 16, 1920 – July 28, 2009



Jean Oakes, who had been a significant presence in the Hobart medical community since the 1950s, died suddenly in the “good country”, England, aged 89, on her final trip home. Despite serious physical handicaps as she got older, she was able to continue to pursue a wide range of interests until her death.

Jean Christie was born in Clevedon, Somerset on the west coast of England where her father was a dentist. Her early life in England was a happy and privileged one. She had a brother Michael and sister Anne. At 12, she went to a prestigious boarding school, Wycombe Abbey, where she learned to work and play hard and developed the self discipline which was to become one of the guiding principles of her life. She excelled in music and her childhood piano, which was transported to Tasmania, became a source of great relaxation in her always-busy life.

Medicine was to become her chosen career and in 1944 she qualified in Bristol. This is where she met Henry Oakes, a fellow student, whom she married in 1942. Henry was sent off to India until the end of the war in 1945.

After a period in England following the war they emigrated to Bothwell, a small town in southern Tasmania, where Henry thought they would find sunshine and an opportunity for general practice.

Jean by then had two small children. She found the isolation of Bothwell depressing and at Henry’s suggestion returned to England (working as a ship’s surgeon) in 1951. But it was not for long. Her determination to make a new life in Tasmania saw her return, this time to Hobart.

She returned to study and qualified as an anaesthetist in the early fifties. When the Faculty of Anaesthetists was

established she was an inaugural member and later became a Fellow. Female anaesthetists were a rare species, but she persevered and established herself in solo practice and was later, for a period, a member of the Hobart Anaesthetic Group.

From 1976 – 77 she took over the Director of Anaesthetics position at the Royal Hobart Hospital from Michael Hodgson until the arrival of Stewart Lamont. She provided excellent and supportive leadership. She was a visiting medical officer at the Royal Hobart Hospital from 1949 until 1984.

Although anaesthesia was her chosen specialty she later moved into community health and general practice. She continued full-time in this role until age 67 and worked part-time until she was 75.

She suffered greatly following the death of Henry in 1982 and her son Simon, also a doctor, in 1996, but in true Jean style, gathered her life together and moved on.

Her continued interest in all things medical, her astute observations of life and people and her genuine warmth, humour and keen intelligence remained until her sudden death. She would have enjoyed knowing that England won the Ashes. She was alive to know they won the second Test.

Her life was a testimony to her adaptability and good sense – a life truly well lived.

She is survived by her daughter, Judy, and sons, Anthony and Julian.

Dr Robert Bown

Above: Jean Oakes is on the far right.

Walter Wyndham Biggs

January 7, 1936 – September 24, 2009



Walter Wyndham Biggs died on September 24, 2009 after a year-long battle with acute myeloid leukemia. Walter - or Wally - as he was known to his friends and colleagues had an interesting and broad career in anaesthesia.

He graduated MBBS in 1959, from the University of Queensland, with honours, and elected to do his first year of residency at what was then the Brisbane General Hospital, a vast conglomerate that included a children's hospital and a women's hospital. He had taken up the offer of a State Government Fellowship during his undergraduate course and so was "bonded" to the Queensland State Health Service for a time after graduation. Wally always enjoyed recounting the story of how he was conscripted into anaesthesia (he had hoped to do obstetrics and gynaecology).

Towards the end of his first year as an RMO, he was called to the office of the Director General of Health who informed him that next year he was to be sent to Longreach as the medical officer (that is anaesthetist) to the Flying Surgical Service, which was based in Longreach and had been established little more than a year before. Wally replied to the director general that he had never actually given an anaesthetic, whereupon, the director general replied: "It's easy son, you can learn in a fortnight". Sadly, this issue still prevails in the minds of many administrators.

Soon after, Wally was sent to the Department of Anaesthesia at the Brisbane General Hospital where the wise counsel of the director at the time, Dr Ruth Molphy, managed to secure an additional four weeks training for him.

Walter spent four years in the Flying Surgical Service (1961-1965) and experienced a wide range of cases, returning to Brisbane to continue his formal training. After being awarded the Renton Prize after passing the primary FFARACS, he followed what was then a familiar path by travelling to the UK, obtaining his FFARCS, then working at the London Hospital, which at the time had a very strong connection with Brisbane.

In 1968 he returned to Brisbane and joined the practice now known as Narcosia and passed the final FFARACS.

Walter's academic interest was soon noticed and he was recruited in 1972 to the Court of Examiners for the final FFARACS, then as a member of the Final Examination Committee, and later the deputy chair, Court of Examiners, final FFARACS 1977-1984. He was also Member of the Board of the FARACS 1977-1981.

During his professional career Walter gave outstanding service to the Faculty of Anaesthetists and for 30 years as a VMO at the Royal Brisbane and Royal Children's Hospital. He was a leader in setting the standards in anaesthesia.

Our specialty has been enriched by his contributions and is the poorer for his loss.

Dr Peter Livingstone
FANZCA

Dr Wah Kim (Harold) Chan

1931 – 2009



Harold Chan was born in Singapore in 1931, one of five siblings. The early years of Harold's life were not easy; he and his family were forced out of their homes during the Japanese occupation of Singapore and moved to Malacca in Malaysia. There, as a young boy, he met his wife, Eleanor, whose family was also suffering considerable hardship as a result of the war. With no school to attend and little food, Harold sought work but there were few jobs available. Eventually Harold was befriended by a local Japanese businessman who encouraged him to learn Japanese and secured him a job as an office boy with his company.

When the war ended Harold returned to Singapore and completed his schooling. He attended the highly respected Anglo Chinese School in Singapore where he became a King's Scout in 1945 and was dux of the school. His passion was for engineering but he won a scholarship to study medicine. Harold's medical undergraduate years were spent at the large and extremely busy "GH" (Singapore General Hospital) and at "KK" (Kandang Kerbau Women's Hospital) with 100 births each day. One of his important mentors at this time was the obstetrics and gynaecology professor, Benjamin Sheares, who was to become the second President of Singapore. Harold qualified in 1956 winning the prize for surgery.

This was a time of great change in Singapore. Prior to World War II and the Japanese occupation, Singapore had been under British rule. Negotiations began in the 1950s for independence and a gradual process of elections led ultimately to effective independence (Kemerdekaan) in 1959. As part of this process the health service came under local governance in the mid 1950s and recruiting in Great Britain for the Colonial Medical Service in Singapore ceased.

The inevitable result of this process was a shortage of trained personnel. The Singapore Department of Anaesthesia was very short staffed and for most of the 1950s had no more than two qualified anaesthetists. The surgical professor, Yeoh Ghim Seng, a visionary surgeon who was to become the Speaker in the Singapore Parliament and its Acting President at times, encouraged his trainees to complete twelve months of anaesthesia. This practice was to create many fine surgeons and was most likely the reason Harold was encouraged to take up anaesthesia. However, he remembered that it was a result of failing the first part of the surgical exam and being told "you can either choose to work at the mental hospital or you could consider anaesthetics – at least then you will be in the operating theatre with the surgeons"!

There was no specialist anaesthetic training program in Singapore at that time but some places were available in Liverpool with T Cecil Gray. These were eagerly sought after and sponsored by the Singapore government. Many Australian doctors visited Singapore under the auspices of the Colombo plan and Harold learnt much by working with them. Once he decided to specialise, he elected to travel to Melbourne where the Faculty of Anaesthetists had recently been established at the College of Surgeons.

This was not his first trip to Australia. In 1948, at the age of 17, Harold attended the first Pan Pacific Scout Jamboree in Wonga Park in Victoria. He and his fellow scouts travelled on a boat usually used for sheep transport and their living quarters were the sheep pens which had not been well cleaned.

To add to the discomfort, when they docked in Perth, the city was in quarantine due to a polio epidemic and they were unable to disembark. Eventually the quarantine was lifted and they travelled by train to Victoria. After the jamboree they spent some time in Tasmania. This was a difficult time for Harold as his mother died while he was away and there was no way for him to return home.

These were very busy days for the few anaesthetists in Singapore. As an employee of the government, Harold was expected to cover all the hospitals doing whatever cases were required. Largely self taught, Harold and his colleagues anaesthetised everyone in Singapore, from the very old to the very young. "I am sure we must have made a lot of mistakes," he would say.

In 1959 he travelled to Australia and visited the Melbourne hospitals with anaesthetists such as Bernie Dunn and Noel Cass, learning their skills and preparing for the exams.

He sat and passed the first part of the new Fellowship exam on September 9, 1959 and returned to successfully complete the final exam in October 1960. The final exam at that time consisted of two, two-hour papers on one day, followed by clinicals and vivas the following week. Harold studied very hard for the exam but ultimately the final fellowship exam was not difficult because he had gained so much experience.

"When I was asked how to manage a bleeding peptic ulcer, I told them everything," he said. "They asked me how I knew so much. I said in Singapore there is no one else, we do them all."

After becoming the first Singaporean to gain the Australian Fellowship, Harold continued working for the Singapore government but also expanded into private practice.

Some private hospitals had anaesthetic machines but he also had his own which he required in some places, especially dental surgeries. Harold made this machine, mounting various components such as a circle absorber and ether bottle on a metal frame with room for spare cylinders and a carrying handle. He used this machine throughout his career.

Usually there would be someone to help carry the equipment once he arrived at the hospital and, although he carried his own cylinders, he would also arrange for oxygen cylinders to be delivered to the site as well.

His private practice was not without incident and on a particularly memorable day he was anaesthetising a patient in a dental surgery in the Hong Kong and Shanghai Bank Building in Orchard Road. It was 3.07pm on March 10, 1965 and Singapore was in the middle of a conflict with Indonesia (Konfrontasi).

A bomb was detonated in the lift well. Harold and his patient were blown across the room, shattered windows covering the floor in broken glass. The patient had been intubated but the tube and circuit remained by the dental chair and Harold had to frantically crawl through the ruins of the room to re-intubate this patient.

He and the Malay attendant then carried the patient down five flights of stairs, woke him up in the foyer and put him in a passing car with instructions to take him to a hospital.

Two people were dead and the foyer was a sea of broken glass and bleeding bodies. Harold spent the remainder of the afternoon resuscitating people and putting them into more passing cars. He remembered another explosion that he witnessed during the same conflict that was on the roof of a night club; on that occasion he decided it was prudent to run in the opposite direction.

In 1986 his career almost came to a sudden end when he was diagnosed with an expanding thoracic aneurysm. He travelled to America to have a repair but awoke from the operation with a dense paraplegia. Months of physiotherapy followed with him crawling around the room, determined to regain the use of his legs. Eventually he developed some feeling in his legs and was able to walk with the aid of sticks. No airline would carry him on the interstate leg required to get him home via San Francisco and in the end he had to personally hire a Lear Jet.

Once back in Singapore, his old friends from the scouts and many of his surgical colleagues rallied around to encourage him and with extraordinary tenacity he eventually returned to work, confining his practice to just two hospitals. He was able to drive a car and also returned to playing golf - "not very good golf mind you..." - with the help of a second-hand golf cart.

Harold was an expert and enthusiast in many fields. Ultimately he was pleased that he took up medicine rather than engineering because it was a career that allowed him to pursue all his other interests. He had a ham radio licence (call sign 9V1XH), was a wonderful photographer, grew beautiful orchids and had the most extraordinary collection of walking sticks, including some with quite dangerous concealed weapons! He loved gourmet traditional foods and fine wine and had the command of a number of languages and dialects. Despite the obvious hardship he had to overcome, his enthusiasm for life never diminished.

In the course of his busy life, Harold befriended a large number of overseas anaesthetists and other doctors and their families. He was a generous host and with his extraordinarily capable wife Eleanor, was able to assist these friends in many ways.

He is remembered by his Australian friends as a loyal friend and a most generous person. He is survived by his wife, Eleanor, their six children, Gerald, Jackie, Bernie, Noreen, Alvin and Wendy, and their families.

The words of the Bahasa Melayu proverb best represent how Harold treated his friends and how he is remembered by them.

"Hutang emas dapat dibayar, hutang budi dibawa mati" ("A debt of gold can be repaid but a debt of friendship is carried to the grave")

Dr Christine Ball, honorary assistant museum curator, with Bernie Dunn and Noel Cass.

Footnote: In September 2008, Harold Chan discharged himself from hospital after a routine operative procedure to meet Dr Christine Ball in Singapore and tell her the story of his life. He was extremely generous with both his time and his memories and it was a great privilege for Dr Ball to meet him and his wife, Eleanor. This obituary, although compiled by Dr Ball, contains the special memories of his very close friends, Bernie Dunn and Noel Cass.

ANZCA Council meeting report

November 2009

Report following the ANZCA Council meeting on November 21, 2009

College Award and Election ANZCA Medal

Dr Diana Khursandi (Qld) has been awarded an ANZCA Medal in recognition of her long-term contribution to the specialty of anaesthesia. Dr Khursandi has made a significant and sustained contribution in a diverse number of areas including rural and regional practice, anaesthesia workforce challenges, gender issues in medicine, clinical indicators, CPD, education and training, and the health and welfare of doctors.

Election to Fellowship

Professor Michael Irwin (HK) has been elected to Fellowship under Regulation 6.2. Professor Irwin is currently President of the Hong Kong College of Anaesthesiologists.

Dr Khursandi will be invited to receive her medal, and Professor Irwin will be invited to have his Fellowship conferred at the College Ceremony in Christchurch next year.

Death of Fellow

Council noted with regret the death of Queensland Fellow, Dr Agnes Mary Daly, AM – FFARACS 1970, FANZCA 1992.

Quality and Safety Committee

Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC)

The software for the initial phase of the development of the on-line anaesthetic incident reporting system is now in place and being utilised successfully as part of a pilot program. In addition to the originally targeted pilot sites, several others sites have expressed interest in participation and have commenced the approval process.

Two forms of legislative protection are each required to run the program in both New Zealand and Australia:

- In New Zealand, national ethics approval was sought and obtained via the Multi-region Ethics Committee, and the application for recognition as a Quality Assurance Activity (QAA) was sought and approved through the Health Practitioners Competence Assurance Act 2003.

- In Australia, the application for recognition as a QAA was sought and approved under the Health Insurance Act 1973. Obtaining Ethics approval is proving problematic and time consuming as there is no national ethics committee approval system in Australia, and individual applications to each hospital must be made. Individual applications will be sought throughout the pilot phase, with the investigation of alternative methods for the future roll-out of the program across all jurisdictions in Australia.

Association of Anaesthetists Great Britain and Ireland (AAGBI) – International Guidelines Group

Council has agreed to endorse the AAGBI Guideline on the Management of Severe Local Anaesthetic Toxicity. The group that developed the guideline included anaesthesia and emergency physician representatives from Chicago University, James Cook University Hospital, Waikato and Hutt Hospitals.

Regional/National Committees

It has been agreed to include a Quality and Safety Officer in the membership of the Regional/National Committees.

The main aims of the role are to:

- act as a point of contact and as a conduit for relevant quality and safety information
- seek opinions for submissions relating to quality and safety reviews
- attend pertinent local quality and safety workshops/meetings where possible

Additionally, all accredited hospitals have a Quality Assurance (QA) Officer, and it is envisaged that the Q&S Officer could act as a conduit with a network of hospital-based QA Officers, to participate in the above three activities.

Regulation 3.15 has been amended to reflect this decision.

Education and Training Committee Educational Programs at the ASM

As part of the re-design of teacher development and support activities, Council approved the introduction of an educationally focused stream each year at the ASM, commencing from 2011. The activities will be planned and delivered by Education Development Unit staff and will be budgeted as part of the ASM budget. They will be aligned with the College training program, and will include core training for all clinical teachers, with options for a more tailored approach to meet the needs of those who progress to increased educational responsibilities, e.g. educational leadership, scholarship, teaching and/or management.

ANZCA Guidelines on Assessment

As stated in the Regulations, the duties of the Assessments Subcommittee include the provision of advice regarding non-examination, non-workplace-based assessments, and the blueprinting, co-ordination and evaluation of assessments (examinations, workplace-based and other) as part of the curriculum for education and training of trainees in anaesthesia. To this end, a set of guidelines has been developed, and endorsed by Council, to guide the review and redesign of ANZCA assessments. This work will include blueprinting the assessments to the curriculum outcomes framework. A copy of the guidelines is available in a public section of the College website.

Educational Innovation Funding for 2010

This funding was established to support small workplace-based projects with modest budgets that are directly relevant to the ANZCA training program. The total quantum of funding available is \$40,000 and the following projects were supported by Council for next year:

Name	Project	Funding Approved
Graham, J et al	PCAT: Provisional Check of Anaesthesia Trainees	\$20,000
Misur, M et al	The Mini-Clinical Evaluation Exercise (Mini-CEX)	\$10,000
Castanelli, D	Multi-source feedback for trainees in anaesthesia	\$10,000

Finance **2010 Budget**

Following an exhaustive consultation and review process, and in line with the recommendation of the Finance, Audit and Risk Management Committee, the budget for 2010 was approved by Council. An overall increase in fees of 4.8% was accepted, and the fee schedule for next year is available on the ANZCA website in the News section under Council Reports.

Fellowship Affairs Committee **2010 Annual Scientific Meeting**

Prof Paul Myles is the Australasian Visitor to this meeting, and as part of his commitments, it has been agreed that he will visit Western Australia following the ASM in Christchurch.

2013 Annual Scientific Meeting

The dates for the Melbourne ASM have been confirmed for 4 – 8 May 2013.

New Fellows' Conferences

It has been agreed that the NFC will be incorporated into the area of responsibility of the ASM Officer who will act as an advisor to NFC convenors.

Dr Michelle Mulligan has been appointed Councillor in Residence to the 2010 NFC which will be held in Hanmer Springs, NZ. The theme of this meeting is Adventure and Anaesthesia.

Anaesthesia Continuing Education **Co-ordinating Committee (Acecc)** **Establishment of a Perioperative** **Medicine Special Interest Group**

Council has supported the establishment of a Perioperative Medicine SIG to progress the work commenced through the Perioperative Medicine Taskforce in 2004. The proposal is still to be formally approved by the ASA and NZSA Councils.

Dr Leona Wilson
President

Associate Professor Kate Leslie
Vice-President

ANZCA Council meeting report 2

October 2009

Report following the ANZCA Council meeting on October 10, 2009

Resignations from Council

Drs Richard Waldron and Peter Cook have tendered their resignation from Council.

Dr Waldron was elected to Council in 2006, following a year as a co-opted member and resigned in August. His portfolios were Honorary Treasurer and ASM Officer. In addition to these portfolios, during his time on Council, Richard served as a member of the Continuing Education and Quality Assurance (CE&QA) Committee, the Hospital Accreditation Committee and was chair of the Workforce and Anaesthesia and Industry Liaison committees.

Dr Cook was elected in 2007 and resigned on October 2. During his time on Council, Peter was a member of the CE&QA Committee, was co-opted to the Overseas Trained Specialist (OTS) Committee and was ANZCA representative on the Joint Consultative Committee on Anaesthesia and JFICM Board.

In accordance with clause 11.2.1 of the Constitution, the casual vacancy resulting from Dr Waldron's resignation has been filled by Dr Mark Reeves. Dr Reeves will join Council as a co-opted member for an initial period to May 2010.

In accordance with clause 8.5 of the Constitution, the casual vacancy resulting from Dr Cook's resignation will be filled by Dr Patrick Farrell.

Associate Professor Kate Leslie was appointed Honorary Treasurer, and Dr Nicole Phillips as ASM Officer.

College Awards

Orton Medal

Professor Peter Kam (NSW) has been awarded an Orton Medal. This is the College's highest form of recognition for its Fellows and has been awarded to Professor Kam for his immense contribution to training and education across Australia, New Zealand and South-East Asia over many years.

ANZCA Medal

Dr Robert Wong (WA) has been awarded an ANZCA Medal in recognition of his contribution to diving and hyperbaric medicine, his initiation of the formal qualification in this area in 2003 and his ongoing work to maintain the program at the highest possible standard.

Professor Kam and Dr Wong will be invited to receive their medals at the College Ceremony in Christchurch next year.

Death of fellows

Council noted with regret the deaths of the following Fellows:

- Dr Wah Kim (Harold) Chan (Singapore) FFARACS 1961, FANZCA 1992
- Dr Walter Wyndham Biggs (Qld) FFARACS 1968, FANZCA 1992

Honours, Appointments and Higher Degrees

Two Fellows received prizes in the 2009 British Medical Association Book Competition:

- Professor Teik Oh was awarded first prize in the anaesthesia category for the sixth edition of the *Intensive Care Manual*.
- Dr Richard Riley's *Manual of Simulation in Healthcare* won first prize in the basis of medicine category.

Quality and Safety Committee

WHO Safe Surgery Saves Lives – safe surgery checklist launch

The Australian launch was held on August 19 at Parliament House, Canberra, and was attended by the Federal Minister for Health, Ms Nicola Roxon, as well as representatives of anaesthesia, surgery, obstetrics and gynaecology and perioperative nursing. In New Zealand, the checklist was launched by the Minister of Health, Mr Tony Ryall, on August 27 and was supported by medical groups including anaesthetists, surgeons, obstetricians, ophthalmologists, gastroenterologists and representatives from organisations such as the Ministry of Health and the Health and Disability Commission.

Evidence based medicine portfolio – set of 'outcome definitions'

It has been agreed that a workshop will be held to define a minimum set of pre-operative and post-operative data collection for the purpose of auditing anaesthesia outcomes.

Education and Training Committee Review of in-training assessment process

It has been agreed to introduce a "portfolio of evidence" approach to in-training assessment (ITA). To this end, the ITA form will no longer be the assessment tool, but rather will be a summary of performance assessed by direct observations made in the workplace with sources of evidence documented on the form. The revised form was supported by Council and it was noted that there will no longer be ITA1 and ITA2 forms. The new form and revisions to the process will be implemented from the start of the 2010 training year, and TE14 will be amended accordingly.

These changes represent the first part of a staged process that will parallel the curriculum review and redevelopment. A phased ITA revision will also be supported by the outcomes of the Clinical Teacher Development Working Group which is reviewing the support and training provided for ANZCA clinical teachers and supervisors of training.

IMGS Committee

International medical graduate specialists - workplace based assessment process

At the beginning of 2009, the College introduced a new international medical graduate specialists (IMGS) process that allowed any IMGS determined to have advanced standing towards substantial comparability to undertake a workplace based assessment (WBA) during the final three months of their supervised practice, in lieu of the Final Examination/IMGS Performance Assessment. Two assessors conduct the WBA, and at its conclusion, a narrative report, including recommendations is forwarded to the IMGS Committee for approval. In order to streamline the process, it has been agreed that all WBA narrative reports will be considered for approval by the DPA Assessor and the DPA IMGS. Unsatisfactory WBAs will continue to be forwarded to the IMGS Committee for consideration.

Anzca Training Scholarships for 2010

Training scholarships were introduced in 1999, and provide a 50% concession on the annual training fee for trainees with limited income. Scholarships for 2010 were awarded to the following trainees:

- Dr Manoharan, Jaya Raj V K (Malaysia)
- Dr Mohammad Ilyas, Sajidah Ilyas Bt (Malaysia)
- Dr Abu Baker, Anisa Aisha (Malaysia)

Fellowship Affairs Committee

Annual Scientific Meeting 2010 – Christchurch

Mr Robbie Deans has accepted the invitation to deliver the Oration at the College Ceremony.

2016 – Sydney

The dates for this meeting have been confirmed for April 29 to May 4 at the Sydney Convention Centre.

Internal Affairs

Strategy plan 2010 - 2012

Council has accepted the 2010-2012 strategic plan with implementation a work in progress over the next three years.

Joint Consultative Committee on Anaesthesia (JCCA)

The final draft of the Advanced Rural Skills Curriculum Statement on Anaesthesia was endorsed by Council. This curriculum was last reviewed in 2003 and is used as the basis of training for the supervision and examination of GP registrars and GPs wishing to complete a 12-month advanced rural skills post in anaesthesia. The JCCA accredits the Advanced Rural Skills (ARS) training posts and oversees the anaesthesia examination process.

National Health Workforce Planning and Research Collaboration Anaesthetic Medical Workforce Study.

Dr Richard Willis has been nominated as ANZCA representative to the above study.

Regulation 23 – Advice Regarding Recognition as a Specialist in Anaesthesia

In keeping with regulations 14 and 15 relating to examinations and training that include reference to interpretation and non-binding decisions, Regulation 23 has been amended with the addition of the following clauses:

23.14 Interpretation and non-binding decisions

23.14.1 Any decision, approval, consent or the exercise of any discretion, by the Council or other committee or authority under Regulation 23 will be considered on a case-by-case basis, having regard to the particular circumstances of each case.

23.14.2 Notwithstanding Regulation 23, Council may exercise or dispense other decisions after consideration of relevant circumstances.

23.14.3 Any such decision, approval, consent or exercise of discretion will not be binding on any other or future decisions or set any precedent for other or future decisions regarding Regulation 23.

23.15 Communications

All enquiries, applications, and communications regarding Regulation 23 must be made in writing and addressed to the Chief Executive Officer, Australian and New Zealand College of Anaesthetists, 630 St Kilda Road, Melbourne, Victoria 3004, Australia.

Professional

Professional Documents

PS10 – Handover of Responsibility During an Anaesthetic

Council accepted a recommendation from the Quality and Safety Committee that PS10 be reviewed to include recent progress regarding “time-out” features and the WHO Safe Surgery Checklist.

PS46 – Recommendations for Training and Practice of Diagnostic Perioperative Transoesophageal Echocardiography in Adults

It has been agreed that PS46 will be reviewed under the new process outlined in ADP1, and to this end, a Quality and Safety-hosted workshop will be convened in 2010 to assemble the appropriate individuals to undertake the review.

PS40 – Guidelines for the Relationship Between Fellows and the Healthcare Industry

Council established a working group to examine the issues surrounding relationships between Fellows and trainees and the healthcare industry. As a result of their deliberations, it has been agreed that a revision of PS40 will be undertaken.

Joint Faculty of Intensive Care Medicine/college Of Intensive Care Medicine Arrangements

Transitional arrangements relating to the New Zealand National Committee and Queensland Regional Committee have been agreed. Administrative support to the other regions will be provided centrally by the College of Intensive Care Medicine (CICM).

In response to a specific request from the joint faculty, Kate Briggs, ASM Co-ordinator, will continue to co-ordinate the CICM ASM for a period up to 24 months under the transitional arrangements agreed to with JFICM.

ANZCA Council meeting report 2

continued

Research

Research awards for 2010

The following projects were supported by Council:

Researchers	Project	Funding Sought	Funding Recommended
Greenland, Keith B.	"A re-appraisal of the sniffing position and the 'three axes alignment theory' for direct laryngoscopy"	\$25,202.95	\$15,000
Sleigh, James W.	"The genetics of the analgesic response to opioids in the post-anaesthesia care unit"	\$60,000	\$50,000
Warrillow, Stephen J	"Evaluation of exercise rehabilitation for survivors of intensive care"	\$50,630.40	\$20,000
McDonnell, Nolan J.	"Determination of equivalent dose rates of metaraminol and phenylephrine, when administered by continuous intravenous infusion, to prevent hypotension during elective Caesarean section under spinal anaesthesia"	\$21,562	\$10,000
Wrigley, Paul J.	"Regional changes in cerebral perfusion associated with persistent spinal cord injury neuropathic pain"	\$56,422	\$45,645
Myles, Paul S.	"ENIGMA-II trial long-term follow-up study"	\$60,000	\$60,000
Merry, Alan F.	"Validation of the 'WHO Surgical Safety Checklist' to reduce postoperative morbidity and mortality - the check WHO study"	\$51,751	\$51,751
Finch, Philip M.	"Adrenergic receptor involvement in an animal model of complex regional pain syndrome type I"	\$56,630	\$47,000
Barrington, Michael J.	"The Australian and New Zealand Registry of Regional Anaesthesia (AURORA study)" (Fellowship)	\$76,954	\$70,000 (Year 1 of 3)
Chan, Matthew	"Re-defining the warning criteria for intraoperative neurophysiologic monitoring"	\$59,438	\$59,438
Hogg, Malcolm N.	"Perfusion levels and correlation of pain processing regions in the brains of chronic pain patients and healthy people"	\$59,948	\$40,000
Lin, Enjarn	"Does remote ischemic post-conditioning reduce ischaemia reperfusion injury in patients undergoing lung transplantation?"	\$33,500	\$20,000

The following application was supported for funding of the second and third year of the project, pending committee review of a satisfactory progress report.

Applicant	Project Title	Requested for 2010	Funding Recommended for 2011 & 2012
Barrington, Michael J.	The Australian and New Zealand Registry of Regional Anaesthesia (AURORA Study)	\$76,954	\$70,000

Second year funding from 2009

The following application was supported for funding of the second year of this project, pending a satisfactory progress report.

Applicant	Project Title	Requested for 2010	Funding Recommended for 2010
Law, Corinne	“Intraoperative tiratability of opioids – can electroencephalographic (EEG) monitoring help us predict how much to give?”	\$75,000	\$45,000

Third year funding from 2008

The following application was supported for funding of the third and final year of the project.

Applicant	Project Title	Requested for 2010	Funding Recommended for 2010
Sumpter, Anita	“Age related changes in effects of sedatives and analgesics on quantitative EEG monitoring in paediatric intensive care”	\$80,000	\$40,000

In addition to the above, the **Harry Daly Research Award** was awarded to **Dr Matthew Chan** for his project “Re-defining the warning criteria for intraoperative neurophysiologic monitoring”.

The **Mundipharma ANZCA Research Fellowship** was awarded to **Dr Paul Wrigley** for his project “Regional changes in cerebral perfusion associated with persistent spinal cord injury neuropathic pain”.

The **Pfizer ANZCA Research Fellowship** was awarded to **Professor Alan Merry** for his project “Validation of the ‘WHO Surgical Safety Checklist’ to reduce postoperative morbidity and mortality - the check WHO study”.

The **ANS ANZCA Research Fellowship** was awarded to **Dr James Sleigh** for his project “The genetics of the analgesic response to opioids in the post anaesthesia care unit”.

Simulation-education grant for 2010

Dr Sandy Garden was awarded a grant of \$32,226 for his project “Training for debriefing after simulation of anaesthetic crises: current practices”.

Novice investigator awards for 2010 – the following projects were supported by Council:

Name	Project	Funding Sought	Funding Recommended
Hockey, Brad M.	“The use of mechanically skinned muscle fibers for the diagnosis of MH: a pilot study”	\$18,570	\$18,570
Phan, Tuong D.	“Comparison of oesophageal doppler with arterial pressure waveform derived cardiac output and stroke volume variation”	\$19,200	\$15,000

The **Academic Enhancement Grant** was not awarded for 2010.

Training Accreditation Committee

Accreditation of retrieval of services

Council supported the promulgation of a professional document for retrieval services seeking College approval for vocational training in anaesthesia. The consultation process will include a request for feedback from the regional/national committees and the ANZCA Trainee Committee.

New Programs Committee

Certificate in Diving and Hyperbaric Medicine

It has been agreed that completion of the Diving and Hyperbaric Medicine (DHM) formal project will no longer be a prerequisite to for candidates to sit the DHM examination. It is now acceptable for the formal project to be completed after the examination but before the award of the certificate. Regulation 36.4.9 has been amended accordingly.

Dr Leona Wilson
President

Associate Professor Kate Leslie
Vice-President

Professional documents

Australian and New Zealand College of Anaesthetists

Professional documents

P = Professional

T = Technical

EX = Examinations

PS = Professional standards

TE = Training and Educational

TE1	(2005)	<i>Recommendations for Hospitals Seeking College Approval for Vocational Training in Anaesthesia</i>	PS9	(2008)	<i>Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical or Surgical Procedures</i>
TE2	(2006)	<i>Policy on Vocational Training Modules and Module Supervision (interim review)</i>	PS10	(2004)	<i>Handover of Responsibility During an Anaesthetic</i>
TE3	(2006)	<i>Policy on Supervision of Clinical Experience for Vocational Trainees in Anaesthesia</i>	PS12	(2007)	<i>Statement on Smoking as Related to the Perioperative Period</i>
TE4	(2003)	<i>Policy on Duties of Regional Education Officers in Anaesthesia</i>	PS15	(2006)	<i>Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery</i>
TE5	(2003)	<i>Policy for Supervisors of Training in Anaesthesia</i>	PS16	(2008)	<i>Statement on the Standards of Practice of a Specialist Anaesthetist</i>
TE6	(2006)	<i>Guidelines on the Duties of an Anaesthetist</i>	PS18	(2008)	<i>Recommendations on Monitoring During Anaesthesia</i>
TE7	(2005)	<i>Guidelines for Secretarial and Support Services to Departments of Anaesthesia</i>	PS19	(2006)	<i>Recommendations on Monitored Care by an Anaesthetist</i>
TE8	(2003)	<i>Guidelines for the Learning Portfolio for Trainees in Anaesthesia</i>	PS20	(2006)	<i>Recommendations on Responsibilities of the Anaesthetist in the Post-Anaesthesia Period</i>
TE9	(2005)	<i>Guidelines on Quality Assurance in Anaesthesia</i>	PS21	(2003)	<i>Guidelines on Conscious Sedation for Dental Procedures</i>
TE10	(2003)	<i>Recommendations for Vocational Training Programs</i>	PS26	(2005)	<i>Guidelines on Consent for Anaesthesia or Sedation</i>
TE11	(2008)	<i>Policy on the Formal Project (interim review)</i>	PS27	(2004)	<i>Guidelines for Fellows who Practice Major Extracorporeal Perfusion</i>
TE13	(2003)	<i>Guidelines for the Provisional Fellowship Program</i>	PS28	(2005)	<i>Guidelines on Infection Control in Anaesthesia</i>
TE14	(2007)	<i>Policy for the In-Training Assessment of Trainees in Anaesthesia</i>	PS29	(2008)	<i>Statement on Anaesthesia Care of Children in Healthcare Facilities without Dedicated Paediatric Facilities (reissue)</i>
TE17	(2003)	<i>Policy on Advisors of Candidates for Anaesthesia Training</i>	PS31	(2003)	<i>Recommendations on Checking Anaesthesia Delivery Systems</i>
TE18	(2005)	<i>Guidelines for Assisting Trainees with Difficulties</i>	PS37	(2004)	<i>Regional Anaesthesia and Allied Health Practitioners</i>
EX1	(2006)	<i>Policy on Examination Candidates Suffering from Illness, Accident or Disability</i>	PS38	(2004)	<i>Statement Relating to the Relief of Pain and Suffering and End of Life Decisions</i>
T1	(2008)	<i>Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations (interim review)</i>	PS39	(2003)	<i>Minimum Standards for Intrahospital Transport of Critically Ill Patients</i>
T3	(2008)	<i>Minimum Safety Requirements for Anaesthetic Machines for Clinical Practice</i>	PS40	(2005)	<i>Guidelines for the Relationship Between Fellows and the Healthcare Industry</i>
PS1	(2002)	<i>Recommendations on Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia</i>	PS41	(2007)	<i>Guidelines on Acute Pain Management</i>
PS2	(2006)	<i>Statement on Credentialling and Defining the Scope of Clinical Practice in Anaesthesia</i>	PS42	(2006)	<i>Recommendations for Staffing of Departments of Anaesthesia</i>
PS3	(2003)	<i>Guidelines for the Management of Major Regional Analgesia</i>	PS43	(2007)	<i>Statement on Fatigue and the Anaesthetist</i>
PS4	(2006)	<i>Recommendations for the Post-Anaesthesia Recovery Room</i>	PS44	(2006)	<i>Guidelines to Fellows Acting on Appointments Committees for Senior Staff in Anaesthesia</i>
PS6	(2006)	<i>The Anaesthesia Record. Recommendations on the Recording of an Episode of Anaesthesia Care</i>	PS45	(2008)	<i>Statement on Patients' Rights to Pain Management</i>
PS7	(2008)	<i>Recommendations on the Pre-Anaesthesia Consultation</i>	PS46	(2004)	<i>Recommendations for Training and Practice of Diagnostic Perioperative Transoesophageal Echocardiography in Adults</i>
PS8	(2008)	<i>Guidelines on the Assistant for the Anaesthetist</i>	PS47	(2008)	<i>Guidelines for Hospitals Seeking College Approval of Posts for Vocational Training in Diving and Hyperbaric Medicine</i>
			PS49	(2008)	<i>Guidelines on the Health of Specialists and Trainees</i>
			PS50	(2004)	<i>Recommendations on Practice Re-entry for a Specialist Anaesthetist</i>
			PS51	(2009)	<i>Guidelines for the Safe Administration of Injectable Drugs in Anaesthesia</i>

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

Professional documents

IC-1	(2003)	<i>Minimum Standards for Intensive Care Units</i>
IC-2	(2005)	<i>Intensive Care Specialist Practice in Hospitals Accredited for Training in Intensive Care Medicine</i>
IC-3	(2008)	<i>Guidelines for Intensive Care Units seeking Accreditation for Training in Intensive Care Medicine</i>
IC-4	(2006)	<i>The Supervision of Vocational Trainees in Intensive Care</i>
IC-6	(2002)	<i>The Role of Supervisors of Training in Intensive Care Medicine</i>
IC-7	(2006)	<i>Administrative Services to Intensive Care Units</i>
IC-8	(2008)	<i>Quality Assurance</i>
IC-9	(2002)	<i>Statement on the Ethical Practice of Intensive Care Medicine</i>
IC-10	(2003)	<i>Minimum Standards for Transport of Critically Ill Patients</i>
IC-11	(2003)	<i>Guidelines for the In-Training Assessment of Trainees in Intensive Care Medicine</i>
IC-12	(2001)	<i>Examination Candidates Suffering from Illness, Accident or Disability</i>
IC-13	(2008)	<i>Recommendations on Standards for High Dependency Units Seeking Accreditation for Training in Intensive Care Medicine</i>
IC-14	(2004)	<i>Statement on Withholding and Withdrawing Treatment</i>
IC-15	(2004)	<i>Recommendations of Practice Re-entry for an Intensive Care Specialist</i>

Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine

Professional documents

PM2	(2005)	<i>Guidelines for Units Offering Training in Multidisciplinary Pain Medicine</i>
PM3	(2002)	<i>Lumbar Epidural Administration of Corticosteroids</i>
PM4	(2005)	<i>Guidelines for Patient Assessment and Implantation of Intrathecal Catheters, Ports and Pumps for Intrathecal Therapy</i>

PM5	(2006)	<i>Policy for Supervisors of Training in Pain Medicine</i>
PM6	(2007)	<i>Guidelines for Longterm Intrathecal Infusions (Analgesics/Adjuvants/Antispasmodics)</i>
PS3	(2003)	<i>Guidelines for the Management of Major Regional Analgesia</i>
PS38	(2004)	<i>Statement Relating to the Relief of Pain and Suffering and End of Life Decisions</i>
PS39	(2003)	<i>Minimum Standards for Intrahospital Transport of Critically Ill Patients</i>
PS40	(2005)	<i>Guidelines for the Relationship Between Fellows and the Healthcare Industry</i>
PS41	(2007)	<i>Guidelines on Acute Pain Management</i>
PS45	(2008)	<i>Statement on Patients' Rights to Pain Management and Associated Responsibilities</i>
PS49	(2008)	<i>Guidelines on the Health of Specialists and Trainees</i>

College Professional Documents adopted by the Faculty:

PS4	(2006)	<i>Recommendations for the Post-Anaesthesia Recovery Room (Adopted February 2001)</i>
PS7	(2008)	<i>Recommendations for the Pre-Anaesthesia Consultation (Adopted November 2003)</i>
PS8	(2008)	<i>Guidelines on the Assistant for the Anaesthetist (Adopted November 2003)</i>
PS9	(2008)	<i>Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical or Surgical Procedures (Adopted 2008)</i>
PS10	(2004)	<i>The Handover of Responsibility During an Anaesthetic (Adopted February 2001)</i>
PS15	(2006)	<i>Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery (Adopted February 2001)</i>
PS18	(2008)	<i>Recommendations on Monitoring During Anaesthesia (Adopted February 2001)</i>
PS20	(2006)	<i>Recommendations on Responsibilities of the Anaesthetist in the Post-Anaesthesia Period (Adopted February 2001)</i>
PS31	(2003)	<i>Recommendations on Checking Anaesthesia Delivery Systems (Adopted July 2003)</i>
T1	(2008)	<i>Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and other Anaesthetising Locations (Adopted May 2006)</i>