ANZCA
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

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

October 2008

The ANZCA Bulletin

Anaesthesia in Vietnam: Restoring sight to the poor

Contents

The ANZCA Bulletin

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

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Submitting letters and material
The ANZCA Bulletin is published four times a year by the Australian and New Zealand College of Anaesthetists. We encourage the submission of letters, news and feature stories. We prefer letters of no more than 500 words and they must indicate your full name and address and a daytime telephone number. By submitting your letter to us for publication you agree that we may edit the letter for legal, space or other reasons.

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Cover: Post operative patients who have undergone anaesthesia for cataract surgery as part of the Vietnam Vision project.

Photo by Jack Tran.

Vietnam Vision Project: Restoring sight to the poor

Dr Jenny Carden travels to a hospital in provincial Vietnam as part of the Vietnam Vision Project (VVP) team.

Anaesthesia roundtable: South Australian Fellows

Three new Fellows discuss topics ranging from training to working overseas.

Destination Everest: Human performance at extreme altitude

New Zealand anaesthetists' four-month expedition to Nepal.

President's message

Colleges agree on a process for an independent College of Intensive Care Medicine while important issues surround the regulation of medical practitioners in Australia and New Zealand.


Dr Leona Wilson

'We fully support the introduction of a national uniform registration process and consistent standards for medical practitioners ... however, we have concerns about the accreditation component of the IGA.'

ANZCA, with the Royal Australasian College of Physicians and the Joint Faculty of Intensive Care Medicine (JFICM), has agreed on a process for formation of an independent College of Intensive Care Medicine (of Australia and New Zealand), which will take over the functions of the JFICM. We will be working collaboratively to ensure that the new College is successful, with appropriate governance and management, ensuring the highest clinical standards for the benefit of patients and the community.

We have not taken this decision lightly. Many of you have contacted us about this, and we have appreciated the care and thought that has obviously gone into your communications on this matter. The Fellows of JFICM have given a clear indication that this is the direction that they wish to take, and we must respect that. Many of us will remember the formation of our College from the Faculty of Anaesthetists RACS. As we proceed with the formation of the new College, there are many issues that will require particular care. These include the interests of trainees in our programs, those who have double (or triple) Fellowships, and those FANZCAs who practice intensive care medicine but do not have FJFICM. I would urge Fellows and trainees with further concerns to contact us, either in Melbourne or in the regions.

The legislation covering regulation of medical practitioners is being reviewed in both our countries. In Australia, the proposals for National Registration and Accreditation as detailed in the Inter Governmental Agreement (IGA) of the Coalition of Australian Governments (COAG) are being pushed through. *(For non Australians, the governments referred to in COAG are those of the states/territories and the Commonwealth of Australia).* We have made submissions to the Practitioner Regulation Subcommittee of the Health Workforce Principal Committee on matters within the IGA. We fully support the introduction of a national uniform registration process and consistent standards for medical practitioners across Australia. This will reduce complexity by ensuring that only suitably qualified medical practitioners are able to practice, and allow significantly enhanced portability between states/territories. However, we have concerns about the accreditation component of the IGA. The international standards for accreditation bodies are contained within the World Health Organisation and World Federation for Medical Education (WHO/WFME) *Guidelines for Accreditation of Basic Medical Education* (Geneva/Copenhagen 2005). These guidelines state that *'The accreditation system must operate within a legal framework. The legal framework must secure the autonomy of the accreditation process and ensure the independence of its quality assessment from government, the medical schools and the profession. The legal framework must authorize the accrediting body to set standards, conduct periodic evaluations and confer, deny and withdraw accreditation of medical schools and their program of medical instruction'.*

In New Zealand, the Health Practitioners Competence Assurance Act 2003 is having a major review. Protection for the information gained in quality assurance activities, including the ANZCA Continuing Professional Development program, is covered by this Act. We are concerned that this section of the Act may be significantly changed, and the New Zealand National Committee has been lobbying vigorously for its retention.

I would like to thank all Fellows who have been involved in our relations with various stakeholders, lobbying governmental and other bodies, attending meetings and in preparing submissions. ANZCA's submissions to government have been posted on the ANZCA website. These activities are required to ensure the future of the specialties and the College, and we are very grateful for your efforts.

Dr Leona Wilson
President

News

Supporting rural and regional trainees

ANZCA has been successful in attracting additional funding of $100,000 for 2008/09 from the Rural Advanced Specialist Trainee Support (RASTS) Program, Commonwealth Department of Health and Ageing. This project aims to enhance the value of education and training in a rural setting and address the relative disadvantage experienced by rural and regional trainees in accessing learning activities which are currently available in metropolitan areas.

The videoconference series will incorporate 20 sessions per year, based on the ANZCA curriculum for the final Fellowship examination. The program is being coordinated by ANZCA, with session development and delivery focused on two Departments with experience in this type of education program. These sessions will also be available in web streaming format, and Web 'pod-casts' will be prepared from the sessions and loaded onto the ANZCA website for later access by trainees.

National Code of Professional Conduct

The Australian Medical Council has released a draft code of professional conduct for medical practice. The Code will be used by the proposed national medical board and is intended to supersede existing state and territory medical board professional conduct codes. The draft is available at *www.goodmedicalpractice.org.au* and medical practitioners are invited to comment.

2009 NICS Fellowship

The NHMRC is offering Fellowships for two years, half-time to health professionals who are future leaders in evidence-based health care and wish to address an evidence-practice gap in their area of clinical practice. Applications close 27 October 2008. For further information please visit *www.nhmrc.gov.au/nics*.

ANZCA Councillors

Who are your Councillors and what are their backgrounds and interests? Biographical profiles together with photographs of ANZCA's Councillors have now been posted on the College's website at *www.anzca.edu.au*. Details can be found under the Structure and Governance section.

ANZCA Council, back row from left: Dr Michelle Mulligan, Dr Peter Cook, Dr Genevieve Goulding, Dr Lindy Roberts, Dr Richard Waldron, Dr Mike Richards (In attendance member and CEO), A/Prof David Scott, Dr Margie Cowling, Dr Nicole Phillips.

Front row from left: Dr Kerry Brandis, Dr Penny Briscoe (Dean, FPM), A/Prof Kate Leslie (Vice President), Dr Leona Wilson (President), Professor Vernon Van Heerden (Dean, JFICM), Dr Frank Moloney.

Absent: Professor Alan Merry

Accreditation

The *Forum of Australian Health Professions Councils* which includes the Australian Medical Council recently wrote to the national registration and accreditation project team calling for the maintenance of independence of accreditation functions. The submission states: 'Unless this independence is maintained, international standing, recognition and reciprocity of recognition of graduates from Australian universities will be lost ... Accreditation against standards by assessment teams and the decisions reached must be independent of direction from registration committees or boards as well as workforce considerations. If this independence is lost, then the standards will be compromised, putting public safety at risk'.

Communications strategy

ANZCA is currently developing a communications strategy which will establish key priorities and programs for the next three years. If you have any ideas, suggestions or feedback about how communication internally and externally can be improved we would like to hear from you. Please send your comments to Nigel Henham, Director Communications – nhenham@anzca.edu.au.

Workforce issues

The Federal Health Minister, Nicola Roxon, recently gave a speech to the Australian Healthcare Hospitals Association Congress in Canberra where she outlined the government's general direction on workforce issues:

'I firmly believe that we need the right professionals in the right place to provide the right care, and this will involve a better role delineation. For instance, I see no reason why appropriately trained, nurses, physiotherapists, psychologists or dieticians, for example, could not relieve doctors of some of their workload and allow them to better utilise their skills.

This would have to be done with care – and doctors would remain central – but if we can encourage doctors to focus on the more complex elements of their craft, while encouraging other health professionals to take on other aspects, then we could deliver significant improvements in the way we use our existing workforce'.

ANZCA Curriculum Review – Submissions

The ANZCA Curriculum Review Working Group (CRWG) is inviting submissions from individuals or group with an interest in the ANZCA Training Programme and/or ANZCA Clinical Teacher Development and Support Initiatives. The deadline for submissions is 31 December 2008. For details, please see *www.anzca.edu.au/edu/projects/curriculum-review/submissions/*

Letters to the editor

Humanising the patients' experience

For some time now, I have been involved as a 'consumer' representative, engaged in committee work with medical practitioners in examining quality in provision of clinical care, particularly related to adult patients with cancer. (My background is engineering, both in industry and academia, including

hour before being moved to preparation room, and in decided that, as I was not would prefer not to be were an option. When and spoke to me in the I asked whether it was ne sedated, and he replie esthetist about th

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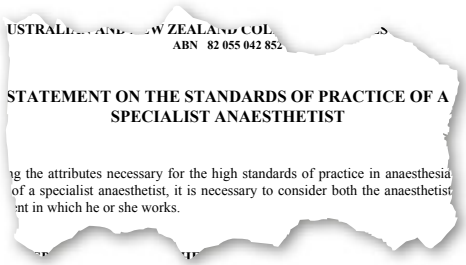
The ANZCA Bulletin

Anaesthesia in Vietnam: Restoring sight to the poor

Welcome to the new-look ANZCA Bulletin. As part of the College's efforts to improve our service to Fellows and trainees, the Bulletin has been redesigned with a greater emphasis on news and features from around Australia and New Zealand, as well as improved navigability and layout. The effectiveness of the Bulletin as a communications channel is ultimately dependent on the contributions and participation of its membership. We are therefore particularly keen to hear from our readers of suggested stories, profiles, news and events so we can further improve the level and quality of communication within the College. We welcome your ideas and suggestions as well as photos, articles or other submitted materials for publication. Please send us your feedback (nhenham@anzca.edu.au).

Nigel Henham
Editor



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ABN 82 055 042 852

STATEMENT ON THE STANDARDS OF PRACTICE OF A SPECIALIST ANAESTHETIST

...g the attributes necessary for the high standards of practice in anaesthesia ... of a specialist anaesthetist, it is necessary to consider both the anaesthetist ...nt in which he or she works.

Ageing issues

I would like to pass on to the Council my commendation of the *Statement on the Standards Of Practice of a Specialist Anaesthetist – 2008*.

As someone approaching retirement age within the next 10 years, I am pleased to see statements regarding the issues of non-clinical work, fatigue and age. It is disappointing to see unrealistic expectations of my surgical colleagues that anaesthetists' time should be all in operating theatres (they never are themselves of course), that working continuously for periods of 12 plus hours a day with minimal or no breaks is just part of the job and a total lack of awareness of the impact of fatigue on critical decision making.

Our specialty clearly requires significant hand-eye co-ordination, fine motor skills and critical decision making. Such skills decline with age (which is why Dentists have relatively short working careers) as the statement recognises. In the not-too-distant past, I felt compelled to report to the Medical Board concerns expressed to me by nursing staff in several hospitals about the competency of an older colleague.

I am not certain how 1.3.6 of P16 can be effectively used. When we are younger, we all recognise the issues of ageing, but I am not sure that such a recognition continues to occur as we get older.

Dr Grant Carr

Correction

In the ACT Regional Committee Annual Report published in the July issue of the ANZCA Bulletin, it stated, under Education and Training: 'Trainees also performed well in the Part 1 examination with Hon **Sen** receiving a merit award.' The name of the trainee receiving the award should have been Hon **Sim.**

We apologise to Dr Sim for this misprint.

Patient communication

I would like to take the opportunity to respond to Dr Mark Tweeddale's letter entitled 'Humanising the patient's experience' in the July 2008 edition.

I would like to firstly thank him for his reminder to us all of the importance of patient communication. I agree that we should stand in front of the patient and explain what we are about to do and why. However, when a patient declines my recommended normal practice, I strive to ensure that the decision is based on good information and understanding.

Personally I believe, though not all is supported by Level 1 evidence, that intravenous midazolam in the anaesthetic room may fill the following functions:

- Relieve anxiety
- Reduce intraoperative awareness
- Decrease post-operative nausea and vomiting
- Allow more accurate calculation of the propofol induction dose
- Reduce blood pressure and pulse rate and thus reduce the fractional change in blood pressure on induction

I have seen patients who work in the healthcare industry come to theatre and request no sedation. Most, to my eye, have nonetheless appeared to be anxious. Other patients have commented that they didn't realise that they were anxious until the midazolam had been given.

Though I am sure that Dr Tweeddale had full information and understanding, was definitely not anxious and had a good reason for requesting a change to the anaesthetist's routine practice, I would like to caution others to the many problems that accrue to VIP patient syndrome. Though we are experts in our own field, this may not translate to other medical fields. And even if we are experts in that field, self-perception may sometimes escape us in times of stress and we may not be the best arbiters of what is good for us.

Peter McLaren FANZCA
Gold Coast

Reference:

Schneck, SA. *Doctoring Doctors and Their Families*. JAMA 1998;280:23:2039-2042

Award

Dr Patricia McKay
Courtesy of Leader Newspapers

Queen's Birthday Honours

Dr Patricia Mackay received the Order of Australia Medal (OAM) in the Queen's Birthday Honours on 9 June 2008, having served as Chairman of the Victorian Consultative Council on Anaesthetic Mortality and Morbidity (VCCAMM) from 1991 until 2005.

Dr Patricia Mackay has made an outstanding contribution to the Australian community for more than fifty years by virtue of her work in the promotion of patient safety in anaesthesia and the related disciplines of perioperative medicine, pain management and intensive care.

Dr Mackay graduated in medicine in Dunedin, New Zealand in 1949 and completed her postgraduate training in the speciality of anaesthesia in NZ, Australia and the UK. In 1954 she moved permanently to Australia to take up an appointment in the Department of Anaesthesia at Royal Melbourne Hospital. She thereby commenced her long career in teaching hospital-based clinical anaesthesia, but very early on also became one of the world's pioneers of modern intensive care. She was directly involved in promoting the emerging concepts of mechanical ventilation in patients with impaired respiration due to such conditions as head injury or neurological diseases including tetanus.

Between 1959 and 1984, Dr Mackay maintained a busy practice in clinical anaesthesia while she and her husband Ian raised a family of five children. Throughout this period she continued as a consultant anaesthetist at Royal Melbourne Hospital but also held appointments at several other Melbourne hospitals. Dr Mackay was also very active in the broader development of the speciality of anaesthesia and its emerging role in the promotion of patient safety. She was a leader in the development of preoperative assessment of patients before anaesthesia and surgery. She was actively engaged in both the Faculty of Anaesthetists of the Royal College of Surgeons (now the Australian and New Zealand College of Anaesthetists, ANZCA) and the Australian Society of Anaesthetists (ASA). Throughout this period, Dr Mackay was a frequently invited speaker at national and international scientific meetings. She had a strong interest in both teaching and administration. She held appointments as Secretary and later Treasurer of the ASA and was appointed as the President from 1966 to 1968. In 1971, she became an Examiner for the Fellowship at the Faculty of Anaesthetists, a position she held for 12 years.

In 1984, Dr Mackay was appointed as Chairman and Head of the Department of Anaesthesia at the Royal Melbourne Hospital, a position she held until 1992. In this capacity she initiated major advances in not only the organisation and practice of clinical anaesthesia, but also the promotion of research and co-ordinated teaching programs. She was responsible for the professional development of many anaesthetists at all levels. She established the first acute pain management unit in Victoria. Her interest and influence continued more broadly and she was a foundation member of the Australian Patient Safety Foundation. She was made a life member of the World Federation of Anaesthesiologists in 1985.

In 1991, Dr Mackay was appointed by the Victorian Minister of Health to the position of Chairman of the Victorian Consultative Council on Anaesthetic Mortality and Morbidity (VCCAMM). This Council has been a major platform for the promotion of safety and quality in anaesthesia and peri-operative care, not only in Victoria and Australia, but internationally. Through her role as Chairman of VCCAMM, she was responsible for the development of a classification system for reported adverse events that has been adopted as the national model. Dr Mackay has been a world leading figure in the promotion of safer patient care through adverse event reporting and analysis of system issues. Australia is acclaimed internationally for its extremely high standard of anaesthesia care and safety, and Dr Mackay has been a key contributor in this achievement. As Chairman of VCCAMM she has authored the 5th, 6th, 7th and 8th Reports of the Council (in 1993, 1996, 2000 and 2004). These publications are major sources of information that have led to improvement in the quality and safety of anaesthesia and related activities such as preoperative and postoperative care including pain management. She was also the editor of the Review of Anaesthesia Related Mortality (Safety of Anaesthesia in Australia) 1997–1999, published under the auspices of the Australian and New Zealand College of Anaesthetists. In 2005, Dr Mackay resigned as Chairman of VCCAMM, but fortunately for the Council, the broader anaesthesia community and most importantly for the citizens of Victoria and Australia, she has been retained on the Council as Emeritus Consultant.

In addition to her major contribution within her own speciality of anaesthesia, Dr Mackay has been active in broader community service. She has served the Victorian rural community specifically through her role as a member of the Board of the Mansfield District Hospital since 1990. She was President of the Board from 1991 to 1993.

Dr Mackay has been recognised for her outstanding and amazingly sustained contribution to patient safety and the development of anaesthesia and in 2000 was awarded the Australian and New Zealand College of Anaesthetists Medal. Soon after that, she also received an award as the Woman Doctor of the Year by the Australian Medical Association. She has undoubtedly been an outstanding role model for not only female anaesthetists and doctors, but for all career women.

In summary, Dr Patricia Mackay has been an advocate for the individual in our community for more than fifty years. She has pioneered the development and establishment of anaesthesia as a major medical speciality, and in particular has led this speciality to the forefront of advances in the quality and safety of patient care. She has been responsible for the mentorship and professional development of two generations of specialist anaesthetists. She is held in high esteem by all her colleagues in anaesthesia, surgery and the broader medical community and continues to make a major contribution with enthusiasm, wisdom and compassion.

Associate Professor Larry McNicol
Victoria

People & Events

From left:
David Merefield, Di Khursandi and Daryl Catt

Below:
Conference attendees enjoy the social program at Ayers Rock

The Accidental Intensivist

The Rural Special Interest Group held its inaugural conference at the Voyages Resort, Uluru (Ayers Rock) on 1–2 August 2008. The meeting was held in association with the JFICM Rural Special Interest Group and this was reflected in the theme of the conference – 'The Accidental Intensivist'. The program was designed to update rural anaesthetists (and physicians) without formal ICU training who, from time to time, find themselves managing high care patients. Either the topic or the venue struck a chord as more than 100 delegates registered for the conference, at which there were four trade displays.

The opening session – chaired by Daryl Catt – included presentations by Michael Corkeron and David Rowe on the topics covered by the FAST HUG mnemonic, along with an insight by Brian Spain into the cultural aspects of caring for the indigenous population of the Top End. The session also included an original paper by Sydney Jacobs about the severity of community acquired pneumonia presenting to the Alice Springs Hospital.

The second session covered cardio-respiratory topics and was chaired by Craig Mitchell. Robert Herkes discussed the CLABicu project running in NSW (aiming to reduce central line related bacteraemia) and Lynn Abraham discussed Early Goal Directed Therapy for patient resuscitation. The respiratory half of the session covered Non-Invasive Ventilation, by Todd Fraser, intubation on ICU, by Rob Ray and Invasive Ventilation & Weaning by Paul Goldrick.

The third and final session saw Di Khursandi take the chair for a session aimed at improving initial care for patients likely to be evacuated. Michael Corkeron spoke about early management of acute head injury and Paul Goldrick covered the early management of severe burns before Matt Hooper provided us with an insight into the world of retrieval medicine. The final presentation was given by Todd Fraser and covered the recent changes to the CPR algorithms and a discussion about post-arrest cooling.

All the talks generated lively discussions and there are plans to make the abstract and some slides available on the website via the Rural SIG webpage.

The social aspects of the conference made the most of the stunning surroundings of the resort. A drinks reception was held beside the pool of the Sails in the Sands Hotel on the Friday evening as the sun set, attended by delegates and their families. The conference dinner was the resorts trademark 'Sounds of Silence Dinner'. We were taken to a private sand dune for Champagne and Canapés as the sun set over Uluru and Kata Tjuta followed by a buffet under the stars, the only downside of which was the layer of cloud between us and the stars.

I would like to thank the organising committee which included Michael Corkeron and Todd Fraser, who helped develop the program and recruit the speakers, and Juliette Mullumby who converted our program and choice of venue into a very high quality conference.

The positive feedback has encouraged the Rural SIG to consider running another meeting in 2009 with a focus on rural obstetric anaesthesia with Norfolk Island as a possible venue. Anyone interested in joining the organising committee can contact us via ANZCA.

David Rowe
Convener

2008 Combined SIG Meeting – Queenstown, New Zealand

Back row: Karl Alexander, David Andrew, Karen Smith, Simon Scothern, Martin Lum, Joanna Newton, Sandy Garden, Simon Jenkins, Lyndall Patterson

Front row: Rod Tayler, Jennifer Parlow, Alan Goody and his daughter Meghann

The 2008 Combined Special Interest Group meeting was held at Rydges Lakeside Resort in Queenstown from 29-31 August.

With a stimulating theme, 'Better, Cheaper, Faster – Changing Values in Anaesthesia', the delegates were challenged by 25 presenters who addressed the economic imperatives creeping into surgical and anaesthesia services and the impact on personal health.

The invited speaker was Professor John Cartmill from the Australian School of Advanced Medicine at Macquarie University. Prof Cartmill's innovative presentation grew from his approach into looking outside medicine for insight and new ideas to apply to the perennial challenges of life in medicine.

The conference dinner was held in the Skyline Gondola Restaurant perched high over Queenstown with stunning view over Lake Wakatipu and the Remarkables.

During the afternoons, in beautiful sunshine, many of the delegates took the opportunity to take to the ski slopes while others enjoyed a walk around Lake Walatipu.

Conference dinner at the Skyline Gondola Restaurant

Above, left to right: Karen Pedersen, Kerry English, Karen Smith (Chair) Amber Chisholm, Nadia Forbes

Left, left to right: Graham Roper, Anna Illingsworth, Simon Scothern

2008 Spring Meeting
Pain at the Centre

1 **Olga's tour**
2 **Invited speakers, Professors Josef Zacher, Dan Carr and Kay Brune with Scientific Convenor Professor Stephan Schug**
3 **Sounds of Silence dinner**
4 **Monica Di Ianni, Orphan Australia**

The 2008 Spring Meeting of the Faculty of Pain Medicine, held in conjunction with the Acute Pain SIG of ANZCA, ASA, NZSA and the Acute Pain SIG of IASP, at Voyages Ayers Rock Resort was a great success with more than 200 delegates in attendance. The meeting featured a number of outstanding medical speakers, including Professor Kay Brune, University of Erlangen, Germany; Professor Josef Zacher, HELIOS Klinikum Berlin Buch, Germany; Professor Dan Carr, Tufts University, Boston, USA; Professor Maree Smith, University of Queensland; and Dr Malcolm Dobbin, Victorian Department of Human Services.

The meeting focused on advances and new developments in pain management and explored topics such as the 'Drug interactions in Pain Management'; 'Progression of Acute to Chronic Pain'; and 'Acute Neuropathic Pain'. There was a great deal of goodwill and enthusiasm between acute and chronic pain practitioners who recognised that improved outcomes can be achieved with improved communication. Plans are underway for a 2009 Spring Meeting Program with a similar focus, aiming to strengthen the ties.

Thanks go the sponsors, exhibitors and all the presenters, including those who prepared PBLDs and Topical Sessions, for their contribution and expertise and to the Organising Committee: A/Prof Pam Macintyre (Convenor), Professor Stephan Schug (Scientific Convenor) and Dr Steve Jones for their effort in bringing together this exceptional program.

ANZCA Council Meeting reports

June 2008

Report following the Council Meeting of the Australian and New Zealand College of Anaesthetists held on 28 June 2008

Death of Fellows

Council noted with regret the death of the following Fellows:

- Dr Ann Elizabeth Newton (Qld) – FFARACS 1988, FANZCA 1992
- Dr Graham Chudleigh Fisk (NSW) – FFARACS 1959, FANZCA 1992

Honours, Appointments and Higher Degrees

Two Victorian Fellows were awarded a Medal of the Order of Australia (OAM) in the Queen's Birthday Honours List.

- Dr Patricia Mackay received her award for the exceptional contributions made over many years to clinical anaesthesia, and especially the improvement in quality and safety of patient care through her work as a member of the Victorian Council on Anaesthetic Mortality and Morbidity.
- Dr Sidney Giddy was recognised for his outstanding and long-term commitment to the community of Ballarat in the provision of anaesthesia services.

Dr Leona Wilson attained Fellowship of the Australian Institute of Company Directors (FAICD).

Quality and Safety

Quality and Safety website

A Working Party has been established to develop a proposal on establishing a Q&S website.

Difficult Airway Management Training Module Workshop

Following the success of the workshop held on 5 April 2008, it has been agreed that a follow-on workshop will be held in July/August to address training requirements for managing difficult airways.

Mortality Committee

There has been positive progress in both the ACT and New Zealand towards the development of a Perioperative Mortality Committee.

Education and Training

The Dr Ray Hader Trainee Award

Following receipt of a proposal from Dr Brandon Carp, the above award has been established for trainees that promotes a compassionate approach to the welfare of anaesthetists, other colleagues, patients and the community. Dr Hader was a College trainee, and the award commemorates the 10th anniversary of his death. Dr Carp has generously pledged $2,000 per annum for five years to this project. The award is open to Trainees, and Fellows within three years of admission to Fellowship.

Educational Innovation Funding

In August 2007, Council supported a proposal for Educational Innovation Grants, which were advertised in December 2007. No applications were received by the due date, and as a result, the Education and Training Committee will review the process for the grants.

Trainee Committee

As the Trainee Committee now reports direct to Council, it has been agreed that when Minutes from the Committee are included on a Council agenda, a representative will be invited to participate, either in person or via teleconference, for discussion of that item.

Continuing Education

New Fellows' Conference 2008

Dr Sally Ure attended the Council meeting and provided a presentation on the New Fellows' Conference held in the Hunter Valley in May. The theme of the conference was *Fitness to Practise – Achieving Career Longevity*. Major topics included generational differences and some of the difficulties encountered in managing such differences, and the increasing demands on the anaesthesia workforce.

Renaming the Foundation Speakers at the Annual Scientific Meeting

A number of the named speakers at the ASM have been changed as follows:

- The ANZCA Foundation Visitor will be known as the ANZCA ASM Visitor
- The FPM Visitor will be known as the FPM Foundation Visitor
- The State visitors in anaesthesia will be named the ANZCA 'Region/Country' Visitor
- The State visitors in pain medicine will be named the FPM 'Region/Country' Visitor

The title Australasian Visitor will remain unchanged.

Funding of the JFICM Foundation Visitor

It has been agreed that the costs for the JFICM Foundation Visitor will be covered by the meeting that the visitor attends.

2012 Annual Scientific Meeting

The 2012 ASM will be held on the Gold Coast.

Internal Affairs

Bulletin

Dr Michelle Mulligan has been appointed as Editor of the Bulletin, and will act as liaison officer between Council and the Communications Department.

Calendar for 2009

The calendar for next year was approved.

Travel Guidelines

Following receipt of feedback on the travel guidelines promulgated in April, some modifications were considered through the Executive Committee, and supported at Council.

Professional

Professional Documents

Following the normal review process, the following Professional Documents were approved by Council.

- PS16 – *Statement on the Standards of Practice of a Specialist Anaesthetist*
- PS47 – *Guidelines for Hospitals Seeking College Approval for Vocational Training in Diving and Hyperbaric Medicine*
- T3 – *Minimum Safety Requirements for Anaesthetic Machines for Clinical Practices*

These may be found on the ANZCA website: *www.anzca.com.au/resources/professional-documents*

Garling Inquiry

Following ANZCA's submission to the Special Commission of Inquiry into Acute Care Services in New South Wales public hospitals, an invitation was extended to meet with Commissioner Garling. Prof Barry Baker, Dr Joanna Sutherland from the ANZCA NSW Regional Committee, and

ANZCA Council Meeting Reports

Continued

John Biviano met with the Commissioner in Sydney on 24th June to discuss ANZCA's recommendations and explore related areas for the Commissioner's consideration.

The College's submission covered workforce, education and training, service delivery, safety and quality, as well as structural issues. ANZCA has called upon the NSW government to implement a series of improvements including the provision of enhanced support and appropriate incentives to sustain rural anaesthesia services; the establishment of more places for paediatric and rural anaesthesia training; the provision of special arrangements for emergency surgery; recognition of the expanded role of anaesthetists; and the review of hospital organisational structures and removal of unnecessary layers of bureaucracy.

Research

ANZCA Foundation

The Foundation had been in receipt of an annual donation of $10,000 from Organon. This company now forms part of Schering-Plough which recently pledged an annual donation of $20,000 towards research.

Research Committee Membership

The Faculty of Pain Medicine has nominated Dr Chris Hayes as their representative to the Research Committee. Prof Stephan Schug will remain on the Committee as a co-opted member.

Training Accreditation Committee

Community Representation

Following the resignation of the previous incumbent, Mrs Susan Sherson has been appointed as Community Representative to the Training Accreditation Committee. Mrs Sherson is a registered nurse with Certificates in Intensive Care, and Anaesthetic and Post-operative Care Nursing. She holds a BA (Moral Philosophy and History and Philosophy of Science) from the University of Melbourne. She is the Chair of the Melbourne Health Clinical Ethics Committee and a Member of the Melbourne Health Peer Support Program Advisory Committee.

August 2008

Report following the Council Meeting of the Australian and New Zealand College of Anaesthetists held on 16 August 2008

Honours, Appointments and Higher Degrees

Dr Leslie Galler, FANZCA, FJFICM (NZ) was invested as a Member of the New Zealand Order of Merit (MNZM) in the Queen's Birthday Honours List. Dr Galler was recognised for providing an exceptional standard of service, saving countless lives and displaying high levels of diplomacy in the most difficult situations.

Honorary Fellowship of the Academy of Medicine of Malaysia was conferred upon Dr Leona Wilson (NZ).

A/Prof Stephen Gatt (NSW) was honoured by the Indonesian Society of Anesthesiology and Reanimation (INSAR) with its highest award. This was awarded in recognition of his many years of committed service in Indonesia.

Death of Fellow

Council noted with regret the death of New Zealand Fellow, Dr Warwick Mayne Smeeton, OBE, FFARCS 1955, FANZCA 1992.

The death of Mr Noel Sheales on 11 August was also noted. Mr Sheales was remembered by Council as a great supporter of the College over many years.

An Independent College of Intensive Care Medicine

Council has accepted that the vote taken at the JFICM Annual General Meeting in June has given the Board of JFICM a mandate to proceed with the formation of a separate College of Intensive Care Medicine.

It has been agreed that Council and the Board will jointly appoint representatives who will work with the Honorary Solicitor to develop the Heads of Agreement for the separation of JFICM from ANZCA for formal approval by Council and the Board. The Council representatives for this process will be Dr Leona Wilson, A/Prof Kate Leslie, Prof Barry Baker and Dr Mike Richards.

Council has also ratified a Memorandum of Intent between ANZCA and JFICM which provides a strategy and a process for progressing the collaborative separation of JFICM and ANZCA.

Education and Training

Curriculum Review Working Group

The inaugural face-to-face meeting took place on 14 August. There was agreement that the CanMeds principles revised in 2005 would be used as a framework for the College's revised curriculum.

Appointment of Examiners

In order to expedite Examiner appointments, it has been agreed that appointments will be discussed at each meeting of the Education and Training Committee (February, June and October), for approval by Council at its meeting the following day.

Examination Dates 2009

The following dates have been approved for next year:

Primary Examination

	Location	1st Exam	2nd Exam
Closing Date	15 Dec	1 June	27 July
Written	All Major Centres	2 March	27 July
Oral	Melbourne Hong Kong	27,28,29 April 27,28,29 April	14–16 Sept 18 Sept

Final Examination

	Location	1st Exam	2nd Exam
Closing Date		13 February	3 July
Written & Medical	Adelaide, Brisbane, Melbourne, Perth, Sydney, Auckland & Hong Kong	3 & 4 April	28 & 29 Aug
Oral	Melbourne Sydney	29 & 30 May	23 & 24 Oct

Web streamed Final Examination Resource

The pilot of the web streamed Final Examination tutorial received a positive response. Dr Tracey Tay is in the process of receiving suggestions for topics and speakers for a framework of 20 sessions.

Orientation/induction Module (Module 0)
It has been agreed that the Module 0 Project will not be pursued further at this stage.

Rural Advanced Specialist Trainee Scheme (RASTS)
The College has been successful in obtaining $100,000 of funding under the RASTS scheme. The primary focus of the project will be trainees in regional/rural areas.

Educational Innovation Grants
Council reiterated its support for the maintenance of annual funding for research into Education Innovations. It was agreed that the value of individual projects should be increased from the previous limit of $5,000 to $10,000 each, to amounts applicable to the projects proposed (at the discretion of the Education and Training Committee, and the Education Development Unit).

Council supported an interim process for re-advertising and allocating 2009 Education Innovation funding for small, 12-month projects; with awards being recommended to Council in June 2009 and funding available from July 2009. For the 2009 interim funding process, applications will be accepted for projects which have relevance to the FANZCA Training Program. It has been agreed that preference will be given to projects focusing on either: 'work-place based assessment of anaesthetic trainees' or 'clinical teacher development'.

Changes to Royal College of Anaesthetists SHO Program and Approval of Experience as Part of FANZCA Training
The changes were agreed in principle by Council; the detailed regulations will be promulgated after October Council.

International Medical Graduate Specialists (IMGS)

IMGS Assessment Process
Progress continues to be made in updating the College's IMGS Assessment Process, and bringing it into line with Government terminology. Formal approval of the new process will occur in October, with implementation planned for all applicants assessed after 1 January 2009.

Internal Affairs

Certificates in Non-Clinical Areas
Following advice from the Education and Training Committee and the Education Development Unit, it was considered that the College is not currently in a position to develop a position on non-clinical certificates. It was recognised that the College may wish to do so at some time in the future.

Regulations
Two new Regulations were promulgated:

- ***Regulation 35*** – ANZCA Certificates
- ***Regulation 36*** – Diving and Hyperbaric Medicine Certificate

Regulation 14.5 – Application for Final Examination
This Regulation was amended to clarify that Advanced Trainees applying for admission to the Final Examination must, *by the application closing date,* have submitted the appropriate documentation.

Professional

Professional Documents
Following the normal review process, the following Professional Documents were approved by Council (copies attached):

- PS7 – *Recommendations on the Pre-Anaesthesia Consultation*
- PS18 – *Recommendations on Monitoring During Anaesthesia*
- PS29 – *Statement on Anaesthesia Care of Children in Healthcare Facilities without Dedicated Paediatric Facilities* (this document was reissued as there were no amendments suggested during the review process)
- PS45 – S*tatement on Patients' Rights to Pain Management*
- PS49 – *Guidelines on the Health of Specialists and Trainees*
- TE11 (Interim Review) – *Formal Project Guidelines*

Guidelines for the Safe Administration of Injectable Drugs in Anaesthesia
Council supported the promulgation of a Professional Document on this topic. As part of the approval process, a further draft will be prepared by Prof Alan Merry for October Council and will then be put to the Regional/NZ Committees for comment.

Malignant Hyperthermia Resource Kit
Council endorsed the MH Resource Kit produced by Malignant Hyperthermia Australia and New Zealand. Included in this, is the recommendations for an initial dantrolene dose of 2.5 mg/kg and a minimum stock-holding of 24 vials at each anaesthetising location.

Section 3.2.4 of ANZCA Professional Document T1 – *Recommendations on Minimum Facilities for Safe Anaesthesia Practice in Operating Suites and Other Anaesthetising Locations* has been amended accordingly, and the interim review posted on the website.

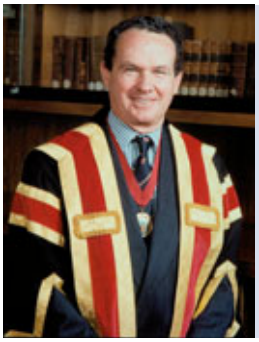
Research

ANZCA Foundation
Mr Ian Higgins commenced as ANZCA Foundation Director on 4 August.

Dr Leona Wilson
President

A/Prof Kate Leslie
Vice-President

Dr Peter David Livingstone



Dr Peter David Livingstone

Dr Peter David Livingstone was the nineteenth and last Dean of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons, and the first President of the Australian and New Zealand College of Anaesthetists. He held this post in 1991 and 1992. He was preceded by Prof Barry Baker and followed by Dr Michael Hodgson.

Peter Livingstone was born on 14 October 1934 in Dalkeith Hospital, Brisbane, and was the youngest of three sons of Robert and Susan Livingstone. He attended primary school at Eagle Junction State School, Brisbane from 1940-1948 and then proceeded to secondary schooling at Church of England Grammar School, East Brisbane from 1949-1952.

Peter's medical degree was undertaken at University of Queensland from 1953-1958. Internship and second post-graduate year were at Royal Brisbane Hospital. Peter married Lurlene in 1959 and they had five children Donna, Cameron, Anna, Russell and Simon.

He entered anaesthetic training at Royal Brisbane Hospital, Brisbane Women's Hospital, Brisbane Children's Hospital, and then in Melbourne at the Royal Women's Hospital and Royal Children's Hospitals in 1963 and the Alfred Hospital in 1964. He successfully completed the Diploma of Anaesthetics, University of Melbourne in 1965.

It was during this time that Peter credits Dr Kevin McCaul – later to become Dean of the Faculty – with 'inspiring my lifelong interest in obstetric anaesthesia'. During this time he also worked with Dr Greta McClelland 'who was Director of Anaesthesia at the Royal Children's and probably the first full-time specialist in paediatric anaesthesia in Australia', Dr John Stocks, her deputy and later to be Director at RCH, and Dr Robert Orton, again a pioneer of anaesthesia in Australia and early Dean, with whom he credits great support and assistance whilst studying for the Diploma. Those he remembers inspiring him in Brisbane were Prof Tess Brophy – again a person who served as Dean – and Dr Roger Bennett who would become President of the ASA; Dr Ruth Molphy, Director of Anaesthesia at the Brisbane General Hospital, 'who was continually coming to the rescue of her fledgling staff and the late Dr John O'Donnell, Director at Princess Alexandra Hospital'.

After completing the Diploma in 1965, Peter returned to Brisbane, initially joining a group with Dr Roger Bennett and being appointed as a VMO with two sessions a week of neurosurgical anaesthesia. This continued 'until 1970 when after many years of lobbying by the anaesthetic community, the Brisbane Women's Hospital established its own Department and there was a Director, myself and VMOs. I continued in this role as senior consultant until I resigned in 2003. O&G anaesthesia has really been my life interest.'

For several years Peter was also involved, with several others, in an ENT Research team examining ear disease in aboriginal children. During this time, they visited almost every aboriginal community in Queensland giving anaesthetics and making observations.

Peter Livingstone was elected to the Board of the Faculty in June 1981, having previously held the post of regional secretary and then Chairman. In June 1982 he became Treasurer of faculty, a little later Chair of the executive committee, vice-Dean and finally Dean, then the inaugural President of ANZCA in February 1992 when the college was established. He retired from College Board in 1993 after twelve years of service, the maximum permitted under our constitution.

When asked about the issues that had been the most importance during his tenure he gave the following response:

'The Board was constantly being encouraged by many to become totally independent of the RACS. The Board moved slowly in this respect until mid-1990 when the momentum really began, but it was a long and tedious process requiring an enormous amount of work by the Board, to whom I will always be grateful.

Money was always in short supply (it always is in these sort of organisations) but when I became Treasurer the annual subscription was very low, Fellows subsidised trainees and examinations ran at a loss. So it was resolved to reset the Faculty on a proper financial basis and this did happen. The College was able to purchase its home in Melbourne and refurbish it without a call on Fellows, and the same with the new building as well as sites in other parts of Australia and New Zealand.

The subscription in advance program, which was introduced with some small amount of resistance, proved to be an enormous boost to research activities in Australia and New Zealand and, whilst the Treasurer had to field some flak over it, I think the results are there for all to see.

Examinations: The Faculty had basically been conducting the same exam system for many years. There was a lot of controversy over some aspects, like the primary exam failure rate and the multiple choice exam and, as Dean, I introduced a wide ranging review of the exam system that resulted in a much more questioning education environment, and I am pleased to say this attitude continues.

It was clear to me that Intensivists were unhappy with the 'section of IC' as it was called and I encouraged them at the time when the Faculty was becoming a College, to consider using the template we had used for 42 years to establish a Faculty of Intensive Care. This they did, as has Pain Management.

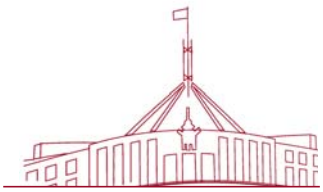
No doubt they will eventually have a 'critical mass' large enough to sustain their own college and I hope that if and when this happens, the separation can be managed with the same dignity achieved when FARACS became ANZCA.

I have always felt honoured to have been able to serve anaesthesia, intensive care, pain management and the community in this way, but I could not have done so without the support of my wife, my family and every member of the Faculty Board and College Council. I have never served in any other organisation which has always debated the important issues vigorously but, once consensus was reached, given total support to the result.'

I would like to record my great appreciation for the assistance of Dr Livingstone in preparation of this monograph.

Assoc/Prof T E Loughnan

Raising awareness, influencing policy



HEALTH POLICY, currently under the spotlight in Canberra, is facing major change over the next few years. One of ANZCA's key strategies is to improve our engagement with, and infuence the direction of, Government health policy. This is crucial to the future development of the College and its mission to educate and train anaesthetists. The continuing modernisation and professionalisation of our operations, together with the appointment of new senior roles addressing both policy and communication, has brought new capabilities to assist ANZCA respond to the many challenges facing the health system.

Recently, ANZCA been proactive in making representations to government across a broad range of issues that impact on patients and the broader community. In 2008, we have made seven submissions. They range from calling for more specialist training in public hospitals in New South Wales (Garling Inquiry) to having an input into the federal government's review of Australia's health system.

Highlights

Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals

- Improve the recruitment, appointment and retention of specialists and trainee specialists in NSW public hospitals
- Establish more places for paediatric and rural anaesthesia training
- Improve the supervision of trainees in public hospitals
- Ensure training supervisors have sufficient time allocated to supervise adequately
- Provide special arrangements for emergency surgery

National Health and Hospitals Reform Commission

- It is time for governments at every level (federal/state/local) to work together, and accept responsibility collectively, to improve the health and well being of the community
- Promote better linkages between major health services and smaller peripheral services
- Ensure adequate numbers of funded medical specialist training positions to enable balanced training rotations
- Provide dedicated teaching time for training in public hospitals
- Improve Quality Assurance programs in hospitals
- Investigate innovative workforce approaches in relation to peri-operative medicine and health prevention
- Promote integrated public health programs aimed at preventing and managing chronic diseases

National Registration and Accreditation Scheme

- We welcome the introduction of a national registration scheme
- We are concerned that any proposed changes to accreditation must adhere to established international guidelines and standards
- An independent authority with medical expertise should be delegated with the authority to make decisions on accreditation and standards – for medical practitioners this should be the Australian Medical Council
- Medical specialist colleges must continue to play an important prevocational and specialist training role ensuring the highest clinical standards and assessing competencies to protect patient safety
- The medical profession must be consulted and have input into the key issues before any final decisions are made
- Professional boards must be consulted in relation to any proposed scope practice changes

National Health and Medical Research Council Review of Public Health Research

Anaesthetists are well placed to provide active interventions to promote healthy lifestyles as part of the pre and post operative assessments which are times when patients are particularly receptive to medical advice.

Severe persistent pain is one of the top four most expensive health care conditions in Australia. There is growing emphasis on developing multidisciplinary management strategies for chronic illnesses such as chronic pain. *Australia is at the forefront internationally in developing this specialist area through the Faculty of Pain Medicine, part of ANZCA.* The Faculty of Pain Medicine includes five medical specialties; this is a world first. Chronic pain costs Australia $34 Billion per annum, that equates to 36 million lost workdays and affects one in five working age Australians.

Review of Australian Higher Education

ANZCA is the *primary conduit of specialist education in anaesthesia, intensive care and pain medicine* in Australia and New Zealand. It has developed a world-class training and education program with a built-in system-wide quality assurance mechanism that includes on-going professional development.

The colleges are important, efficient and effective providers of postgraduate higher education and training of medical specialists. They do this in partnership with the universities, all requiring the same academic and research needs to ensure on-going development and innovation.

ANZCA's submissions can be found at www.anzca.edu.au

Vietnam Vision Project: Restoring sight to the poor

A surgeon from the Saigon Eye Hospital takes a moment to smile for the camera with his team in the background

IN JUNE THIS YEAR, Dr Jenny Carden arrived at a hospital in provincial Vietnam where hundreds of people were waiting for her as part the Vietnam Vision Project (VVP) team. They unpacked, set to work and in six days at three hospitals in Central and South Vietnam and in Cambodia, the VVP group performed just under 500 cataract operations.

'The days were long, it was extremely hot and humid, there was inadequate or no air conditioning and the hospitals lacked resources. The group had to provide all the drugs, instruments and disposable equipment, sterilisers, microscopes and phaeco machines,' Dr Carden said. 'I've never worked so hard in my life'.

The VVP was established in 2003 when a number of members of the Vietnamese Health Professionals Association in New South Wales, many of whom arrived in Australia as refugees, wanted to raise funds to help poor people living in Vietnam. Rotary became involved with both fundraising and with trip volunteers and the money raised allow the group to make the trip to Vietnam each year to perform cataract surgery. Cataract blindness is a widespread problem in Vietnam and it is estimated that approximately 800,000

Patients wait in the corridor prior to anaesthesia

Members of the Vietnam Vision team

'Cataract blindness is a widespread problem in Vietnam and it is estimated that approximately 800,000 people currently live with the condition.'

Dr Jenny Carden

Patients, with their eyes marked, wait in the corridor for cataract surgery

'Doing the ward round at the end of the day was fantastic – it was very rewarding to see the number of people whose lives had been dramatically changed with sight.'

The anaesthetist from the Saigon Eye Hospital during surgery

people currently live with the condition, with another 82,000 new cases developing each year. The massive backlog exists because of the limited access to free health care with people relying on charity programs such as VVP. The project prefers to treat people in the provinces close to where they live.

'It was suggested we bus people from the provinces to the city for treatment, however patients were hesitant about leaving their families, their homes and their rice paddies even for a short time. Travel within Vietnam is not easy for poor people in remote areas. While we were there it was the wet season and they had planting to do and families could not spare anyone. People cannot travel for health care so we went to the provinces and convinced people to come to us locally,' Dr Carden said.

The VVP group from Australia consisted of optometrists, GPs, one anaesthetist, surgeons, pharmacists, a dentist (who ran the steriliser and assisted with interpreting), nurses and administrative staff as well as three Rotary volunteers. They also worked in conjunction with, and funded doctors and nurses from, the Saigon Eye Hospital who traveled with them.

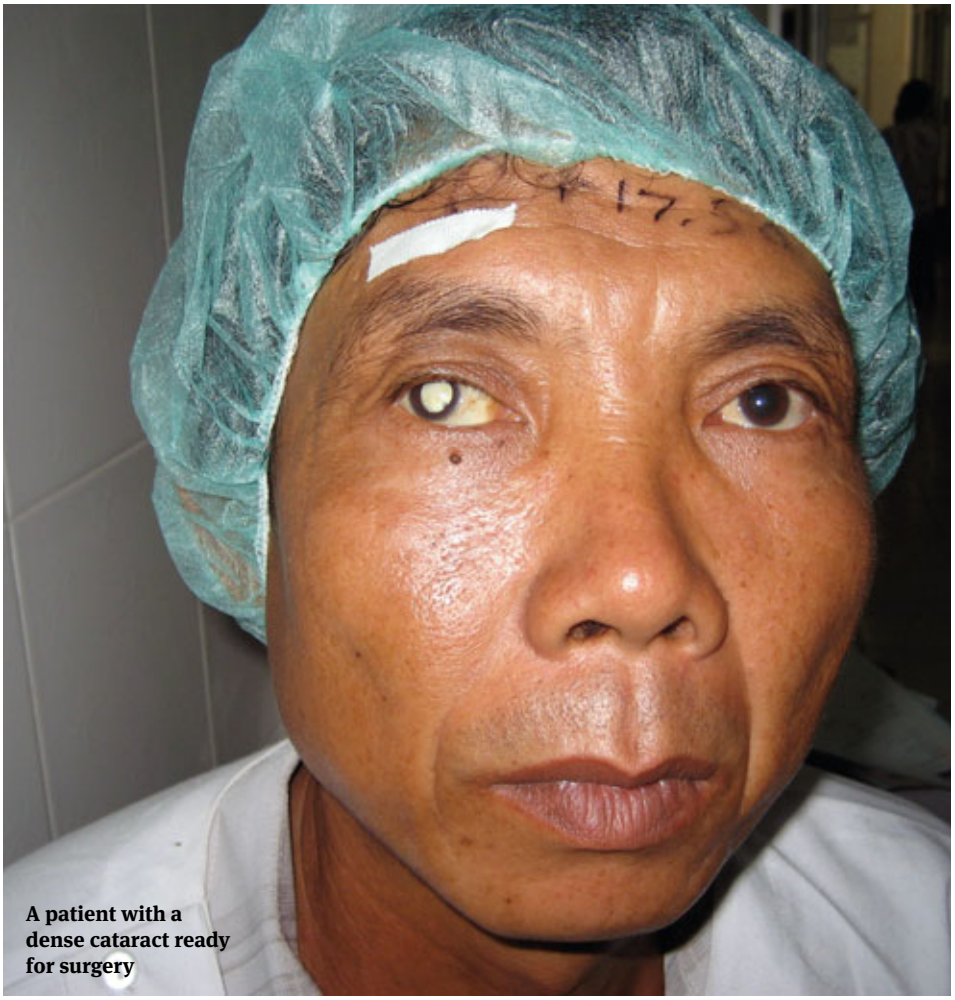
'We'd arrive at the hospital late in the afternoon to set up the operating theatres – we never knew what to expect when we got there and we were literally operating on the run and making do where we could. Often we had to find tables, trolleys and equipment and if the hospital didn't have it, then too bad,' Dr Carden said.

'We'd return the next morning to begin work and often we had up to six operating tables running at the same time.'

First, the administrative staff processed the patients and allocated them an ID number. The optometrist then assessed patients' eyes and the GPs conducted general health checks, particularly looking for diabetes and hypertension, which are very common and not well treated. Due to the very high incidence of diabetes, malnutrition and hypertension, the group had to make on-the-spot decisions about whether surgery was advisable because of the risk of complications. The VVP doctors treated the conditions but they had to keep in mind that medication wasn't going to help patients in the long term as VVP could

Vietnam Vision Project: Restoring sight to the poor

Continued



A patient with a dense cataract ready for surgery

only give them a limited supply. The patients then had their eye marked either left or right, drops were put in to dilate the pupil and then they would jump on one of the six beds lined up in the corridor where Dr Carden performed the block. The patients then walked into theatre for the surgery.

Many of the team visiting from Australia spoke Vietnamese so they could talk to the patients about what was going to happen early in the procedure and get consent. There were also Vietnamese-speaking nurses explaining and answering questions throughout the day. The situation in Cambodia was more difficult and the group relied heavily on local staff for communication with patients.

The risk of postoperative infection was extremely high due to the heat, humidity and poor water quality which posed special problems and was overcome with antibiotic prophylaxis. The VVP group also had to be very frugal with medicines and supplies.

'Anything we didn't bring was not guaranteed and we were forced to try and anticipate everything when we were packing for the trip in Australia. Fortunately, VVP's prior experience working in Vietnam made planning easier,' Dr Carden said.

'At the beginning of the trip we had potentially 600 cases to do and I had to make sure my supplies would last so I was very careful with waste. Unfortunately I ran out of betadine in Cambodia, our last stop, and the hospital was unable to supply any. We had to send someone out to purchase it locally.'

The cataracts were much denser than those seen in Australia and so the patients' vision was very poor. The aim of VVP was to perform a blindness-curing procedure and so this usually meant only performing surgery on one eye. Surgery for these denser cataracts was technically more difficult, especially with the portable equipment and instruments and unfamiliar environment. Dr Carden said another challenge was that many of the Vietnamese patients have very small orbits so the blocks were technically difficult. She learnt a lot from the Vietnamese eye team and they exchanged ideas on techniques. Dr Carden said it was an excellent learning experience for all concerned, however, she points out the trip wasn't a teaching exercise and the group was there purely to perform surgery.

'At one point I was also asked about the feasibility of performing a general anaesthetic on a small child with cataracts. The facilities equipment and drugs for general anaesthesia were rudimentary and there where also concerns about assistance and communication. We decided that the brief for the trip was to do as many cataracts as possible in the allocated time, so we thought it would be better to take a photo of the girl, return to Australia and organise some fundraising for her surgery to be done in Saigon. In this situation, it was preferable to treat a number of people in the period of time rather than spend potentially a whole morning giving one person a general anaesthetic in trying conditions,' Dr Carden said.

'Doing the ward round at the end of the day was fantastic – it was very rewarding to see the number of people whose lives had been dramatically changed with sight. VVP restores independence as the patients can now return to work and participate in family activities.'

There was extraordinary teamwork between everyone involved with the project. All members of the group pitched in to help whether it was setting up, carrying equipment, running the steriliser, moving patients or helping with their eye drops, translating and packing.

Since returning to Australia, Dr Carden and the VVP group have been collecting equipment and sending it to Vietnam. The anaesthetic departments at the hospitals they visited particularly need laryngeal masks and laryngoscopes. Everything is sent through the Poor Peoples Association of Vietnam, a government organisation, to ensure what is donated actually reaches the hospitals and patients in need.

Dr Carden said she will be involved with the VVP trip again next year because it was such a fulfilling experience culturally, professionally and personally. In the mean time, the VVP group will continue to fundraise and plan for 2009.

Volunteers for VVP are welcome including people interested in fundraising, making a donation or the trips. The group is particularly seeking volunteers who speak Vietnamese or Cambodian. Enquires can be made via the VVP website at *www.vvp.org.au*

Dr Jenny Carden works in private practice with the Victorian Anaesthetic Group.

Getting involved with ANZCA – one Fellow's experience

When I was asked to write this article for the Bulletin on how to become involved in College affairs, it stumped me for a while. How did I get involved? Was I crazy? Didn't I have enough to do in my already busy life? I looked back over the past few years to see how and when it started.

When I was a trainee, I was surrounded by many inspiring anaesthetists. What made them special was that they were great at their jobs, committed to their family and friends and found time to make significant contributions to our specialty.

They were involved in exams, supervision of trainees, the New South Wales regional committee and continuing education. The list was endless. I looked at this group of people and saw that they were really happy and part of this happiness stemmed from their job satisfaction. And their job satisfaction was partly due to their involvement with College affairs.

Like most people I spent my registrar years consumed by exams, formal project and striving to just get to the other end. Once the fellowship exam was over, I had a strong desire to share some of my new-found knowledge with others. I was acutely aware that everything I had learned would disappear from my brain if I didn't try and retain it. I helped to organise fellowship trial viva nights for the subsequent exams and as a result had my initial contact with the New South Wales regional office.

I completed my training and, as a first year consultant, was asked to consider the role of Deputy Supervisor of Training. I jumped at it. The chance to learn about the role from an experienced Supervisor of Training was a wonderful opportunity. I was keen to get involved in the training and education aspects of College affairs. This new role brought me into contact with a whole new group of inspirational individuals. I was very impressed with the Supervisors of Training that I met. They were dedicated individuals who made a real difference to the lives of trainees. I could not think of a better community service – to train the best anaesthetists possible.

At the same time I became involved in teaching at the Sydney Medical Simulation Centre. It was a fun and rewarding experience and I met individuals from different hospitals and different states. My horizons were broadened and I learnt a bit more about my profession as a whole.

Dr Nicole Phillips

'When I was a trainee I was surrounded by many inspiring anaesthetists. What made them special was that they were great at their jobs, committed to their family and friends and found time to make significant contributions to our specialty.'

These experiences led to my involvement with the ANZCA Annual Scientific Meeting (ASM) in Sydney in May this year. They were looking for some 'youngsters' to get involved so there would be some corporate knowledge in Sydney when it was our turn to hold the meeting again. It was two years in the planning but it was a fantastic committee to work with and project to work on. It was a chance to learn about College politics, meet the crowd at the College in Melbourne and some of the leaders in our profession. It was incredibly hard work but also very rewarding.

In the final few months leading up to the ASM, a letter arrived from the College about the Council elections. The New Fellow position on Council was up for election. The position is a two-year one, and our first ever New Fellow on Council, Annabel Orr, had just completed her two-year term. I was completely snowed under with the ASM but knew it would be over when the New Council commenced in May so threw my hat into the ring. I was surprised and delighted to be elected. I have attended two Council meetings so far and am impressed by what the College can achieve. I am on the Education and Training Committee, which is in the exciting process of reviewing the entire curriculum and examinations. I am also involved with the Fellowship Affairs Committee, which oversees continuing education, professional affairs and communication.

Many people thought I was absolutely crazy to get involved but I am so glad I did. It is a great chance to give something back to a profession that has given, and continues to give, me so much.

Sometimes it is not entirely clear how to get started, but if you have even a slight inkling to get involved then, borrowing the Nike slogan, 'just do it'! Identifying individuals who make a contribution and expressing your interest to them is a good way to start. Decide what areas of anaesthesia you would like to contribute to: it may be teaching, mentoring, research, training, leadership or more. The regional committee and its officers are also resources within your local environment that can help you find a niche. Specific examples include things like running a workshop at a CME meeting, organising a trial viva night or getting involved with your regional committee. If you are a New Fellow then you can apply to go to the New Fellows Conference. There are many ways to contribute and all of them are very rewarding.

Dr Nicole Phillips

Developing your CPD plan

A series of short articles on different aspects of the ANZCA CPD program will be published in the Bulletin. Requests for explanation of any aspect of the CPD program are most welcome.

Attributes? Professional?

'Developing your CPD plan' mentions 'Attributes of a Specialist Anaesthetist', 'professional role' and 'professionally'. When I graduated from medical school, the Hippocratic Oath was in vogue, and I had read William Osler's 'Aequanimitas' with interest. I observed my role models, both good (mostly) and bad (rare), and thought I had all the attributes of a professional anaesthetist when I obtained my Fellowship in 1969. Between then and 1995, there was CME, then MOPS came along, now CPD. What's different?

When the Australian Medical Council (AMC) was given the task of accrediting specialist medical education and training and professional development programs of the medical colleges in 1999, it modified the broad roles of medical specialists from work published by the Royal College of Physicians and Surgeons of Canada (RCPSC), and referred to the general properties of the practitioner established by the United States Accreditation Council for Graduate Medical Education (ACGME). The differences at the time are shown below:

RCPSC Roles	ACGME Competencies
Clinical expert	Patient care
Team player	Medical knowledge
Manager	Practice based learning/ improvement
Health advocate	Interpersonal/ communication skills
Scholar/teacher	Systems-based practice
Professional	Professionalism

The RCPSC stated 'While all the competencies within the defined roles are recommended for all specialists, there will be variation in the degree of expertise within these competencies between specialists.'

The principles underlying the Canadian, US and other 'roles' and 'competencies' of doctors are similar when read in detail, and include clinical expertise, the ability to communicate effectively, to be a member of a patient care team, to be a scholar and a teacher, to have personal and professional managements skills, and to develop key competencies of a professional.

Prof Garry Phillips

But the twist is that, as expressed in the RCPSC CanMEDS 2000, there are two fundamental concepts underlying CPD today:

- 'changing the focus of the specialty training from the interests and abilities of providers to the needs of society';
- 'orienting these programs to consider the needs of individual participants in context of the population at large.'

So just as society changes, medicine changes, and anaesthesia changes, so does CPD.

In particular, 'professional' has taken on expanded meanings. It is explored well in the ANZCA curriculum modules (especially modules 2 & 12), and in the ANZCA Code of Professional Conduct, and in a number of ANZCA Professional Documents – especially TE6, TE9 and PS16, as well as in the CPD program itself.

In some ways, 'professional' encompasses most of the other 'attributes' or 'roles'. The Macquarie Thesaurus relates the word professional to competent, capable, efficient, proficient, resourceful, skillful, expert, masterful, talented.

The World Federation for Medical Education (WFME) Global Standards for Quality Improvement in Medical Education – European Specifications (2007) states that 'Professionalism encompasses the knowledge, skills, attitudes, values and behaviours expected of individuals during the practice of their profession, and includes concepts such as maintenance of competence, information literacy, ethical behaviour integrity, honesty, altruism, service to others, adherence to professional codes, justice and respect for others.'

The Maintenance of Certification Program of the RCPSC (2008) states that 'professional' means 'being committed to the health and well-being of individuals and society through ethical practice, profession-led regulation and high personal standards of behaviour.'

The General Competencies of the ACGME (2007) include under 'Professionalism' demonstration of compassion, integrity, and respect for others; responsiveness to patient needs that supersedes self-interest; respect for patient privacy and autonomy; accountability to patients, society and the profession; and sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities and sexual orientation.

Further reading:

ANZCA documents: *www.anzca.edu.au/fellows/cpd*

RCPSC documents: *http://rcpsc.medical.org*

WFME documents: *www.ifmsa.org/scome/wiki/index.php?title=World_Federation_for_Medical_Education_(WFME)*

ACGME documents: *www.acgme.org/acWebsite/home/home.asp*

AMC documents: *www.amc.org.au*

American Board of Internal Medicine Foundation, American College of Physicians, European Federation of Internal Medicine. *Medical professionalism in the new millennium: a physician charter.* Ann Intern Med 2002; 136: 243-246

Gruen RL, Arya J, Cosgrove EM, et al. *Professionalism in surgery.* J Am Coll Surg 2003; 197: 605-608

Surdyk PM, Lynch DC, Leach DC *Professionalism: identifying current themes. Current Opinion in Anaesthesiology* 2003; 6: 507-602

Prof Garry Phillips
CPD Committee Member

Developing your CPD plan

Example vignette: You are an anaesthetist working 50% at a teaching hospital and the other 50% in private practice. The main subspecialty involvement includes ENT, obstetrics and ophthalmology. You are the newly appointed anaesthetic representative on the hospital obstetric and perinatal committee. Your public hospital is introducing new electronic ventilators. You have been asked to give one tutorial a month to the part 2 candidates on your areas of work.

Background:
Your plan is exclusively for you, to guide you in your professional development. You may wish to modify your plan during your triennial CPD program. The plan is the reference point for your CPD.

Your plan must be relevant to your professional role and responsibilities, and should reinforce the attributes of a specialist anaesthetist, i.e.:

- Medical Expert
- Communicator
- Collaborator
- Manager
- Health Advocate
- Scholar
- Professional

CPD is not limited to medical education. It may include any activity that develops the professional role of the anaesthetist. Using the vignette as an example the individual may identify that they need to learn about meeting behaviour, conflict resolution, writing a business case, the modular program for ANZCA, new ventilation modalities and any of a number of other skills to enable them to professionally undertake the scope of their work commitments.

Other skills might include, but are not limited to:

- Knowledge (specific areas to update or new information to learn)
- Procedural skills (specific skills to update or new skills to learn)
- Problem solving
- Responding to a clinical emergency
- Communicating with patients and colleagues
- Handling conflict
- Networking with health professionals
- Management of work and time
- Organising skills
- Dealing with change
- Presentations
- Teaching skills
- Engaging effectively in quality assurance activities
- Improving your own learning

The plan can be developed using the online tools via *www.anzca.edu.au/fellows/cpd/*

Step 1: Complete Your Needs Assessment
Think about what education and skills you might wish to develop over the next period of time.

Ask yourself:

What are my roles and responsibilities in my practice?

Will my role and responsibilities change in the coming years? And if so, how?

What knowledge do I need to develop to meet these changing roles and responsibilities?

Action: Write down a list of things you might identify for yourself that you wish to develop.

Triage that list into three categories; 'urgent', 'needs attention', and 'general' continuing education.

Step 2: State Objectives
Some learning goals will need to be achieved this year; others will be fulfilled over a longer timeframe.

Ask yourself:

What are my objectives in undertaking CPD?

Your objectives must be clear, specific, and realistic. Set yourself reasonable targets and time frames for achieving each identified need.

If your objective is to achieve the CPD completion certificate ensure that your objectives will enable you to achieve the outcomes of each section of the program.

Action: Write down, next to each identified need, when you hope to achieve it.

Step 3: Choose Learning Options

Ask yourself:

What is my preferred learning style?

What CPD activities will cover my needs and what is available?

You may prefer to learn mainly by yourself, or in groups of any size. Take note of ANZCA and your Medical Board/Council requirements.

Choose suitable learning activities that best suit your practice and learning style to fulfil each item identified in your needs assessment e.g. conferences, department meeting, internet or library.

Action: Write down how you plan to address each identified need.

Write down the anticipated CPD points for each objective.

Ensure adequate points are achieved in each section of the CPD program.

Step 4: Reflection and Evaluation
The plan may not always be perfect and it is necessary to think about how it needs to be modified over time to continue to be appropriate for your identified needs. Your needs may change over time too.

Ask yourself:

Why include reflection in my CPD program?

When and how often should I undertake and document reflection?

Incorporate into your CPD plan periodic occasions for reflection. This will give you opportunities to think over experiences, self-review your practices, and consider barriers to your professional development, so as to continually improve your practice as a specialist.

Your CPD plan should also include an evaluation of your progress in achieving each of your learning goals. This is required in the last year of your ANZCA CPD program.

Action: Plan time for reflection.
Plan time for evaluation.

How many credits can I claim?
You may claim 2 credits per hour under Category 2, Level 2 for development of your own CPD plan. Also, when you reflect upon the success of your plan, modify your learning goals and evaluate how well you achieved what you set out to do, you also earn 2 credit points per hour.

Action: Claim your points for developing your plan.

References:
TE6 Guidelines on duties of an anaesthetist

CPD program on college webpage: *www.anzca.edu.au/fellows/cpd/*

Contact: cpd@anzca.edu.au

Dr Michelle Mulligan
CPD Committee Member

Nicholas Jansen: Disaster recovery

WHEN NICHOLAS JANSEN WAS 11, he became involved with what was then known as the St John Ambulance Brigade as a cadet, an association that has continued throughout his adult life. Now, at age 38, he is Victoria's Deputy Commissioner with St John Ambulance Australia.

There was a time when Jansen thought this early interest might lead him to emergency medicine and he did a rotation as part of his internship at The Alfred A&E in Melbourne, but it was anaesthesia that eventually became his vocation.

Jansen says that his initial interest in anaesthetics was partly due to the anaesthetists he met as a junior doctor: 'They came across as calm, collected and able to take control in often very stressful situations; almost always averting some kind of disaster and making it look easy!'

Since becoming an ANZCA Fellow in 2005, Jansen has carved out a unique role for himself.

He spends two days a week at the Royal Melbourne Hospital and two days a week at the Royal Women's Hospital.

Jansen also works as a Retrieval Physician for the newly established Adult Retrieval Victoria (ARV), part of Ambulance Victoria (formerly the Victorian Adult Emergency Retrieval and Coordination Service). 'We work closely with Air Ambulance Victoria and most of the work involves going to regional centres where a patient overwhelms the local resources or requires specialist management in Melbourne.'

The work is varied and extremely challenging. Jansen recalls flying to Swan Hill last year to retrieve a 24-year-old woman with burns to 80 per cent of her body, following a house fire. The woman's two-year-old daughter had died in the fire. Jansen was required to commence resuscitation and management. 'Intubating someone with severe airway burns in an unfamiliar hospital at 3am was without doubt the most challenging clinical experience of 2007,' says Jansen. He remembers catching a taxi home and listening to the morning news reporting the tragedy and how a 'burns team' had flown up to get the patient – something up until then he had never considered himself as!

Given the onerous after-hours commitment of the work and relatively poor remuneration (compared with other areas of anaesthesia), Jansen says he has been involved since 2004 because he finds it interesting: 'It gets you out of the hospital and working with paramedics, pilots and rural communities who are immensely grateful for your help. Anaesthetists are well placed to provide expert aeromedical transfers because they are used to dealing with intubated, ventilated patients in often hostile environments.'

Above: Nicholas Jansen, in uniform as a Retrieval Physician for the newly established Adult Retrieval Victoria, part of Ambulance Victoria.

Right: Nicholas Jansen inside the Air Ambulance Superking Air 200C.

Despite this, in Victoria there are only a handful of anaesthetists working for ARV, with most clinicians coming from an Emergency background.

His fourth and final 'job' is more obscure. He is a Field Emergency Medical Officer (FEMO) under the State Health Emergency Response Plan (SHERP), which is part of the Victorian government's state disaster arrangements. There are five metropolitan FEMOs in Victoria that provide a 24/7 consultant-led service. A FEMO's role is to coordinate the medical response in a mass casualty disaster. Two such recent examples in Victoria include the Kerang train crash and the Burnley tunnel crash. While surface transport accidents and bush fires have historically accounted for the majority of activations, the threat of terrorism (particularly around the time of the Commonwealth Games) has been the focus of several large exercises which Jansen has attended.

The reality, Jansen says, is that he has been despatched only once since he started in 2006: 'There was a sub-station explosion in one of the city's buildings in Bourke Street with approximately 140 people trapped in the lifts across two buildings. The buildings had lost power and thick smoke was billowing out on to the street. There was great concern that those trapped were being exposed to the same smoke and that on restoration of power the Ambulance

Service may have been overwhelmed with patients suffering heat and smoke related illnesses. Fortunately none of those trapped were affected and the biggest issue became retrieving Christmas presents from the affected offices!'

Jansen says he had considerable concern about his abilities when he first signed on as a FEMO. 'As an anaesthetist, I didn't have any experience or any perceived expertise in the area of disaster medicine other than my pre-hospital experience with St John Ambulance. Medical colleague and mentor, A/Prof Joe Epstein, encouraged me to apply for the position telling me that there are very few true disaster experts owing to their infrequent nature. There is little ability to test the effectiveness of what we do in disaster situations or even by what criteria we should measure effectiveness.'

Jansen says that the majority of the job is preparing and planning for disasters: 'It involves going to meetings with both local and state government and other agencies to plan for a variety of events. Many of these events are festivals, fun runs and other mass gatherings, which are part of every day life in Victoria and not disasters per se. It's been great meeting people within the Department of Human Services (DHS). As an anaesthetist working purely in theatre you don't usually have any direct contact with 'The Department' or an understanding of the complex process or systems by which decisions are made.'

Jansen comments that during his time practising anaesthesia, one of the main tools that has changed since he started training is the increased use of ultrasound. 'As a trainee, I didn't train with ultrasound very much but we are now using it to do nerve blocks, vascular access and echo-cardiography. It will be interesting to see in 10 years what will become of current (pre-ultrasound) practices and if they will continue to have a place in clinical work.'

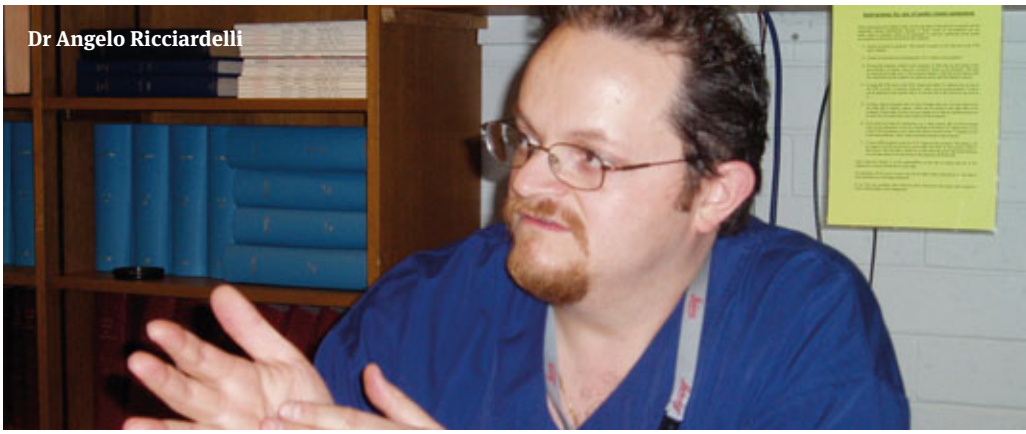
Jansen notes the trend to move away from using nitrous oxide in his relatively short anaesthetic career and laughs at the reaction of some of his registrars when he uses it. 'It's like I have turned on the poison dial!'

Jansen remarks that anaesthetists may sometimes suffer from community misconceptions about what roles they perform. Jansen hypothesises that if ten people on the street were asked whether an anaesthetist is a doctor, there would be two or three who would say no. He is passionate about anaesthetists becoming involved in non-traditional roles and raising the profile of the profession. Anaesthetists are generally quiet achievers who perform their craft as leaders within the medical community particularly when it comes to safety, critical incident management, audit and reporting. 'There's no reason anaesthetists can't bring these skills to other areas of the health system,' says Jansen.

Roundtable discussion with new Fellows from South Australia

Working as a recently qualified anaesthetist presents a number of challenges. We caught up with three new Fellows from South Australia in a roundtable discussion on topics ranging from training to working overseas.

Dr Angelo Ricciardelli works full time at Flinders Public Hospital, Dr Kelly Bratkovic has just returned from maternity leave and is working part time at Flinders and as a locum in private and Dr Justin Porter splits his time between the Royal Adelaide Hospital and private practice.


Dr Angelo Ricciardelli


Dr Kelly Bratkovic


Dr Justin Porter

How did you find ANZCA's training program generally?

Justin Porter (JP) – I thought it was a good program and we're lucky in South Australia because we get to rotate through a number of different hospitals. We also have the opportunity to work in the Northern Territory. I spent nine months in Darwin and really enjoyed the experience.

Angelo Ricciardelli (AR) – The training program was really good. As Justin mentioned, in South Australia we're rotated through all the hospitals and were exposed to all the sub specialties of anaesthesia. The rotation system is also used in Western Australian and Queensland. Other states have to apply directly to the hospitals. This is something South Australia has done for a long time so when the formalised modules were introduced during my second year of training I thought we already did things quite well here.

Kelly Bratkovic (KB) – The hours and registrars were also good to work with. I did 18 months of training in Sydney but I preferred the training program in South Australia. I think New South Wales was more organised with the modules, though.

Do you feel ANZCA's training program adequately prepared you for practice?

JP – I felt well prepared. I spent my final six months at Sir Charles Gairdner Hospital in Perth. I learnt a lot there, and feel I grew more in a professional sense than if I'd stayed in South Australia, because I had a focused program and was given opportunities to work as a junior consultant. I was involved with teaching and encouraged to flourish in my chosen area of regional anaesthesia, with expert tutelage. I feel this is lacking in the South Australian program, particularly in regard to senior trainees.

KB – It would be nice if your final year were different to the other years in some way.

AR – Halfway through my final year I was offered a position as a consultant at Flinders and so from then on I was given more responsibility.

KB – I was not that well prepared for the business side of private practice. While it's not hard, it was completely different to what I was used to. I ended up asking colleagues for help because when you start you can have dozens of forms to fill out plus insurance and accreditation with the private hospital to complete.

JP – It's like you're running a business in private hospitals and there's no real preparation for that side of it in the training program. I think some exposure would be very useful. As a trainee, we only get to see the way the public system operates.

FELLOWSHIP AFFAIRS FEATURE

Roundtable discussion with new Fellows from South Australia

Continued

Dr Justin Porter

What worked well? What improvements would you recommend?

JP – The examinations worked well. I've heard from various people that the second part exam may change so that trainees do the multiple choice questions (MCQ) related to a particular module at the completion of that module. Hence they would be done in a piecemeal fashion. I'm not sure that needs to happen. MCQs are very useful in that they make you read around the topics you need to know. Vivas also work well. With respect to the introduction of modular training, it probably hasn't had so much impact here because South Australian training is based on a rotation system.

AR – I agree the modules did not have much of an impact here given our rotation system. I know the modules are designed to make us well-rounded anaesthetists but I found it difficult to get extra exposure to a particular module once I had been deemed to have already completed time in that area. I think perhaps more flexibility needs to be introduced with regard to modules.

KB – I felt well supported by the College throughout the training program but I'm not sure what to do about Continuing Professional Development (CPD). The message has got out that it has changed and it's new but not the nuts and bolts of how to actually go about it.

JP – The College guidelines are excellent and indeed useful to help mould our practice. If you are unsure about where you stand on a particular issue, you can refer to them. They can also be used as a framework in negotiating with surgeons and hospital administrators.

What are your working conditions like? Private compared to public?

KB – The beauty of anaesthetics is that it's so flexible. For example, when I was on maternity leave I worked one day a fortnight. Or you can spend six days a week in private if you want to.

JP – The quality of one's working conditions (public or private) is somewhat determined by the individual surgeons, hospitals and theatre team. I have been fortunate enough to experience a good level of camaraderie and support from my colleagues in both fields of my practice. I work in a strong, friendly department in public and my private group has a mentoring scheme available as well. Private is definitely a more efficient way of working, however it doesn't necessarily mean more pressure. In some ways you practice differently in private than public; for example, the services available at a particular hospital for post operative pain management. Larger hospitals generally have in-house pain services, intensive care, high dependency unit (HDU) monitoring etc and so your choice of post-operative management may differ.

AR – I currently work full time in public which allows me to work in different sub specialities of anaesthesia and be involved with teaching. I would like to retain skills in as many areas of anaesthesia as possible and this would be difficult if I was working in private. It is also nice to belong to a department and feel at home at a particular hospital.

KB – I find it difficult to get used to the idea that in bigger private cases, the surgeon looks after all the pain relief after the operation. Basically you do the case and paperwork but the surgeon decides what pain relief is required because you don't see the patient again unless you organise your practice so you're at that particular hospital often. JP – It can often be more difficult to follow up a patient in private because you work in a number of different hospitals and may find yourself on the other side of the city the following day.

KB – In public you have an anaesthetic department, but in private you operate as a solo practitioner and manage everything. I'm sure the longer you work in private the more you get used to it, but when you're new it can be quite daunting.

JP – In public hospitals, most patients are seen in the pre-admission clinic so anything sinister is flagged well in advance. In private, often the first time you meet the patient is 10 to 20 minutes before you're about to anaesthetise them. Many surgeons are very good and will refer complex patients to you in advance, however you are reliant on their judgement of anaesthetic complexity.

KB – In private you're very reliant on the surgeon to refer any sick patients. If you suddenly come across something before surgery there is a lot of pressure on you if you cancel that case. It's a hard decision to make. If you call patients prior to surgery, they might get anxious because they think something must be wrong.

JP – Today, with our training, equipment and drugs, we've become very good at anaesthetising very sick patients for complex procedures that we would never have contemplated previously. However, because we've become so good at doing this with a minimal amount of fuss – surgeons, patients and nurses seem to assume everything will be fine. So when a difficult case comes up with little warning and we need to do further investigations or alter management, everyone stands around asking why things are taking so long.

KB – We're silent achievers really.

JP – The challenge for anaesthesia is to raise its profile and demonstrate its independence and ability to provide a complete perioperative service in close liaison with our surgical and physician colleagues. It's important that we're not just seen as technicians who can get on and cope with anything without any fuss because that's not the reality. Prolonged surgical time in a complex case is tolerated far better in most circumstances than extended anaesthetic time. This should not be the case and it is only through increasing the awareness amongst our non-anaesthetic colleagues of why and how we approach safe anaesthetic management that this will change. This is true of administrators as well. Often lists are planned assuming no time for anaesthetic planning, management and teaching.

KB – Private practice tends to be financially driven that instead of bringing all patients in at 7am (so you can see each of them and start your list at 8:30am), most hospitals now bring in two patients at 7am and stagger the rest throughout the day. This system costs hospitals less money but means we don't see patients until you wheel one into recovery and welcome the next person on the list.

What is your view of South Australia's health system particularly as it relates to anaesthesia?

JP –One of the major attractions to the public system is being a part of a department where there's camaraderie, teaching, research and program development. Private is more so about


Dr Angelo Ricciardelli

'In public hospitals we want to do formal research, training and develop programs for anaesthesia...'
Dr Kelly Bratkovic


Dr Kelly Bratkovic

independence, efficiency and caseload with the consequent financial benefits. However, in the South Australian public health system we tend to just do lists – there's little research, miniscule time allocated for program development and we don't really get a meaningful non-clinical component to our work.

KB – In public hospitals we want to do formal research, training and develop programs for anaesthesia. Currently there's no set non-clinical session.

JP – Most interstate public anaesthetists have a non-clinical component built into their job and I'm sure this is an important factor in recruiting and retaining staff in the public system. Time and recognition of pursuits other than just clinical work definitely improves job satisfaction. There is an increasing trend towards managing work around life rather than the converse amongst my contemporaries.

KB – A journal club would be great and these are all things we can put towards CPD. Currently at Flinders we have one meeting a week and it's crammed full of everything so there's not much time for new topics, interesting cases, journals, articles etc. We really need this in our profession.

AR – South Australia is probably no different to any other state in Australia at the moment. There are long waiting lists, a decreasing number of public beds and increased pressure to just become a production line. Teaching and research are usually the first casualties in such a system. There needs to be more protected time for teaching and personal professional development.

JP – Departmental meetings and continuing medical education (CME) sessions are an important tool for achieving departmental cohesion, and indeed necessary for maintaining individual and departmental integrity. One of the benefits of public hospital employment is to be regularly involved in such organised activities, however rather than taking place outside of hours, they should be incorporated into rostered duties. If we just go to work, do lists and go home we're technicians. However, if we invest more time and effort into developing programs and managing patients in a more complete sense then we are defining ourselves as a profession.

Why did you choose anaesthetics as a career path?

KB – I felt it was one of the few general specialties because you see a range of patients and so can keep up to date with the different surgical techniques and new medical therapies. I think anaesthetics appeals to people who like doing technical things and seeing immediate results.

AR – Anaesthesia is an area of medicine where you can work as a team. Our skills are very portable and working part time is possible so that you can develop interests outside of work. I like the fact that we get immediate results with our therapeutic measures – there's no waiting around for six weeks like some physicians for their treatment to have an effect.

JP – It's an intellectually challenging specialty as every patient/procedure combination is different. Besides the intellectual, anaesthesia also offers the technical aspects of medicine. I enjoy the procedural aspect but find the mental challenges very rewarding. Sometimes people suggest one might do anaesthesia to avoid patient contact but conversely I enjoy the strong relationship I form with my patients perioperatively. The patient is placing an enormous amount of trust in us and it's rewarding to be able to provide a good service to them.

What do you find challenging in your job?

JP – Social interactions can be challenging at times. You interact with surgeons, intensivists and physicians to try and get your patients optimally prepared for surgery and the anaesthetic and sometimes there are occasional misunderstandings about what we do. I do a lot of regional anaesthesia and at times I've found myself having to convince surgeons that regional blockade is good for a particular patient.

KB – It takes an extra five minutes and yet no one minds when the surgeon takes an extra half an hour to sew something up. The nurses question why we're doing things and that social interaction is a challenge. You also have to get used to working with new surgeons and other people you haven't worked with before in private.

Are you interested in research?

JP – We don't have any time allocated currently. Research is incredibly time consuming and it can be frustrating trying to get projects through ethics.

KB – I've had a couple of case reports published. It takes a lot of effort but if we were allocated non-clinical time more research could be undertaken and as a department grows, more interesting things come out of it.

JP – Where I worked at Charles Gairdner Hospital, staff specialists had allocated non-clinical time and the research, teachings and programs that came out of that department was phenomenal.

KB – People know that particular department because they have motivated people and the time to do research. One way to attract the top people to a hospital is by having non-clinical sessions and the time to foster and support their interests.

AR – Research is very important so we can continue to improve our practice. Some people are better suited to research than others. I would certainly like to get involved in research in the future.

Would you consider working overseas or doing aid work?

KB – I'm interested in working overseas. Probably in Ireland or Canada once the kids are at school. I'd also like to do aid work one day. I work with people who go to East Timor quite regularly so it would be easy to get involved when the time is right.

JP – I would like to work overseas, but only in short bursts. I wouldn't rule out working in a rural region for a year or so.

AR – I would, but at present my family comes first.

Would you like to get involved with the College in the future?

KB – Examinations.

JP – Yes I'm interested in being an examiner and supervising trainees.

KB – It would be a good way of keeping up-to-date.

AR – I am interested in training and in the future would consider becoming involved with examinations. I think it's important to give back to a system that helped train us.

Successful Candidates 2008

Primary Fellowship Examination

February/April 2008
The written section of the examination was held in all capital cities in Australia, Cairns, Launceston, Newcastle, Townsville, Auckland, Christchurch, Dunedin, Hamilton, Hong Kong, Kuala Lumpur, Singapore and Wellington.

The viva examination was held at the Australian Institute of Management in Melbourne.

A total of 97 candidates successfully completed the Primary Fellowship Examination at this presentation and are listed below:

Primary Fellowship Examination – Court of Examiners

Fayavar Ajvadi	QLD
Sheila Barnett	NZ
Melinda Bradshaw	VIC
Mathew Brbich	WA
Kimberley Browne	VIC
Vitali Broyda	NSW
Stacey Byers	NZ
Owen Callender	NZ
Frances Cammack	NZ
Martin Chau	NSW
Tin Lun Chiu	NZ
Alexander Cottle	VIC
Rosalba Cross	NSW
James Dalby-Ball	NZ
Michelle Daly	UK
Craig Daniel	QLD
Amanda Diaz	SA
Yvette D'Oliveiro	VIC
Alexander Duthie	NSW
Thananchayan Elalingam	NSW
Jacqueline Evans	QLD
Perry Fabian	SA
Michael Farquharson	SA
Adam Feldman	VIC
Sarah Flint	SA
Renee Franklin	NZ
Amy Gaskell	NZ
Andrew Good	NZ
Oksana Gorlanchuk	SA
Anthony Guterres	SA
Kathryn Hagen	NZ
Louise Hails	NSW
Amir Haq	NZ
Kevin Hartley	WA
Stuart Hastings	VIC
Joshua Hayes	SA
Lisa Hendy	NSW
Irina Hollington	SA
Matthew Hope	NSW
Kwok Fui Hor	NZ
Jason Howard	QLD
Jonathan Kapul	QLD
Balvindar Kaur	VIC
Fong Wee Kim	SGP
Jason Koerber	SA
Indunil Kumarasinghe	VIC
Annlynn Kuok	WA
Naoife Lavin	NSW
John Lee	NSW
Jean Lee	NSW
Heidi Liesegang	VIC
Nicholas Lightfoot	NZ
Yeow-Kwong Ling	WA
Li Nyuk Loo	NZ
Andrew Lovett	NSW
Ian Maddox	WA
Yip Vivian Mai Man	HKG
Julian Marshall	NSW
Simon Martel	NSW
Rachelle Mason	NZ
Melissa McDougall	VIC
Meena Mittal	VIC
Sajidah Ilyas Mohammad Ilyas	MAL
Joanne Moore	SA
Cameron Morgan	VIC
Shuh Fen Moy	NZ
Lisa Nasis	VIC
Anna Negus	NZ
William Chuk Kit Ng	NSW
Rowan Ousley	SA
Dana Pakrou	QLD
Jason Pincus	NSW
Florian Pracher	NZ
Peter Robinson	NZ
Anthony Ryan	NSW
Timothy Sampson	QLD
Jason Scott	QLD
Minka Springham	QLD
Larissa Stevenson	VIC
Emily Stimson	NSW
Angela Suen	NSW
John Svendsen	WA
Joyce Tai	NZ
Amy Taylor	NSW
Bronwyn Thomas	QLD
Rhys Thomas	NSW
Sarah Thomas	TAS
Andrew Travis	WA
Jonathan Trinh	NSW
Tarin Ward	VIC

Suzanne Whittaker	VIC
Anthea William	WA
Lauren Williamson	NZ
Terence Wong	WA
Ng Lip Yang	MAL
Tey Wan Yee	MAL
Joanne Yeo	NSW

Renton Prize
The Court of Examiners recommended that the Renton Prize for the half year ended 30 June 2008 be awarded to:

Dr Ann-Lynn Kuok WA

Merit Certificates
Merit certificates were awarded to:

Dr Sheila Barnett	NZ
Dr Frances Cammack	NZ
Dr Amanda Diaz	SA
Dr Kathryn Hagen	NZ
Dr Stuart Hastings	VIC
Dr Andrew Lovett	NSW
Dr Terence Jen Keat Wong	WA

Final Fellowship Examination (Anaesthesia)

April/May 2008
The medical clinical and written sections of the examination were held in Adelaide, Auckland, Brisbane, Hong Kong, Melbourne, Perth and Sydney.

The anaesthesia vivas were held in Melbourne at the Melbourne Convention & Exhibition Centre.

176 candidates presented in for medical clinical and written sections of the examination and 158 were invited to attend the anaesthesia vivas. A total of 139 successfully completed the final examination.

Rabea Anja Abdo	WA
Hossam Abouelnasr	NSW
Mahnaz Afsari	VIC
Elspeth Louise Alfredson	NSW
James Battye	NSW
Paul David Bent	VIC
Paul Martin Blundell	NZ
David Martin Blundell	NZ
Louise Kathleen Borland	VIC
Andrew Reuben Braun	VIC
Nicola Anne Broadbent	NZ
William Benjamin Browne	VIC
Kathryn Elizabeth Brunello	QLD
Teresa Frances Bulger	NZ
Kelly Patrick Anthony Byrne	NZ
James Paul Cameron	NZ
Hester Mary Damaris Cardwell	NZ
Carmel Laurelie Cassar	QLD
Timothy Mark Chapman	NZ
Rui Siang Cheng	SA
Man Yiu Cheung	VIC
Peter Chi-Ming Ching	SA
Tan Chern Ching	VIC
Jing-Chen Jason Chou	WA
Chui Sze Wing	HK
Chu Chung Yin	HK
Peter Chung	NSW
Russell Craig Clarke	WA
Matthew William Coghlan	VIC
James Corcoran	SA
John James Peter Dally	SA
Mark Dilda	QLD
Yi-Feng Cindy Ding	QLD
Michael Francis Dobbie	NSW
Carl Edward D'Souza	NSW
Erika Petra Dutz	VIC
Bridget Kate Effeney	QLD
Norman Feist	QLD
Alister Ross Ford	VIC
Benjamin Gibb Freeman	VIC
Martin Willem Frouws	QLD
Fu Yim Ting	HK
Kim Lisa Fuller	QLD
Veronica Christina Gin	NZ

Marshall Guy Godsall	VIC
James Julian N Hafner	NSW
Nigel David Hamilton	VIC
Andrew Morgan Hart	NSW
Jonathan Gurney Hiller	VIC
Maryam Horriat	VIC
Andrew James Howard	NSW
Jack Shao-Cheng Huang	QLD
Craig Humphries	VIC
Matthew Hung	VIC
Selena Ann Hunter	NZ
David Ip	VIC
Claire Jane Ireland	NZ
David Frederick Isaac	NSW
Dev Jayram	NSW
Matthew Alexander Jenks	NZ
Kam Hau Tse	HK
Rajdeep Kanwar	NSW
Tanya Michelle Kelly	VIC
Andrew John Kennedy	NSW
Sarah Megan Kennedy	NZ
Sarah Keron	NZ
Kay-Lip Khoo	NZ
Orison Minh Oh Kim	NSW
Kong Hang Sze Amy	HK
Emily Gar-Yee Koo	HK
Sally Lacey	VIC
Chung Fei Lai	VIC
David Hui-Fung Lam	VIC
Samuel Hoi-Sing Lau	VIC
Diem Le	SA
Matthew Leach	NSW
Tania Louise Lee	NSW
Graham Duncan Lethbridge	VIC
Li Yi On Yvonne	HK
Ana Licina	WA
Philip Lo	QLD
Janet Ellen Loughran	NSW
Kate Suzanne Luscombe	WA
Anthony Lynch	SA
Gareth Brian Lyttle	SA
Julian Robert Mahood	VIC
Rebecca Eleanor Martin	WA
David Ian McCormack	QLD

Successful Candidates 2008

Continued

Catherine Jane McGregor	NSW
Simone Mossenson	VIC
Louise Margaret Munro	QLD
Nagesh Chowdahalli Nanjappa	SA
Matthew James Newman	SA
Kheng-Heng Ng	NSW
Mark Darren Gye-Len Ng	VIC
Virgilius Viorel Niculescu	SA
Robert John O'Connor	NSW
Ben Luke Olesnicky	NSW
Dick Montague Ongley	NZ
Girish Suhas Palnitkar	ACT
Judith Anne Penney	NZ
Michal Petr	NSW
Steven John Philpot	WA
Michael Siew-Foo Poon	NSW
Quah Yeow Leng Valerie	ACT
Rakesh Rai	NSW
Anand Keshavchandra Rajbhoj	QLD
Nicholas Jason Christopher Randall	NZ
Simon Maximilian Roberts	NSW
Rebecca Jane Ruberry	QLD
Peter John Schuller	QLD
Mir Wais Sekandarzad	NSW
Rachel Elizabeth Shanks	VIC
Sanjay Sharma	VIC
Sing Li Luk	HK
Gabriel Lee Snyder	VIC
Janice Eithne Stafford	QLD
Kushlani Shiromala Stevenson	VIC
Frank Yung-Tai Sun	NSW
Vincent Tan	VIC
Chong Oon Tan	VIC
Arun Kumar Thiagarajan	NSW
Bich-Phuong Tieu	SA
Clifton Edwin Timmins	QLD
Natalya Carol Von Papen	QLD
Damien Robert Wallman	WA
Kristine Yvonne Wardle	VIC
Ingo Weber	SA
Robert Stephen Williams	NSW
Gretchen Ann Willis	NSW
Tai Lun Paschalis Woo	QLD
David William Wright	QLD
Peik Fei Yau	VIC
Amanda Louise Young	VIC
Yue Man Cheung Stephen	HK
Wanda Yung	NSW
Caroline Chunlei Zhou	NZ
John Zois	VIC
Benjamin Mark Zugai	QLD

Cecil Gray Prize

The Court of Examiners recommended that the Cecil Gray Prize for the half year (ended 30 June 2008) be awarded to:

Gabriel Lee Snyder	VIC

Merit Certificates

Merit Certificates were awarded to:

James Julian N Hafner	NSW
Andrew James Howard	NSW
Steve John Philpot	WA
Mark Dilda	QLD
Dick Montague Ongley	NZ

Final Fellowship Examination – Court of Examiners

Overseas Trained Specialists Performance Assessment

Seven candidates presented for the Overseas Trained Specialist Performance Assessment held in April/May 2008 and the following four candidates were successful.

Dr Erna Meyer	NZ
Dr Peter Tiesenhausen	QLD
Dr Morne Terblanche	QLD
Dr Latha Nair	TAS

Professional documents

Following the normal review process by Council, the following Professional Documents have recently been approved:

PS16 – *Statement on the Standards of Practice of a Specialist Anaesthetist*

PS47 – *Guidelines for Hospitals Seeking College Approval for Vocational Training*

T3 – *Minimum Safety Requirements for Anaesthetic Machines for Clinical Practices*

PS7 – *Recommendations on the Pre-Anaesthesia Consultation*

PS18 – *Recommendations on Monitoring During Anaesthesia*

PS29 – *Statement on Anaesthesia care of Children in Healthcare Facilities without Dedicated Paediatric Facilities (this document was reissued as there were no amendments suggested during the review process)*

PS45 – *Guidelines on the Health of Specialists and Trainees*

TE11 (Interim Review) – *Formal Project Guidelines*

Please note that the above documents have been published in full on ANZCA's website – *www.anzca.com.au*. They will also be e-mailed directly to Fellows and trainees via the next edition of the ANZCA e-newsletter which will be published in October.

Australian and New Zealand College of Anaesthetists

ABN 82 055 042 852

Professional documents
P = Professional
T = Technical
EX = Examinations
PS = Professional standards
TE = Training and Educational

TE1	(2008)	*Recommendations for Hospitals Seeking College Approval for Vocational Training in Anaesthesia*
TE2	(2006)	*Policy on Vocational Training Modules and Module Supervision (interim review)*
TE3	(2006)	*Policy on Supervision of Clinical Experience for Vocational Trainees in Anaesthesia*
TE4	(2003)	*Policy on Duties of Regional Education Officers in Anaesthesia*
TE5	(2003)	*Policy for Supervisors of Training in Anaesthesia*
TE6	(2006)	*Guidelines on the Duties of an Anaesthetist*
TE7	(2005)	*Guidelines for Secretarial and Support Services to Departments of Anaesthesia*
TE8	(2003)	*Guidelines for the Learning Portfolio for Trainees in Anaesthesia*
TE9	(2005)	*Guidelines on Quality Assurance in Anaesthesia*
TE10	(2003)	*Recommendations for Vocational Training Programs*
TE11	(2008)	*Formal Project Guidelines (interim review)*
TE13	(2003)	*Guidelines for the Provisional Fellowship Program*
TE14	(2007)	*Policy for the In-Training Assessment of Trainees in Anaesthesia*
TE17	(2003)	*Policy on Advisors of Candidates for Anaesthesia Training*
TE18	(2005)	*Guidelines for Assisting Trainees with Difficulties*
EX1	(2006)	*Policy on Examination Candidates Suffering from Illness, Accident or Disability*
T1	(2008)	*Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations (interim review)*
T3	(2008)	*Minimum Safety Requirements for Anaesthetic Machines for Clinical Practice*
PS1	(2002)	*Recommendations on Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia*
PS2	(2006)	*Statement on Credentialling and Defining the Scope of Clinical Practice in Anaesthesia*
PS3	(2003)	*Guidelines for the Management of Major Regional Analgesia*
PS4	(2006)	*Recommendations for the Post-Anaesthesia Recovery Room*
PS6	(2006)	*The Anaesthesia Record. Recommendations on the Recording of an Episode of Anaesthesia Care*
PS7	(2008)	*Recommendations on the Pre-Anaesthesia Consultation*
PS8	(2008)	*Guidelines on the Assistant for the Anaesthetist*
PS9	(2008)	*Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical or Surgical Procedures*

Professional documents

Continued

Professional documents
P = Professional
T = Technical
EX = Examinations
PS = Professional standards
TE = Training and Educational

PS10	(2004)	*Handover of Responsibility During an Anaesthetic*
PS12	(2007)	*Statement on Smoking as Related to the Perioperative Period*
PS15	(2006)	*Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery*
PS16	(2008)	*Statement on the Standards of Practice of a Specialist Anaesthetist*
PS18	(2008)	*Recommendations on Monitoring During Anaesthesia*
PS19	(2006)	*Recommendations on Monitored Care by an Anaesthetist*
PS20	(2006)	*Recommendations on Responsibilities of the Anaesthetist in the Post-Anaesthesia Period*
PS21	(2003)	*Guidelines on Conscious Sedation for Dental Procedures*
PS26	(2005)	*Guidelines on Consent for Anaesthesia or Sedation*
PS27	(2004)	*Guidelines for Fellows who Practice Major Extracorporeal Perfusion*
PS28	(2005)	*Guidelines on Infection Control in Anaesthesia*
PS29	(2008)	*Statement on Anaesthesia Care of Children in Healthcare Facilities without Dedicated Paediatric Facilities (reissue)*
PS31	(2003)	*Recommendations on Checking Anaesthesia Delivery Systems*
PS37	(2004)	*Regional Anaesthesia and Allied Health Practitioners*
PS38	(2004)	*Statement Relating to the Relief of Pain and Suffering and End of Life Decisions*
PS39	(2003)	*Minimum Standards for Intrahospital Transport of Critically Ill Patients*
PS40	(2005)	*Guidelines for the Relationship Between Fellows and the Healthcare Industry*
PS41	(2007)	*Guidelines on Acute Pain Management*
PS42	(2006)	*Recommendations for Staffing of Departments of Anaesthesia*
PS43	(2007)	*Statement on Fatigue and the Anaesthetist*
PS44	(2006)	*Guidelines to Fellows Acting on Appointments Committees for Senior Staff in Anaesthesia*
PS45	(2008)	*Statement on Patients' Rights to Pain Management*
PS46	(2004)	*Recommendations for Training and Practice of Diagnostic Perioperative Transoesophageal Echocardiography in Adults*
PS47	(2008)	*Guidelines for Hospitals Seeking College Approval of Posts for Vocational Training in Diving and Hyperbaric Medicine*
PS48	(2003)	*Statement on Clinical Principles for Procedural Sedation*
PS49	(2008)	*Guidelines on the Health of Specialists and Trainees*
PS50	(2004)	*Recommendations on Practice Re-entry for a Specialist Anaesthetist*

August 2008

Australian and New Zealand College of Anaesthetists

and

Joint Faculty of Intensive Care Medicine

ABN 82 055 042 852

Professional documents

IC-1	(2003)	*Minimum Standards for Intensive Care Units*
IC-2	(2005)	*Intensive Care Specialist Practice in Hospitals Accredited for Training in Intensive Care Medicine*
IC-3	(2008)	*Guidelines for Intensive Care Units seeking Accreditation for Training in Intensive Care Medicine*
IC-4	(2006)	*The Supervision of Vocational Trainees in Intensive Care*
IC-5	(1995)	*Withdrawn*
IC-6	(2002)	*The Role of Supervisors of Training in Intensive Care Medicine*
IC-7	(2006)	*Secretarial Services to Intensive Care Units*
IC-8	(2000)	*Quality Assurance*
IC-9	(2002)	*Statement on the Ethical Practice of Intensive Care Medicine*
IC-10	(2003)	*Minimum Standards for Transport of the Critically Ill*
IC-11	(2003)	*Guidelines for the In-Training Assessment of Trainees in Intensive Care Medicine*
IC-12	(2001)	*Examination Candidates Suffering from Illness, Accident or Disability*
IC-13	(2008)	*Recommendations on Standards for High Dependency Units Seeking Accreditation for Training in Intensive Care Medicine*
IC-14	(2004)	*Statement on Withholding and Withdrawing Treatment*
IC-15	(2004)	*Recommendations of Practice Re-entry for an Intensive Care Specialist*
PS38	(2004)	*Statement Relating to the Relief of Pain and Suffering and End of Life Decisions*
PS39	(2003)	*Minimum Standards for Intrahospital Transport of Critically Ill Patients*

September 08

Professional documents
P = Professional
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Australian and New Zealand College of Anaesthetists

and

Faculty of Pain Medicine

ABN 82 055 042 852

Professional documents

PM2	(2005)	*Guidelines for Units Offering Training in Multidisciplinary Pain Medicine*
PM3	(2002)	*Lumbar Epidural Administration of Corticosteroids*
PM4	(2005)	*Guidelines for Patient Assessment and Implantation of Intrathecal Catheters, Ports and Pumps for Intrathecal Therapy*
PM5	(2006)	*Policy for Supervisors of Training in Pain Medicine*
PM6	(2007)	*Guidelines for Longterm Intrathecal Infusions (Analgesics/Adjuvants/Antispasmodics)*
PS3	(2003)	*Guidelines for the Management of Major Regional Analgesia*
PS38	(2004)	*Statement Relating to the Relief of Pain and Suffering and End of Life Decisions*
PS39	(2003)	*Minimum Standards for Intrahospital Transport of Critically Ill Patients*
PS40	(2005)	*Guidelines for the Relationship Between Fellows and the Healthcare Industry*
PS41	(2007)	*Guidelines on Acute Pain Management*
PS45	(2008)	*Statement on Patients' Rights to Pain Management*
PS49	(2008)	*Guidelines on the Health of Specialists and Trainees*

College Professional Documents adopted by the Faculty:

PS4	(2006)	*Recommendations for the Post-Anaesthesia Recovery Room (Adopted February 2001)*
PS7	(2008)	*Recommendations for the Pre-Anaesthesia Consultation (Adopted November 2003)*
PS8	(2008)	*Guidelines on the Assistant for the Anaesthetist (Adopted November 2003)*
PS9	(2008)	*Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical or Surgical Procedures (Adopted 2008)*
PS10	(2004)	*The Handover of Responsibility During an Anaesthetic (Adopted February 2001)*
PS15	(2006)	*Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery (Adopted February 2001)*
PS18	(2008)	*Recommendations on Monitoring During Anaesthesia (Adopted February 2001)*
PS20	(2006)	*Recommendations on Responsibilities of the Anaesthetist in the Post-Anaesthesia Period (Adopted February 2001)*
PS31	(2003)	*Recommendations on Checking Anaesthesia Delivery Systems (Adopted July 2003)*
T1	(2008)	*Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and other Anaesthetising Locations (Adopted May 2006)*

September 08

Quality & Safety

Methylene Blue: A Risk for Serotonin Toxicity

Methylene Blue (Methylthioninium chloride) is a monoamine oxidase inhibitor and is likely to precipitate serotonin toxicity (serotonin syndrome) if combined with serotonin reuptake inhibitors.

The fact that Methylene Blue (MB) is a potent monoamine oxidase inhibitor (MAOI) has only recently been established by an in vitro study[1]. The key issue is that severe degrees of serotonin toxicity (ST), involving therapeutic doses of selective serotonin reuptake inhibitors (SSRIs), only occur following combination with MAOIs, but not with other serotonergic drugs with different mechanisms of action[2].

ST is a drug-induced toxidrome; it is not an idiosyncratic reaction like malignant hyperthermia (MH) or neuroleptic malignant syndrome (NMS) and it was recently suggested that several cases of seemingly severe serotonin toxicity (ST), from an interaction between MB and an SSRI, indicated that MB must be an MAOI[3]. MAOIs like MB combined with SRIs (of any sort, specific or non-specific) are the only likely cause of serious (i.e. potentially fatal) serotonin toxicity. Such mixtures produce a high risk of toxicity and there is little doubt that these toxic reactions are ST and that there has been a widespread failure to recognise them. In Kartha's recent series[4] of 193 cases, 12/28 patients on SSRIs pre-operatively, for parathyroidectomy using MB, experienced 'toxic metabolic encephalopathy'; none of the remaining 165 had such problems.

The typical clinical features of ST in humans are:

(i) neuromuscular hyperactivity: tremor, clonus, myoclonus and hyperreflexia, and, in the advanced stage, pyramidal rigidity;

(ii) autonomic hyperactivity: diaphoresis, fever, tachycardia, tachypnoea and mydriasis; and

(iii) altered mental status: agitation, excitement, with confusion in the advanced stage only.

The spectrum concept explains ST as a progression from serotonin-related side effects (at therapeutic doses) through to toxicity, culminating in death with MAOI/SRI combinations. However, since paralysis and anaesthesia constitute effective treatment of severe serotonin toxicity, the clinical picture on emergence from anaesthesia must be expected to significantly modify the situation and previously suppressed ST will 'emerge' as the effects of anaesthesia wear off.

Ken Gillman, MRC Psych
Queensland

Dr Gillman is a retired clinical psychiatrist with a special interest in neuropharmacology and is a recognised expert on serotonin toxicity.

References

1. Ramsay, R.R., C. Dunford, and P.K. Gillman, Methylene Blue and serotonin toxicity: inhibition of monoamine oxidase A (MAO A) confirms a theoretical prediction. Br J Pharmacol, 2007. 152(6): p. 946-51.

2. Gillman, P.K., A Review of Serotonin Toxicity Data: Implications for the Mechanisms of Antidepressant Drug Action. Biological Psychiatry, 2006. 59: p. 1046-51.

3. Gillman, P.K., Methylene Blue implicated in potentially fatal serotonin toxicity. Anaesthesia, 2006. 61: p. 1013-1014.

4. Kartha, S.S., et al., Toxic metabolic encephalopathy after parathyroidectomy with Methylene Blue localization. Otolaryngol Head Neck Surg, 2006. 135(5): p. 765-8.

An Uncommon Complication of Arterial Monitoring

An 18-year-old male with a congenital heart defect presented for semi-urgent open heart surgery. His truncus arteriosus and interrupted aortic arch had been corrected surgically shortly after birth. Over the ensuing years he had had several revision procedures.

He presented for this admission in heart failure with bacterial endocarditis of his prosthetic pulmonary shunt. This, in turn, had caused liver failure. He was scheduled for redo pulmonary valve and conduit replacement following medical optimisation of his condition.

Invasive arterial cannulation was initially attempted at the right radial artery. Although the vessel was cannulated the catheter was unable to be threaded up the vessel. Subsequent site selection was limited: femoral artery cannulation was not considered as the femoral vessels may be required for percutaneous cardio pulmonary bypass prior to sternotomy. The patient had a palpable brachial artery at the right ante cubital fossa, so a 20 s.w.g. Arrow catheter (with integral guide wire) was passed. In retrospect, this was more proximal than usual practice, as this was where the artery was easiest to localise by palpation.

Initial post op review at 24 hours revealed no untoward problems; however, review at 8 days post op demonstrated a painful swelling with decreased mobility in his right upper arm. The swelling was located over the vicinity of the puncture site, and was first noted at the time of ICU discharge 48 hours post op. Vascular surgery review diagnosed a compartment syndrome after examination and investigation with ultrasound. Although usually treated by surgical decompression the surgeon felt in view of the complicated nature of the patient that he would best be treated conservatively with analgesia and physiotherapy to mobilise the elbow. He made a complete recovery.

The proximal siting of the brachial artery cannulation resulted in the catheter passing through the belly of the biceps muscle. When the cannula was removed the artery bled into the muscle compartment (he was on post operative heparin) allowing the compartment syndrome to develop. Cannulation at the skin crease in the antecubital fossa should avoid such a scenario.

Submitted by ANZCA Fellow

Recommended Editorial of the Month:

JW Sear, JW Giles, G Howard-Alpe and P Foëx, *Perioperative beta-blockade, 2008: What does POISE tell us and was our earlier caution justified?* British Journal of Anaesthesia August 2008; 101:135-138.

ALERT
Fires in the Operating Theatre

A recent event highlights the dangers of diathermy in the presence of an oxygen enriched atmosphere. In this instance, burns occurred in the patient and operator as a result of diathermy to the face in the presence of supplemental nasal oxygen in a patient under sedation.

For a review of the risks of fires in the operating theatre go to 'General Articles' on the website of the Victorian Consultative Council on Anaesthetic Mortality and Morbidity *(www.health.vic.gov.au/vccamm/)* and view *Fires in the operating theatre.*

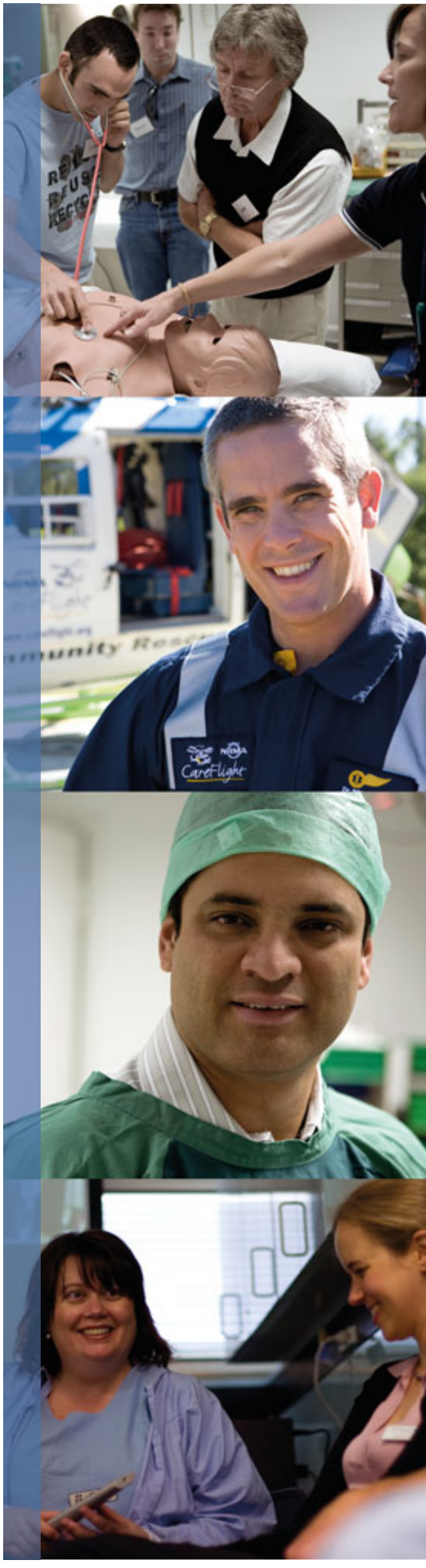
Australia and New Zealand Tripartite Anaesthetic Data Committee (ANZTAD Committee) – Update

The ANZTAD Committee (jointly funded by the ANZCA, the ASA and the NZSA) has maintained steady progress towards reestablishing anaesthetic incident monitoring in Australia and New Zealand. The following milestones have been achieved:

- A proposal document which details the program requirements has been released to targeted vendors. There has been a good response and it looks as if several vendors will submit proposals.
- The New Zealand application for Protected Quality Assurance Activity has been prepared and discussions are in progress with the New Zealand Health Minister.
- The Australian application for Qualified Privilege of a Quality Assurance activity under the Health Insurance Act 1973 has been submitted and is currently under consideration.
- A security document has been drafted and will be subject to a future memorandum of understanding by the three organisations.
- A demonstration program has been produced with the aid of a Queensland University of Technology Masters Student and the intellectual property (IP) for this work has been secured with a signed intellectual property document and is owned by the ANZTAD Committee. It is capable of easy modification so that the data fields can be changed to suit the ANZTAD Committee requirements. The demonstration dataset is illustrative; the final dataset would be more comprehensive.

A presentation was made at the ANZCA ASM in Sydney 2008 and also at the Queensland combined annual CME meeting in July at Hamilton Island. These are the first of a number of presentations during the year to promote communication (both ways) and encourage the reintroduction of anaesthetic incident reporting.

Dr Martin Culwick
Medical Director
ANZTAD Committee



Research

ANZCA Trials Group Update

Multi-centre collaborative efforts are pivotal to the production of scientifically rigorous and robust research. The ANZCA Trials Group has been fundamental in establishing and strengthening ties with numerous Australian and New Zealand sites, particularly with the rollout of its latest research endeavour – the REASON Audit. The Trials Group aims to improve the evidence base of anaesthesia, intensive care, pain medicine, and the emerging field of perioperative medicine, by developing and conducting high-quality, multicentre, randomised-controlled trials and related research.

The recent findings of the BART (Blood conservation using Antifibrinolytics: a Randomised Trial in high-risk cardiac surgery patients, Canada) Trial definitively showed that aprotinin causes excessive mortality compared with lysine analogues. The mechanism of action remains unclear at this stage but is most likely a prothrombotic effect (Brown et al, 2007). This further strengthens the significance of the ATACAS Trial and clearly demonstrates the fundamental importance of conducting large multi-centre randomised controlled trials.

Brown JR, et al. *Meta-analysis comparing the effectiveness and adverse outcomes of antifibrinolytic agents in cardiac surgery.* Circulation. 2007;115:2801-13.

Finally, The ANZCA Trials Group also congratulates the POISE (PeriOperative ISchaemic Evaluation) Trial group on a fantastic trial. The POISE Trial enrolled over 8000 patients to evaluate whether the risks of post-operative cardiovascular events could be lowered by beta-blockers. The study highlighted the unacceptable risks of substantial harm associated with perioperative beta-blocker regimes to patients in the clinical setting.

Devereaux PJ, et al. *Effects of extended-release metoprolol succinate in patients undergoing non-cardiac surgery (POISE trial): a randomised controlled trial.* Lancet. 2008 May 31;371(9627):1839-47.

Pilot Research Grants for 2008

The ANZCA Trials Group invites applications from Fellows of ANZCA, JFICM and FPM for pilot research grants for projects related to anaesthesia, intensive care, pain and perioperative medicine.

The aim of the grant is to assist researchers in the following areas: pilot-phase testing of trials, collection of baseline data using surveys or establishing a network of investigators. The Trials Group will award up to five Grants at A$5,000 with infrastructure support from the Trials Group Research Coordinator.

To be eligible for a pilot research grant, applicants should send a description of the proposed research project, a copy of their curriculum vitae and a covering letter indicating that they are seeking endorsement from the Trials Group and wish to apply for a pilot research grant. Applications will be adjudicated by the Trials Group Executive.

Please visit

www.anzca.edu.au/resources/research/anzca-trials-group/pilot-grant-scheme.html

Or contact Stephanie Poustie, Research Coordinator, ANZCA Trials Group at spoustie@anzca.edu.au or +61 3 8517 5326.

Research Update

REASON Audit – Research into Elderly Patient Anaesthesia and Surgery Outcome Numbers

This audit aims to review postoperative complications in high-risk patients undergoing surgery in Australian and NZ hospitals. The audit will highlight potential areas of concern in terms of patient care, which will follow with interventions that are expected to mitigate these risks and improve outcomes for patients in this high risk group. Twenty-two centres (across Australia & NZ) have currently expressed interest in contributing to the audit (15 of which have already been approved by their ethics committees). Several centres have already started to collect data on their eligible patients and most sites intend to provide data on approximately 150-200 patients. The audit is expected to be concluded by late 2008. A National Ethics Application Form (NEAF) has also been prepared, as a way to reduce the time and effort required by site investigators to complete their ethics application.

Preliminary analysis of some data collected appears to reaffirm the findings of the initial Three-Hospital study (MicNichol et al, 2007), which is a positive sign.

MicNichol L, et al. *Postoperative complications and mortality in older patients having non-cardiac surgery at three Melbourne teaching hospitals*. Med J Aust. 2007 May 7; 186(9):447-52.

For more information, please visit *www.anzca.edu.au/resources/research/anzca-trials-group/projects-research/multi-centre-research/the-reason-audit.html.*

ENIGMA II Trial - Nitrous Oxide Anaesthesia and Cardiac Morbidity after Major Surgery.

The ENIGMA-II trial is progressing smoothly. Currently twenty-three sites are recruiting patients and a further eleven are expected to come online soon (including six in Europe). The trial is exceeding the expected number of patients recruited and we are currently in the process of drawing up the ENIGMA-II 1-year follow-up study.

Myles PS, et al. *Effect of nitrous oxide anaesthesia on plasma homocysteine and endothelial function.* Anesthesiology [in press].

Publications of Interest

Myles PS, et al. *Effect of nitrous oxide on plasma homocysteine and folate in patients undergoing major surgery.* Br J Anaes. 2008;100(6):780-6.

McGregor DG, et al. *Effect of nitrous oxide on neurologic and neurological function after intracranial aneurysm surgery.* Anesthesiology. 2008 Apr;108(4):568-79.

For more information, please visit *www.enigma2.org.au or admin@enigma2.org.au*.

The ATACAS Trial - Aspirin and Tranexamic Acid for Coronary Artery Surgery Trial.

The ATACAS Trial will be the largest study yet conducted to ascertain the benefits and risks of aspirin and antifibrinolytic therapy in coronary artery surgery. Sixteen sites have recruited 401 patients, and an additional 10 sites (in the UK, Canada, India and Malaysia) are undergoing ethics approval. Furthermore, a number of sites have commenced the collection of saliva samples as part of the iPEGASUS (international PErioperative Genetics And Safety oUtcomes Study) sub-study.

Myles PS, et al. *Aspirin and tranexamic acid for coronary artery surgery (ATACAS) trial: rationale and design.* Am Heart J. 2008 Feb:115(2):224-30.

Fergusson DA, et al. *A comparison of aprotinin and lysine analogues in high-risk cardiac surgery.* New Engl J Med. 2008 May 29;358(22): 2319-31.

Cahill RA, et al. *Duration of increased bleeding tendency after cessation of aspirin therapy.* J Am Coll Surg 2005; 200:564-73.

Thygesen K, et al. *Universal Definition of Myocardial Infarction.* Circulation. 2007;116: 2634-53.

For more information, please visit *www.atacas.org.au* or contact admin@atacas.org.au.

If you are interested in contributing to any Trials Group Multi-Centre Research, please contact Stephanie Poustie, Research Coordinator, ANZCA Trials Group via email spoustie@anzca.edu.au or phone: +61 3 8517 5326.

Ray W. *Learning from aprotinin--mandatory trials of comparative efficacy and safety needed.* N Engl J Med. 2008 Feb 21;358(8):840-2.

Shaw AD, et al. *The effect of aprotinin on outcome after coronary-artery bypass grafting.* N Engl J Med. 2008 Feb 21;358(8):784-93.

Conclusions:
Patients who received aprotinin had a higher mortality rate and larger increases in serum creatinine levels than those who received aminocaproic acid or no antifibrinolytic agent.

Schneeweis S, et al. *Aprotinin during coronary-artery bypass grafting and risk of death.* N Engl J Med. 2008 Feb 21;358(8):771-83.

Conclusions:
Patients who received aprotinin alone on the day of CABG surgery had a higher mortality than patients who received aminocaproic acid alone. Characteristics of neither the patients nor the surgeons explain the difference, which persisted through several approaches to control confounding.

Mouton R, et al. *Effect of aprotinin on renal dysfunction in patients undergoing on-pump and off-pump cardiac surgery: a retrospective observational study.* Lancet. 2008 Feb 9;371(9611):475-82.

Interpretation:
Our results have shown that aprotinin seems to be safe during on-pump cardiac surgery. However, the combination of aprotinin and ACE inhibitors during off-pump cardiac surgery is associated with a significant risk of postoperative renal dysfunction.

Dietrich W, et al. *Effects of aprotinin dosage on renal function: an analysis of 8,548 cardiac surgical patients treated with different dosages of aprotinin.* Anesthesiology. 2008 Feb;108(2):189-98.

Myles PS. *Antifibrinolytic therapy: evidence, bias, confounding (and politics!).* JECT 2007; 39:308-10.

Conclusion:
For all anti-fibrinolytic drugs, it remains unclear as to whether the beneficial effect on reduced bleeding outweighs a possible increased risk of thrombotic complications. Debate will continue until we have the results of definitive large randomised trials powered to detect a clinically important effect on outcome.

Destination Everest: Human performance at extreme altitude

LAST YEAR PAUL GARDINER AND MYSELF were involved in a four-month expedition to Nepal as part of Caudwell Xtreme Everest (CXE), a research project coordinated by the UCL Centre for Altitude, Space and Extreme environment medicine (CASE). This is an extensive program of research into hypoxia and human performance at extreme altitude, aimed at improving the care of the critically ill and other patients where hypoxia is the problem.

Caudwell Xtreme Everest recruited 200 healthy volunteers aged 18 to 74 to trek to Everest Base Camp. These trekkers all underwent a day of baseline measurements at our laboratory in Archway, North London. They were organised into groups of 16 people. Each group of trekkers followed an identical ascent profile through the Khumbu valley to Everest Base Camp. They were tested again in laboratories in Kathmandu, Namche Bazaar, Pheriche and, finally, Everest Base Camp.

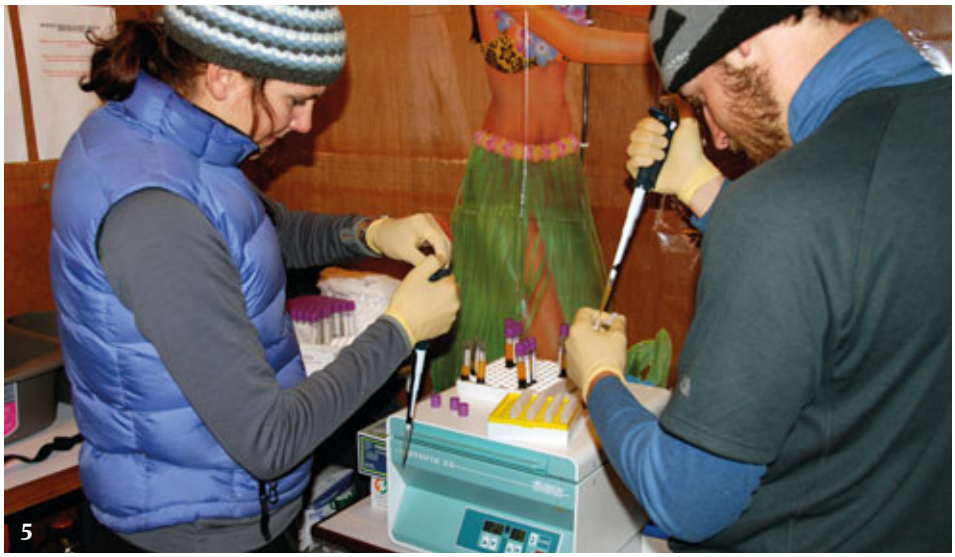
'One of the aims of the expedition was to understand how differences in the ability of individuals to adapt to hypoxia relates to genetic variations.'

Extreme environments are a dynamic challenge for homeostatic physiological systems. Hypoxia is a fundamental mechanism of injury in critical illness. Exercise at altitude was used as a dynamic model for oxygen delivery and utilisation. The classical answers to adaption to hypoxia are built around oxygen flux or delivery. CXE looked at alternative mechanisms including changes in utilisation. One of the aims of the expedition was to understand how differences in the ability of individuals to adapt to hypoxia relates to genetic variations. We looked at inter-individual variation in exercise capacity (VO_2max/ anaerobic threshold), exercise efficiency and organ specific adaptations.

Tests for the trekkers (n=198) included cardiopulmonary exercise testing (VO_2 max & AT), oxygen efficiency, haemoglobin, inflammatory markers, genetic testing, muscle & Brain NIRS, neurocognitive testing, sleep studies, smell & taste, retinal photography. The Xtreme team (n=24) in addition had arterial blood gases, skeletal muscle biopsies, sublingual microcirculation, gastric tonometry, cerebral Doppler, body composition change, brain MRI.

A morning trip up Taboche with views to Ama Dablam (6456m) in background

We were trained and then involved in baseline testing at Archway in London. We ran the laboratory at 4250m in Pheriche, a small summer yak village, on the way to Everest Base Camp in the Khumbu Valley. Paul was part of the logistics team and went ahead to build and set up the laboratories at Namche Bazar, Pheriche and then Everest Base Camp.



'Because of the altitude people started to develop altitude related illnesses such as HACE (high altitude cerebral oedema) and HAPE (high altitude pulmonary oedema).'

In Pheriche, our lab was sponsored by The Intensive Care Foundation. We had two rooms in a local tea house where we also lived. Over a three-month period we tested a number of groups. A typical day involved rising at 5am to start the generators and plug in the cardiopulmonary exercise (CPX) kit. We would then do 8 CPX ramp tests measuring VO_2 max, take bloods and process them including storage in liquid nitrogen and spirometry. Two of the groups also had trans thoracic echos done.

The evenings were spent running medical clinics. Because of the altitude people started to develop altitude-related illnesses such as HACE (high altitude cerebral oedema) and HAPE (high altitude pulmonary oedema). There were also all the normal complaints and illnesses related to travel in Third World countries. The HRA (Himalayan Research Association) hospital was next door to us. This provided care for Nepalese and there were many porters who were not of Sherpa descent who also developed altitude-related illnesses. As we had a lot more medical kits we were often involved in helping the HRA doctors out. We had a number of critically ill people that we had to transfer out by helicopter.

Eight members of the Xtreme team summited Everest in May 2007. The highest blood gas was done on the balcony at 8400m. Mountains of data has been generated including 2,100 exercise tests, 10,000 blood samples and 4,000 person diary days. The end of the expedition meant we had to dismantle all the laboratories and fly our kit again by a combination of helicopter and porters.

The experience was incredible, the living conditions harsh and demanding. We made numerous friends with the Nepalese in our village. Overall, it was an incredibly rewarding and interesting experience.

Amber Chisholm,
Specialist Anaesthetist,
Auckland City Hospital

Paul Gardiner,
Intensivist and Specialist Anaesthetist,
Auckland City Hospital

For further information and results please see *www.xtreme-everest.co.uk*.

1 **Amber in cortex metamax CPX system**
2 **Start of VO_2 max exercise test in lab at Pheriche**
3 **Lab at Everest Base Camp, on the right is the start of the Khumbu ice fall**
4 **Team member with HAPE awaiting helicopter evacuation**
5 **Blood processing – samples stored in liquid nitrogen**
6 **Relaxing outside lab with views of Thamserku and Kantega**

The ANZCA Foundation

An initiative of the Australian and New Zealand College of Anaesthetists

The College formally launched The ANZCA Foundation in April 2007 and over the following 12 months various issues and planning have been considered by The ANZCA Foundation Board and the ANZCA Council.

ANZCA established The ANZCA Foundation to attract funding for research in three specific areas:

- To increase the safety and comfort of patients undergoing anaesthesia
- To improve outcomes for critically ill patients
- To improve the treatment of acute pain, cancer pain and persistent non-cancer pain, focusing attention on 'Pain Relief as a Basic Human Right'.

These are the 12 major research challenges The ANZCA Foundation has set itself:

1. Further refinement and implementation of highly promising new methods for treating acute pain (e.g. after surgery, trauma) to enable more rapid recovery.
2. Research into new techniques and drugs in sedation and anaesthesia for rapid and high quality recovery for patients.
3. 'Brain monitoring' during anaesthesia to give us new insights into the way anaesthesia and the brain work, and which could also prevent awareness under anaesthesia – one of the major fears of patients having surgery.
4. Further development of anaesthesia simulators and other sophisticated medical simulators, which hold great promise of major advances in the management of critical incidents in operating theatres, intensive care units, emergency rooms and many other settings.
5. Initiating new strategies to attack the massive problem of persistent pain in non-cancer patients.
6. Improving methods of prevention and treatment of post-operative problems such as headache, vomiting, fatigue and memory loss.
7. Providing better brain protection following injuries such as trauma and lack of oxygen delivery.
8. Preventing further lung injury in critically ill patients requiring artificial ventilation.
9. Improving existing, and finding new supportive techniques to combat acute renal failure, acute liver failure and major problems in critically ill patients.
10. Developing useful therapies to stop acute circulatory failure, common in the aging population.
11. Implementing new strategies to fight infections, a major cause of death in critically ill patients.
12. Launching a major attack on cancer pain in adults and children – nine out of ten terminally-ill children suffer substantially from pain in their last month of life.

Ian Higgins

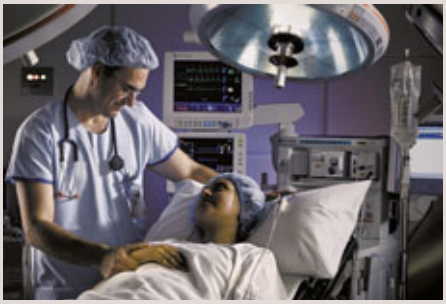
Ian Higgins, Director, The ANZCA Foundation

In July 2008 Ian Higgins was appointed as the Director of The ANZCA Foundation. With a background in the corporate sector and extensive experience in fund raising and philanthropy, Ian comes to ANZCA from the National Gallery of Victoria, where he was the architect of the NGV Foundation's successful bequest program. The program, which is run under the auspices of the Felton Society, has been valued at more than $35 million. Ian is also Chairman of the Arts Management Advisory Board in Victoria.

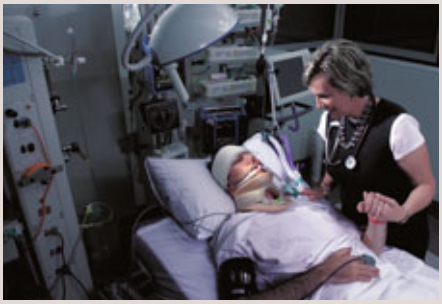
The Bulletin spoke to Ian Higgins about the Foundation and its plans for the future.

What are the immediate priorities of the Foundation?

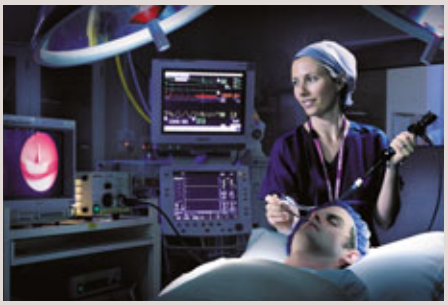
Our first priority has been to design and print a suite of promotional material covering The ANZCA Foundation, its purpose and background and to launch a Bequest Program. The Bequest Program is particularly important as over time bequest income has the potential to be a very considerable portion of the Foundation's finances. Also, together with ANZCA more generally, we need to work on continuing to raise the profile of anaesthesia and pain medicine in the community. Our goal is to significantly grow the College's corpus (investments) so that we can in turn substantially increase the grants for medical research. There is a lot of work to be done but I believe we have a very powerful case to put to people. By working together we have the opportunity to establish The ANZCA Foundation as a major force in the funding of medical research in Australia.



Dr Daryl Williams, FANZCA



Dr Megan Robertson, FANZCA FJFICM



Dr Annabel Orr, FANZCA

These images will feature in the suite of promotional material that is being produced for The ANZCA Foundation (see image below). Many of the people who receive this material will know little, if anything, about anaesthesia. Images such as this are a powerful way to highlight the work of anaesthetists, intensivists and pain medicine specialists.

How important is a bequest program?
As I said, the income that over time comes from bequests is likely to be substantial. Currently the Foundation knows of very few bequests. Our priority will be to encourage people to decide to support the activities of The ANZCA Foundation and make a notified bequest. This is not a quick, one-off campaign. It involves putting our case to people and having them decide that they want to be involved. This is about long-term relationship building and it also involves ensuring we maintain a relationship with our supporters during their lifetime. We must not let an opportunity pass to say 'thank you' to our supporters.

How does a foundation go about raising funds?
In fundraising there is an old saying, 'People give to people not organisations'. This saying really highlights the critical importance of developing relationships with our supporters. You can have a very well run organisation that is well equipped and staffed but if you don't have a real passion for your cause then it is unlikely that you are going to be very successful in raising money. The ANZCA Foundation is currently working on a strategic plan that sets out our goals and the program of activities that we will implement over next three years. For example, we will have a program to invite members of the community to learn about ANZCA and the Bequest Program. We will also embark on a major program of putting our case to corporations seeking their financial support for our medical research.

How can Fellows of the College assist the Foundation?
Each Fellow of the College has the opportunity to be an ambassador for the Foundation. Shortly, every Fellow will receive a presentation folder outlining the role of the Foundation and the research projects that we are undertaking. This folder will also provide information on the Bequest Program. We will continue to keep Fellows regularly informed about the Foundation through the ANZCA Bulletin and the website.

For further information about the ANZCA Foundation please contact:

Ian Higgins
Director, The ANZCA Foundation
ANZCA House
630 St Kilda Road
Melbourne VIC 3004
Tel: +61 3 9093 4900
Fax: +61 3 9510 6931
Email: ihiggins@anzca.edu.au

The ANZCA Foundation Bequest Program will be launched at an evening reception in Sydney on 29 October, hosted by the College President and the Chairman of the Foundation. It is expected that around 300 people will attend, primarily NSW Fellows and special guests including major sponsors of the Foundation. Kieren and Symantha Perkins have kindly accepted the Foundation's invitation to launch the Bequest Program.

New patient information website

Left: Dr Rod Westhorpe, co-author of *All About Anaesthesia*

A long-standing issue for the specialty has been the poor public awareness of anaesthesia and anaesthetists. One of the reasons for this has been the difficulty for patients to gain access to reliable and comprehensive information about the specialty, prior to the time that they encounter an anaesthetist.

The recent publication of *All About Anaesthesia* on the internet, may go some way to addressing this problem. The website is a much revised version of the book by the same name, originally published in 2000.

Former ANZCA Councillor, Rod Westhorpe, and Jan Davies – Professor of Anesthesia at the University of Calgary, Canada – explored the availability of anaesthesia information in 1998. Apart from brochures and pamphlets, they discovered that there was no suitable publication readily available to the public at large.

They spoke to Oxford University Press, who had already established a public information series of books under the 'All About...' banner, covering such subjects as hip replacement and diabetes. As a result, *All About Anaesthesia* was published. As a 200-page book that comprehensively covers all aspects of anaesthesia, including preparation and recovery, *All About Anaesthesia* also includes a number of typical patient stories interwoven into the factual information.

The book found its way into many public libraries, and received high praise from many sources. Oxford University Press decided not to proceed with printing of a second edition when they discontinued the 'All About' series in 2005.

This prompted Rod and Jan to resume copyright ownership and rewrite the book for web publication.

Over the last two years, they have extensively revised the contents to make it suitable for access over the internet. The site is fully searchable, and complies with all requirements of public information websites, with variable text size and simple navigation.

Rod and Jan embarked on the web publication of their book, on the basis that it would be free to anyone to download, print and use, providing any downloads were not used commercially.

Web publication provides an ongoing means of revising and updating the content, and a North American version will shortly also be online (*www.allaboutanaesthesia.com.au*).

To improve awareness of anaesthesia, patient information on anaesthesia will also be added to ANZCA's website over the next few months.

Library update

Reminder to New Zealand Fellows and Trainees
A core collection of anaesthetic textbooks is available for loan from the New Zealand office of the College. Please check the library catalogue at: *online.anzca.edu.au/InmagicGenie/*

Contact details for the New Zealand office are as follows:

New Zealand National Committee (ANZCA)
PO Box 7451
Wellington South
New Zealand
Phone (04) 385 8556
Fax (04) 385 3950
Email anzca@anzca.org.nz

RSS in the Library

- Keep up to date with the latest reports, books and anaesthesia-related articles held in the ANZCA Library by subscribing to the RSS feed for New Resources.
- Click on the New Resources link : *www.anzca.edu.au/resources/library/new-resources*
- Once on the New Resources page, hit the blue RSS button in the top right-hand side
- Add the URL to your RSS reader

If you would like to learn more about RSS or need help setting up this service, please contact the Library.

Websites of interest

Australian Council on Healthcare Standards
New quality measures related to anaesthesia. They will appear in the 'What's New' Archive under September 8:

www.qualitymeasures.ahrq.gov/whatsnew/whatsnew_archive.aspx

Surgery, Theatres & Anaesthesia Specialist Library

Arguably the best website (outside of ANZCA) for current information and resources in anaesthesia. The website is easy to navigate and you can keep up-to-date on the latest reports and discussions in your topic of interest.

www.library.nhs.uk/theatres

Research tools
ANZCA Library staff have collated a number of research tools on our website and welcome further suggestions from our members.

www.anzca.edu.au/resources/library/research-tools.html

Google Docs Templates
You can calculate, plan, organise, present and do almost anything with the 300 Google Docs Templates that are available. Examples include:

– Personal Monthly Budget
– Business Cards
– Credit Card Payoff Calculator
– Wine tasting notes

http://docs.google.com/templates

New titles

58th Annual Meeting Refresher Course Lectures / American Society of Anesthesiologists, 2007.

Atlas of uncommon pain syndromes/ Waldman, Steven D. – 2nd ed - Philadelphia, PA: Saunders Elsevier, 2008. (Book; CD-ROM)

Atlas of ultrasound and nerve stimulation-guided regional anesthesia / Tsui, Ban C H. – New York: Springer, 2007.

Complications of regional anesthesia / Finucane, Brendan T [ed]. – 2nd ed - New York: Springer, 2007.

Handbook on clinical practice guidelines / Davis, Dave; Goldman, Joanne; Palda, Valerie A. – Ottawa: Canadian Medical Association, 2007.

(Also available online)

Intensive care: a concise textbook / Hinds, Charles J; Watson, David. – 3rd ed - Edinburgh: Saunders Elsevier, 2008.

Interpretation of pulmonary function tests: a practical guide / Hyatt, Robert E; Scanlon, Paul D; Nakamura, Masao. – 3rd ed - Philadelphia: Wolters Kluwer Health/ Lippincott Williams & Wilkins, 2009.

Manual of emergency airway management / Walls, R M [ed]. – 3rd ed - Philadelphia: Lippincott Williams and Wilkins, 2008.

A practical guide to regional anesthesia / Mulroy, Michael F; Bernards, Christopher M; McDonald, Susan B; Salinas, Francis V. – 4th ed - Baltimore, MD: Lippincott Williams and Wilkins, 2009.

Resuscitation greats / Baskett, Peter J.F.; Baskett, Thomas F. – Bristol, UK.: Clinical Press Ltd., 2007.

Stoelting's anesthesia and co-existing disease – 5th ed – Philadelphia PA: Churchill Livingstone, 2008.

Understanding anesthesia equipment / Dorsch, Jerry A; Dorsch, Susan E. – 5th ed - Philadelphia PA: Lippincott Williams & Wilkins, 2008.

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

Library update

Continued

International news and resources

4th National Audit Project (NAP4): Major complications of airway management in the UK / RCOA.
The Royal College of Anaesthetists has undertaken to try to enumerate this problem as its 4th National Audit Project. This sets out to determine the number of major complications arising from airway management during anaesthesia and the number of these procedures performed per year. As similar events also occur during care in the emergency department and intensive care the project will capture these events too.

www.library.nhs.uk/theatres/Page.aspx?pagename=ED12

4th Annual Perioperative Medicine Summit, February 5–7, 2009
Registrations are open. Abstracts and webcasts from previous Summits are also available.

http://periopmedicine.org/

VA Pain Bills Moving Ahead / American Society of Anesthesiologists
H.R. 2994 would address the problem of pain in four ways:

1. Authorising an Institute of Medicine Conference on Pain Care.
2. Authorising a Pain Consortium at the National Institutes of Health.
3. Providing comprehensive pain care education and training for health care professionals.
4. Instituting a public awareness campaign on pain management.

www.asahq.org/Newsletters/NL%20Portal/PDF/Sept08.pdf

2008 International Standards for a Safe Practice of Anaesthesia / World Federation of Societies of Anaesthesiologists
An update of the standards developed by the International Task Force on Anaesthesia Safety that were adopted by the World Federation of Societies of Anaesthesiologists 13 June 1992.

These standards are recommended for anaesthesia professionals throughout the world. They incorporate and elaborate upon the core components of the safe anaesthesia part of the 2008 World Health Organization's World Alliance for Patient Safety 'Safe Surgery Saves Lives' global initiative. These WFSA standards are intended to provide guidance and assistance to anaesthesia professionals, their professional societies, hospital and facility administrators, and governments for improving and maintaining the quality and safety of anaesthesia care.

*www.anaesthesiologists.org/en/*latest/*2008-international-standards-for-a-safe-practice-of-anaesthesia.html*

Euroanaesthesia 2008 / European Society of Anaesthesiology
Abstracts available. Euroanaesthesia 2009 will be held in Milan, Italy – registrations now open.

www.euroanesthesia.org/Congresses/Euroanaesthesia%202008/Invitation%20President.aspx

Time of day is associated with postoperative morbidity: an analysis of the National Surgical Quality Improvement Program Data / Annals of Surgery. 2008; 247 : 544-552

Kelz RR et al

Conclusions: When considering a nonemergent procedure, surgeons must bear in mind that cases that start after routine 'business' hours within the VA System may face an elevated risk of complications that warrants further evaluation.

Treatment for meralgia paraesthetica / Cochrane Library [Intervention Review]

Khalil, N, Nicotra, A, Rakowicz, W.

Authors' conclusions: In the absence of any published randomised controlled or quasi-randomised controlled trials, the objective evidence base for treatment choices in meralgia paraesthetica is weak. High quality observational studies report comparable high improvement rates for meralgia paraesthetica following local injection of corticosteroid and surgical interventions (either nerve decompression or neurectomy). However, a similar outcome has been reported without any intervention in a single natural history study.

http://mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD004159/frame.html

Anesthesia Information Management Systems: Almost There Anesthesia and Analgesia. 2008, 107(4): 1100–1102 [Editorial] Sandberg, W.
A recent issue of Anesthesia and Analgesia investigates the increasing adoption of Anesthesia Information Management Systems (AIMS).

Access online through ANZCA Library journal list.

Factors influencing the implementation of clinical guidelines for health care professionals: a meta-review. BMC Medical Informatics and Decision Making. 2008 Sep 12;8(1):38. Francke AA, Smit MM, De Veer AA, Mistiaen PP.
Results show that factors influencing the implementation of clinical guidelines include the guidelines themselves, the professionals creating and using them, the patient population, and the environmental characteristics.

www.biomedcentral.com/content/pdf/1472-6947-8-38.pdf

For further information or to access any resources please contact the ANZCA Library on +61 3 8517 5305.

Regions

Tasmania

The Combined ANZCA/ASA Annual Scientific Meeting will be held from 27 February–1 March 2009 at the Hobart Function and Conference Centre. The venue is situated on the waterfront in Hobart. Further details can be obtained by contacting the State Office.

South Australia/ Northern Territory

We are currently organising the SANTRATS trainee interviews for 2009 intake. Interviews will be on Monday, 22 September 2008 and will be held at the SA/NT College.

Victoria

Embley Memorial Trust – CME Evening Meeting

As part of our ongoing commitment to continuing medical education for Fellows and trainees in Victoria, the Victorian Regional Committee, in conjunction with the Victorian section of the Australian Society of Anaesthetists, will be holding a CME evening meeting on Tuesday, 11 November 2008 at the College, commencing at 6.15pm.

The topic for the evening is 'Management of Acute Pain' and this will be presented by Associate Professor David Scott, Head of Anaesthesiology at St Vincent's Hospital.

We would like to thank the executors of the Embley Memorial Trust for their generous sponsorship of this meeting.

30th Annual ASA/ANZCA Combined CME

The 30th Annual ASA/ANZCA Combined CME will be held on Saturday, 25 July 2009 at the Sofitel Melbourne. The theme and program details will follow.

Regions
Continued

New Zealand

Below: IMG interviews at the New Zealand office From left to right: Jan Brown, ANZCA NZ Administrative Officer, and members of the New Zealand Panel for Vocational Registration, Dr Paul Smeele, Dr Vaughan Laurenson (Chair), Dr Alastair McGeorge and Lorna Berwick (lay member).

ANZCA New Zealand international medical graduates' interviews on behalf of the Medical Council of New Zealand

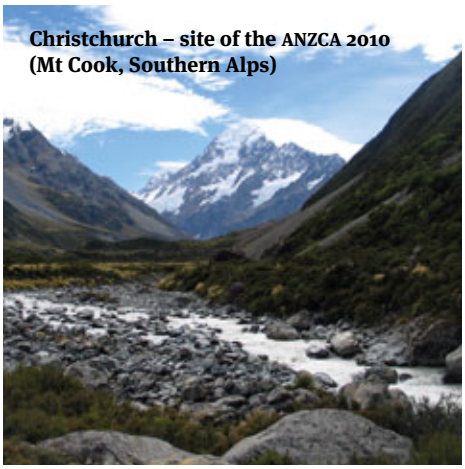
The New Zealand National Committee (NZNC) and the New Zealand office staff work closely with the Medical Council of New Zealand (MCNZ) in a number of areas, the most significant being the assessment of International Medical Graduates (IMGs) on behalf of the Medical Council. IMG is the name now used by MCNZ to replace the previous term, Overseas Trained Specialists (OTS).

In July, Dr Vaughan Laurenson, the immediate past Chair of NZNC resumed the role of the OTS Assessor NZ (this title was recently changed by ANZCA Council to Chair of New Zealand Panel for Vocational Registration). Dr Vanessa Beavis relinquished this role when she was elected as the NZNC Chair. In his annual report, Dr Laurenson thanked Dr Beavis and the members of the assessment panel. Drs Brian Lewer, Alastair McGeorge, Paul Smeele and Leona Wilson have served on the panel over the last twelve months. Lorna Berwick is the lay member of the panel. The ANZCA NZ Administrative Officer, Jan Brown, manages the correspondence with the Medical Council, panel and IMGs and the arrangements for the interviews. Over the last twelve months, 24 interviews have been held plus a number of preliminary assessments. The IMGs interviewed have trained in a number of countries including the UK, Germany and South Africa. New Zealand is considered a desirable place to work and live because of the lifestyle, outdoor activities and work opportunities.

New Zealand workforce data

There has been an unprecedented call for workforce data this year. As New Zealand strives to ensure a sustainable medical workforce for the future needs of the country, NZNC has been approached by many government organisations with requests for workforce statistics for anaesthetists and anaesthesia trainees.

The Minister's appointed Medical Training Board met with NZNC in March this year. Coming out of that meeting, ANZCA was asked to identify various workforce data. Other Government agencies, the



Christchurch – site of the ANZCA 2010 (Mt Cook, Southern Alps)

District Health Board NZ and the Clinical Training Agency sought similar data.

The ANZCA New Zealand office staff members have worked with the ANZCA Strategy & Organisational Development team at ANZCA headquarters to gather accurate anonymised statistics for New Zealand Fellows and trainees. This will answer some of the questions posed by the Government agencies. The unanswered questions will need to be answered either by the employers or when ANZCA conducts a workforce survey amongst its New Zealand Fellows. A similar survey was conducted in Australia in 2007.

This work is crucial to ensure New Zealand can provide the anaesthesia services it needs, so we encourage all to complete the New Zealand survey when it is distributed.

New Zealand – a great destination for CPD

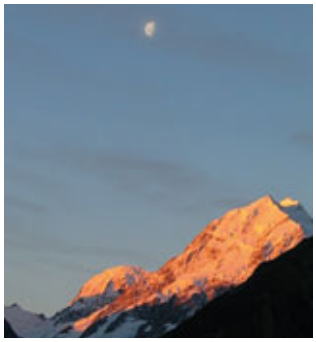
Have you wondered what all the hype is about the beauty of New Zealand? Is it really as beautiful and intriguing as made out in the Lord of the Rings movies? If you haven't explored New Zealand, why not plan to attend the upcoming Annual Scientific Meetings in 2009 and 2010.

In 2009, the New Zealand Anaesthesia ASM (jointly hosted by ANZCA NZNC and NZSA) will be held in Rotorua, 4-7 November *(www.sixhats.co.nz/index.asp?pageID=2145862579)*.

Invited speakers:

Prof Peter Mahofer – Professor of Anaesthesia, Intensive Care, Medicines & Pain Therapy, and Director of Paediatric Anaesthesia at the Medical University of Vienna. His main interests include Paediatric Anaesthesia, Regional Analgesia and the use of ultrasound.

Prof Hans-Joachim Priebe – Professor of Anaesthesia at the University of Freeburg, Germany. From 2002-2005 he served as President of the European Society of Anaesthesiology. His main interests



Christchurch – site of the ANZCA 2010 (Mt Cook, Southern Alps)

Christchurch Botanical Gardens

Rotorua – site of the New Zealand 2009 Anaesthetic ASM

include cardiovascular physiology and pathophysiology.

Dr Ivan Joubert – Director of Surgical Intensive Care at Groote Schuur Hospital and Senior Lecturer in Anaesthetics at University of Cape Town. In 2007, he was awarded the distinguished teaching award (highest teaching honour).

Rotorua is a great tourist destination with the surrounding geothermal activity (geysers, mudpools and colourful silica formations). *www.rotoruanz.com/attractions/?gclid=CLbj4eSM25UCFSaiiQodNlAMWg*

Nearby is Lake Taupo, a world-renowned trout fishing area. There could still be snow on the mountains in the central plateau, so skiing may be a possibility.

If you cannot attend the 2009 NZ Anaesthesia ASM, you can always book to come to the ANZCA 2010 ASM that is being held in Christchurch, 1-5 May, 2010 *(www.conference.co.nz/index.cfm/anzca10)*.

Christchurch in May brings autumn colourings in this most English of New Zealand cities *(www.christchurch.org.nz)*.

From Christchurch you can explore the South Island scenery. Akaroa, the Southern Alps, the Mackenzie Country to Mt Cook and the Tasman Glacier, or the Trans Alpine rail trip through the Alps to the West Coast, where the unspoilt scenery and the Fox and Franz Josef glaciers are special attractions. Further south, Otago province has many inviting activities: Dunedin and its peninsula with the albatross colony; the Central Otago cycle trail, Queenstown and Wanaka, which boast spectacular mountain scenery as backdrops to their lakes or walks through the mountains and native bush on the Milford or Routeburn Great Walks.

The College regularly organises SIG meetings in New Zealand. Successful events have been held in Queenstown, as mentioned above, and in Blenheim at the top of the south island. A short 20 minute air trip from the capital or a leisurely ferry ride across Cook Straight and through the Marlborough Sounds. Blenheim has the most sunshine hours in New Zealand and produces internationally renowned wine.

Why not burn less air fuel and come south for your CPD rather than Europe or the Gold Coast? You won't be disappointed.

Health Practitioners Competence Assurance Act (HPCA Act)

The medical profession in New Zealand has had an added incentive to participate and organise effective continuing professional development activities. The Medical Practitioners Act 1995 made it mandatory for all registered vocational trained doctors to participate in CPD. In 2003, this Act was superseded by the HPCA Act. This Act requires all registered health professions to participate in recertification programs, such as the ANZCA MOPS and CPD programs. The Medical Council approved the new ANZCA CPD program last year.

The Ministry of Health is currently reviewing the HPCA Act and NZNC has participated in consultation workshops and submissions. One section of the Act that is of particular interest is the area of Protected Quality Assurance Activities (PQAA). The Minister approved the ANZCA MOPS program, giving protection for those participating in quality assurance activities. The way the PQAA requirements are administered is being reviewed. ANZCA submits that the QAA undertaken as part of the CPD program, should be protected and is strongly promoting this during the review discussions.

Heather Ann Moodie
ANZCA New Zealand Executive Officer

Regions
Continued

Right: Speakers, Assoc Prof Stephen Bolsin, Dr Michael Barrington, Dr Peter Henderson and Conference Convenor, Dr Gerard Handley

Queensland

32nd Annual ANZCA-ASA CME Queensland meeting 12 and 13 July 2008

Recently the Combined CME Committee of Queensland held its 32nd Annual Meeting at tropical resort of Hamilton Island. The event commenced on the Friday evening with a beachside welcome cocktail party. This was well attended by 250 delegates and family. A special section was organised for the children attending and they each received their own meeting lanyard as well as a specially created menu and play area. The meeting kicked off at 8am on Saturday morning with 125 delegates listening to various speakers including keynote speakers, Associate Professor Stephen Bolsin and Dr Michael Barrington on the topic of 'Staying out of Trouble'.

The meeting finished at midday on Saturday allowing delegates to spend the afternoon with their families before attending the dinner that evening. There were also a limited number of delegates attending an afternoon workshop offered by Avant on 'How to risk proof your practice'.

Pre-dinner drinks in the Phoenix room at the resort were followed by a wonderful fresh seafood buffet. Sunday morning included the ASA Queensland Annual General Meeting where the executive committee for 2008-2009 was decided.

The Scientific Program was very well received and thanks must go to convener, Dr Gerard Handley for putting together a highly rated program. The event had a wonderful casual relaxed feel to it and families, as well as delegates, greatly enjoyed themselves. All are looking forward to the 2009 meeting to be held on the Sunshine Coast.

Medical Clinical exams

The Medical Clinical exams were recently held in all states. In Queensland, the venue was the Princess Alexandra Hospital.

The examiners present for the day were from left: Keith Greenland, Mark Lai, Sally Wharton, Doug McEwan, Megan Gray, Andrew Russell, Kersi Taraporewalla, Chris Butler, Linda Weber, Pal Sivalingam and Queensland Regional Co-ordinator Sharon Meithke.

Dean's Message

I know the saying goes 'Be careful what you wish for, because you may just get it' and that this is meant as a caution against being too ambitious or perhaps enthusiastic. However, on both the personal and the organisation's front, this has not been my experience recently.

I have sat on many other committees and particularly hospital-based committees that take up an inordinate amount of time and have had very mixed results in terms of efficacy. It is against this background that I contrast my experience with the Board of JFICM and its committees. It has been a wonderful experience to deal with a smart, committed group of people who work well together and get results. Keep in mind that all the work done is for the benefit of our trainees and Fellows and that the only payment received by Board members is the great satisfaction of seeing results and of doing things well. It is therefore with great pleasure that I take up the reins as Dean of the JFICM. Professor Richard Lee has left a great legacy as the head of this committed group of individuals and I hope that, in time, history will show that I was able to live up to the high standard set by him.

The Board – the new and the not so new

We were sad to farewell Dr Jack Havill from the board earlier this year. Jack had served on the Board for many years, including a term as Dean. We wish him well in his retirement and long may he enjoy the golf and the painting. Jack's retirement necessitated Board elections and I am pleased to welcome onto the Board, Professor Gavin Joynt from Hong Kong. He has taken on the role of MOPS/CPD officer, as well as the International Liaison role for the JFICM. It is very much hoped that his presence on the Board will spark the formation of a National Committee of the JFICM for Hong Kong, the better to support our trainees in the multiple training hospitals sited in Hong Kong. The rest of the Board is essentially unchanged and retains all the hard-working talent of the previous Board.

Challenges

There are several challenges facing the JFICM over the next few years. The first is keeping an even keel with regard to the operations of a training body – looking after the requirements of our trainees, making sure examinations are set and run, and generally being in the business of continuing to produce world-class intensive care specialists. More than keeping an even keel, work is been done to refine and streamline administrative processes all the time. This facet of our activity, 'running the business', takes up the bulk of our time, effort and resources. It is only with the dedicated work of the staff at our national office in Melbourne that we continue to serve our trainees well in this regard. Secondly, we have to continue to look after our Fellows with regard to aspects like MOPS/CPD, representations to state and federal regulatory authorities and representing the specialty to the rest of the world.

The third challenge is, of course, the future of the JFICM and the specialty of intensive care medicine. By now, everyone is aware of the outcome of the vote earlier this year on the motion to form a new independent college of intensive care medicine within 12 months (90.4% of Fellows voting favoured formation of a new college). The result of the vote was communicated to the Council of ANZCA and the Board of RACP. What was more difficult to convey was the huge enthusiasm displayed at the AGM in May for the formation of a new college.

The College of Intensive Care Medicine of Australia and New Zealand

With regard to the new college I wish to report the following progress.

In light of the fact that the JFICM is currently incorporated with ANZCA, we have had the majority of discussion with that body regarding the formation of a new college. The President of ANZCA, Dr Leona Wilson, suggested the formation of a small working party to progress this matter and several cordial meetings have been held to date, with reporting back to the JFICM Board and the ANZCA Council. In addition, practical progress has been made with the registration of a company called the College of Intensive Care Medicine of Australia and New Zealand Pty Ltd, or CICM (ANZ). A draft constitution has been drawn up for this company and is in the process of being refined. Once the constitution has been finalised, then the company will be incorporated and its tax status established. Essentially the new college, the CICM, will then exist as an entity. A comprehensive business plan is being drawn up for the new college. Other transitional matters such as the transfer of assets and liabilities from the JFICM to the CICM are currently the subject of ongoing discussions between the JFICM and ANZCA, via the working party established for this purpose. The RACP Board is being kept abreast of these developments.

Once all the practicalities have been ironed out, it is envisaged that the CICM will emerge as the new body with aims and objectives identical to those of the JFICM, but with the added freedom to develop as directed by the speciality and as afforded by newfound independence. The CICM will commence 'life' with an excellent heritage and with a 'product' already known around the world. Intensive care specialists produced by this system have an excellent international reputation. To date, the goodwill and cordial attitude of the ANZCA Council, in general, and of the President, in particular, has been heartening and makes one hopeful of a speedy and excellent outcome.

Wishes

So with regard to what I said at the beginning of this message – despite what the saying says – I continue to wish for a speedy resolution and a satisfactory outcome to work currently being expended on forming the new college that Fellows have so strongly indicated they wish for, too. As I've also said before, on the personal front I couldn't wish for a better or more exciting time to be taking on the role of Dean. Know that I and the rest of the Board are extremely committed to the welfare and interests of our trainees and Fellows. Know also that the Board Members are all very approachable. Please contact us via the Melbourne office with your comments and suggestions: +61 3 9530 2861.

Professor PV van Heerden
Dean

1 **Guests at the ASM dinner and graduation ceremony at the Plaza Ballroom**

2 **Graduate Elizabeth Croston with the Dean, Professor Richard Lee**

3 **Professor Richard Lee delivering the Dean's address**

4 **The new JFICM Graduates**

Dean's Message

The Faculty's second Spring Meeting, Pain at the Centre, was held in September at Voyages Ayers Rock Resort. This meeting was held in conjunction with members of the Faculty, of the ANZCA/ASA/NZSA Acute Pain Special Interest Group and of the IASP Acute Pain Special Interest Group. Having these key groups together at a meeting was exciting, as we pain specialists recognise the importance of organised cooperation between different groups. The meeting had a capacity attendance and it was pleasing to see so many people keen to attend what was an excellent program.

Within our hospitals we all need to liaise with different specialist groups and it is important for us to get the message out that pain is not divided into what I believe are artificial divisions of acute, chronic and cancer, but that it is a continuum. It is important for us to liaise with other colleagues who are managing different aspects of pain and all work together for the best outcome for our patients.

Chronic pain specialists are well trained to liaise with other specialists. We already do so as part of our Faculty, where the five parent colleges have worked together now for over 10 years to allow the Faculty to grow to the position where it is now recognised throughout Australasia. Having achieved specialist recognition, we are increasingly being asked to provide input into a number of different groups dealing with the future of healthcare within Australasia.

As pain specialists, we are also used to liaising with other members of our multidisciplinary pain team and perhaps have been one of the first groups of medical practitioners to have worked in this role. Although multidisciplinary teams are now becoming quite commonplace within the hospital setting, our experience of working with our allied health colleagues as team members goes back almost 50 years.

Dr Penelope Briscoe

We still recognise that patients with severe acute pain may go on to develop chronic pain and that can be difficult to manage. It is clearly beneficial if we pain specialists can give other colleagues support and guidance on how to handle what can be quite a complex situation.

As a Faculty, we are wanting to grow so that we will be able spread our message and provide further education, guidance and support to other individuals, both with whom we work and in the wider community. To that end, I would like to encourage more practitioners to consider applying for Fellowship. Fellows of the Faculty may well be working with individuals who they hold in high regard and who they believe would be welcome additions to our Fellowship.

The Board has agreed to look at other specialist backgrounds beyond the five parent colleges. We now have Fellows with backgrounds in obstetrics and gynaecology, ENT and radiology and we have also opened up training to Fellows of the Australian and New Zealand Colleges of General Practitioners and the Australasian College of Emergency Medicine.

If you have colleagues who you believe would be suitable for a Fellowship in Pain Medicine, encourage them to apply. If they do not fully meet the criteria for election, the Board has recently reinstituted the alternate pathway for applicants for election who have been working in Pain Medicine, have a qualification acceptable to the Board, but whose knowledge base is not clearly known to the Board. These applicants may be encouraged that, to satisfy the requirements for election, they may sit and pass the examination. The Board is hoping that this may encourage a number of colleagues to consider this pathway, because, although the examination is demanding, we believe it is fair and also mirrors what knowledge base and experience is required by a specialist working in Pain Medicine.

In closing, I would like to thank Fellows who have provided feedback to the recent survey seeking Fellows' input in determining the future direction of the Faculty and encourage those who have not yet responded to do so.

Dr Penelope Briscoe
Dean

2008 Spring Meeting
Pain at the Centre

1 **Fred Porter (ANZCA)**

2 **Richard Booth (iNOVA) and Dr Tim Semple**

3 **Prof Stephan Schug (Scientific Convenor) and Gary Bird (Janssen-Cliag)**

4 **Walking through the Olgas**

5 **Dr Ray Garrick and Dr Penny Briscoe (FPM Dean)**

Report from the Board meeting held on 4 August 2008

Relationships Portfolio

Intercollegiate Relationships

An informal working group, comprising two Faculty Fellows, a RANZCOG representative, two physiotherapists and two psychiatrists has been meeting over the last year with the aim of producing a document on pelvic pain for consideration by the Education or CE&QA Committees. It is anticipated the process will take six months to complete.

Professor Leigh Atkinson's consistent hard work in liaising with RACS and promoting Faculty activities was acknowledged. He has been successful in attaining a budget of $23,500 over the 2009-2011 triennium for the ASC Pain Medicine program. There is an opportunity for the Faculty to assume responsibility for the pain part of the RACS ASC program. A two day pain program is planned for the Brisbane meeting.

The Faculty has nominated a representative to participate in a review of the RACP Guideline Statements: Management of Procedure-related Pain in Neonates, Children and Adolescents.

Fellowship Affairs Portfolio

Corporate responsibility

On 20 October, a workshop on board member responsibilities, accountability and processes will be convened in conjunction with the Board meeting with a facilitator from the Australian Institute of Company Directors. Terms of reference for the Board and Board members will be delineated following this workshop.

Fellowship

Three new Fellows were admitted by training and examination and Honorary Fellowship was awarded to two notable contributors to the science and practice of our specialty. This takes the number of Fellows to 254.

Alternate pathway to Fellowship

The Board resolved to re-establish an alternate pathway to Fellowship for applicants for election who have been working in Pain Medicine, have a qualification acceptable to the Board, but whose knowledge base is not clearly known to the Board. These applicants may be advised that to satisfy the requirements for election they need to pass the examination.

Regional committees

The FPM Queensland Regional Committee circulated its first quarterly e-newsletter *(The Transmitter)* in August.

- A call for nominations to the committee was undertaken in March. A postal ballot was not required, as the number of nominations did not exceed the number of available positions.
- Composition of the Committee has been confirmed as:

  Dr Paul Gray ANZCA (Chair),

  Dr Jason Ray ANZCA (Vice-Chairman),

  Dr Mark Tadros AFRM (RACP) (Honorary Treasurer/Secretary),

  Dr Richard Pendleton, ANZCA,

  Dr Wilbur Chan (CME Officer),

  Dr Frank New RANZCP, Dr Brendan Moore ANZCA and Professor Leigh Atkinson RACS (Ex-Officio Board Members).

NSW Fellows have expressed an interest in forming a Regional Committee. The Faculty Board is keen to see this established and the CEO's advice has been sought with regard to administrative support through the ANZCA NSW Regional Committee secretariat.

AAPM and Pain Medicine Journal

Faculty Fellows are encouraged to attend the AAPM Meeting in Hawaii.

Website: *www.painmed.org/annual_mtg/index.html*

The *Pain Medicine* journal's Impact Factor has increased from 2.447 in 2006 to 2.741 in 2007.

Fellows Survey

It was agreed to undertake a survey of Fellows in August to seek feedback in determining the future direction of the Faculty and Fellows' interest in contributing expertise to Faculty activities.

Research

The FPM Research Committee had been discussing the development of an outcomes database and one proposal to move this initiative forward is for a pilot project over 18 months. A proposal is under development and information will be disseminated through the Synapse newsletter.

Professional

Opioid Prescribing

The Board reviewed a draft Approximate Opioid Equianalgesic Doses Chart and a document will be posted on the Faculty website for comment.

Submissions

The Faculty has recently contributed to ANZCA submissions to:

- The National Health and Hospital Reforms Commission.
- The NHMRC Public Health Research Review

The Dean has provided input to:

- A Review of Australian Higher Education
- The ACSQHC Medical Scoping Study
- The AMC Good Medical Practice Guide

Continuing Education & Quality Assurance

Patient Education

Two further Patient Information leaflets on *Epidural Injections* and *Caudal Epidural Injections* were accepted for promulgation through the Faculty website in pdf format to provide information for patients and for use by Fellows in the informed consent.

Professional Documents

PM3 – Lumbar Epidural Administration of Corticosteroids is due for review. The Faculty's Queensland Regional Committee has expressed an interest in being involved with the process of reviewing documents for the Faculty.

Educational Documents

A paediatric pain document has been published in FPM forums for Fellows input. *(www.anzca.edu.au/fpm/fpm-forums/document-discussions/637957327)*

Board Members supported the inclusion of a link from the Faculty website to the Association of Paediatric Anaesthetists of Great Britain and Ireland's document 'Good Practice in Procedural and Post Operative Pain'. The document can be viewed at:

www.apagbi.org.uk/docs/APA_Guidelines_on_Pain_Management.pdf

Appendix: *www.apagbi.org.uk/docs/APA_Guidelines_on_Pain_Management_appendix.pdf*

Scientific meetings

ASM 2009
The FPM ASM Visitor, Dr Andrew Rice (UK), will be invited to the RACS meeting in Brisbane and to visit Adelaide following the Faculty's refresher course and Annual Scientific Meeting. The theme of the 2009 Faculty refresher course will be 'Risk Management'.

Spring meeting 2009
The Board resolved that the 2009 Spring meeting will be held in Melbourne. Dates and venue are to be confirmed.

ASM 2010
The Faculty has appointed Dr Jeffrey Mogil as the FPM ASM Visitor for Christchurch.

Dr Richard Rosenquist has also been invited as the FPM New Zealand Visitor.

RACS meetings 2008-2011
A/Prof Leigh Atkinson, with the help of Dr Peter Teddy, a Fellow from Melbourne, organised a three day Pain program at the Royal Australasian College of Surgeons meeting in Hong Kong, This was so well received that RACS, have allocated a budget for the 2009-2011 triennium for the Pain Medicine program at the RACS Annual Scientific Congress. Professor Atkinson's efforts in securing this funding were acknowledged.

AAPM meeting Hawaii January 2009
Fellows are encouraged to attend this meeting. For more details: *www.painmed.org/annual_mtg/index.html*

Trainee Affairs Portfolio

FPM training program
The Board resolved that Fellowship of the Australasian College of Emergency Medicine is a qualification acceptable to the Board for the purposes of Regulation 3.2.1.8 (eligible for admission to Fellowship following completion of all training and examination requirements of the Faculty). ACEM has been recognised by the AMC and has a five year, academically rigorous training program with a primary and final examination component.

The Board discussed whether the Faculty should be more prescriptive of the training requirements in the areas of acute, addiction and paediatric pain. It was agreed that the Education Committee would consider the issues in liaison with TUAC and the SoTs and come back to the Board with a plan.

Following recommendations from the Supervisor of Training Workshop, the Board resolved that quarterly ITAs will be modified to include leave, dates and description (prolonged leave) and that information on retrospective and prospective training and official start dates for individual trainees be made available to the unit's SoT.

Following a review of case report requirements by the Assessor and Examination Committee, the Board resolved that the option of submitting published research for the purposes of the case report requirement be removed and that the requirement of a letter to the referring also GP be removed. Either format (with or without GP letter) will be acceptable for a transition period until January 2009.

Training unit accreditation

Accreditations
Singapore General Hospital was accredited for Pain Medicine training for a period of one year with a paper review to be completed at that time. This is the first unit to be accredited by the Faculty outside of Australia and New Zealand.

St Vincent's Hospital Sydney and the Prince of Wales Hospital, Sydney were reaccredited for Pain Medicine training for a further three year period.

The Training Unit Accreditation Committee is seeking to increase the panel of reviewers and it is hoped that the planned survey of Fellows will identify potential reviewers who are willing to undertake at least two reviews per year.

Training in expanded settings
The Faculty supported applications from Barwon Health, Geelong Hospital, Multidisciplinary Pain Management Unit for funding under the Outer Metropolitan Specialist Trainee Program and the 2008 Strengthening Medical Specialist Training Program.

Examination
The 2008 examination will take place on 26-28 November 2008 at St Vincent's Hospital Sydney.

- Approximately 20 candidates are expected to sit.
- Dr Michel Dubois, Chief Examiner for the American Board of Pain Medicine has agreed to observe.
- Three new examiners were appointed.
- Nine examiners were reappointed for a further three year period.
- There are currently 27 on the examination panel – 15 ANZCA, 4 RACP, 1 RACS, 2 RANZCP, 4 AFRM(RACP) and 1 FARCSI.
- Dr Mark Tadros a Rehabilitation Specialist was appointed to the Examination Committee as the New Fellow Representative.
- A Pre-examination short course is being convened in Adelaide on 11–12 September.

Examination Committee
Dr Ray Garrick took over as Committee Chair. Dr Meredith Craigie accepted the role of Deputy Chair and Dr Melissa Viney was appointed to the Examination Committee. Three new examiners were appointed to the panel. Two new examiners will be asked to observe the 2008 examination. Dr Mark Tadros, New Fellow Representative on the Examination Committee and Dr Michel Dubois, ABPM Chief Examiner will also observe.

Resources Portfolio

Finance
Forward budgeting is commencing for the 2009 year.

OBITUARY

Dr Graham Chudleigh Fisk

1928–2008

Graham was the third of four sons born to Ernest and Florence (nee Chudleigh) Fisk. His father (later Sir Ernest) was British-born, but became fiercely Australian, and was a pioneer of radio in this country.

During Graham's boyhood, the family lived on Sydney's North Shore, where he had the misfortune to contract poliomyelitis, from which he made a good recovery, and was able to enter Geelong Grammar School in 1940.

Unlike some children, Graham found boarding school an enjoyable experience, and was disappointed to have to leave before what would have been his senior year. The whole family had to relocate to the UK where Sir Ernest took up the position of CEO to Electronic and Musical Industries (EMI).

Geelong's Headmaster, Dr Darling, was sufficiently impressed with Graham's qualities to recommend his acceptance at Oriel College, Oxford, where he embarked on a medical course, and, with perhaps even more enthusiasm, took up rowing.

After graduation in 1952, together with a number of other Oxford alumni, Graham joined the Thames Rowing Club, which culminated in his membership of the crew from that Club which represented England at the Helsinki Olympics. Later on, visitors to the Fisks could not fail to observe his oar, prominently displayed on the living room wall.

At the Middlesex Hospital, Graham's first term was in orthopaedics, which he found only moderately interesting. Of greater importance was his first meeting with Flora MacLachlan, who was nursing at Barts. After a year at Middlesex, Graham took up an appointment at Bellevue (New York), where he contrived to renew acquaintance with Flora who had taken a job at Mount Sinai. This encounter led to their engagement, and they were married back in the UK in August 1955.

Graham badly wanted to return to Australia, but for an impecunious young married couple this was not easy. Neither had been able to save from the miserable salaries which were paid in those days to junior hospital staff. Their unlikely fairy godfather was the Royal Australian Air Force, which accepted Graham as a recruit in December 1955, and paid his and Flora's fares back to Sydney, where he was based at Richmond.

Dr Graham Chudleigh Fisk

He must have shown aptitude for anaesthesia, despite the relatively primitive techniques current in those days, because a visiting surgeon suggested he consider anaesthetics as a career, and encouraged him to apply for a registrar post at Royal North Shore Hospital, in which he was successful. He and Ross Holland shared the roster for the whole of 1958.

Successful in the Faculty Fellowship examination in May 1959, Graham was encouraged by the late James McCulloch to acquire overseas experience in anaesthesia. James' recommendation to Philip Helliwell led to Graham's appointment at Guy's, commencing in September of that year. This time the Fisks travelled as a family with two young boys, Graham as ship's doctor, which certainly helped with the finances, as well as being pretty much of a vacation.

Returning to Australia in 1960, his appointment as Honorary Anaesthetist at the Royal Alexandra Hospital for Children at Camperdown kindled what was to become a lengthy and distinguished career in paediatric anaesthesia and intensive care. Seizing the opportunity to join Prince of Wales Hospital as Director of Paediatric Anaesthesia in 1969, he formed a close relationship with Don Harrison, collaborating in a number of research projects. The scarcity or absence of apparatus specifically designed for children, especially neonates in those days, led to Graham's successful modification of adult ventilators for paediatric use.

These two outstanding clinicians now took a close interest in the Faculty of Anaesthetists' examination system, Graham eventually chairing the Final Fellowship Examination Committee. But there was much work to be done to bring the Faculty's training and examination system up to date, so he applied for, and was granted, the Lennard Travers Professorship with this in view. The results of his recommendations were such that many of them survive to the present day.

No-one has contributed more to Australian anaesthesia and Intensive Care than Graham Fisk. It was therefore entirely appropriate that he should have the rare distinction of being awarded both the Faculty and Orton Medals, the former for contributions to the College, the latter to anaesthesia in general.

Despite these well-deserved honours, he was not the kind of person to cling to power and authority where younger Fellows were displaying great talent. Gracefully withdrawing in favour of such successors as John Vonwiller, Graham entered upon a new phase of clinical activity, becoming a much sought after anaesthetist in private practice in the vicinity of Sydney's northern beaches. Sadly, this most enjoyable phase of his career was brought to an end by his last illness, which he bore with characteristic stoicism and good humour.

Together with Flora, all of their four sons survive him, as do two of his brothers, and seven grandchildren.

Ross Holland
August 2008

OBITUARY

Dr Ann Elizabeth Newton

1955–2008

Anne Elizabeth Newton was a much loved and respected Brisbane paediatric anaesthetist. She died after struggling with cancer first diagnosed in September 2003. Her premature retirement two years ago was a great loss to the anaesthetic community.

Ann was the second child of Tom and Sadie Newton. She was born and raised in Brisbane. She commenced her education at age 4 at the Buranda Girls School Brisbane and completed her secondary education at Brisbane State High School.

She was accepted into medicine at the University of Queensland in 1972 at the age of 16. She graduated with an MBBS from the University of Queensland in 1979 and worked as a resident at the Royal Brisbane Hospital, obtaining her anaesthetic primary exam in 1986 and the Final Examination in 1988. She was admitted as a Fellow of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons in 1988 and as a Fellow of the Australian and New Zealand College of Anaesthetists in 1992.

Anne's training was completed at a number of different hospitals throughout Queensland. Following this she worked as a specialist, predominantly at the Mater Hospital, but also in private practice with an overseas sabbatical in the Department of Obstetric Anaesthesia at Grace Hospital Vancouver and the Children's Hospital Vancouver in 1992.

A consistent theme in Ann's professional life was her dedication to the Hippocratic tradition of looking after the education, professional development and wellbeing of more junior doctors. She was the College Supervisor of Training at the Mater Hospital for many years. This was a role that Ann did not look upon lightly. Many of us were extremely privileged to have been trainees under Ann's care.

Anne was the Honorary Secretary to the Australian Society of Anaesthetists from 1997 to 1999. She was appointed Clinical Senior Lecturer with the University of Queensland in 1991.

From 1999 to 2001, Ann was a member of Operation Smile, travelling to the Philippines and Vietnam as part of an operative team correcting cranio-facial abnormalities predominantly in children.

She was an outstanding paediatric anaesthetist, clinically superb and dedicated. She often stayed late to help and would always make sure all the registrars were okay. She was approachable and fun to work with. She treated every patient with dignity and compassion. We all loved working with her; even on call was a treat. Ann's skill and professional composure in dealing with neonates was inspirational.

Music was a big part of Ann's life. She played a number of instruments including the piano, double bass and cello. She had a close circle of friends to whom she was exceedingly generous of her time and care. Her love of life remained with her until the very end. She was nearly always smiling, cheerful and caring of the people around her despite some considerable pain at times.

She is survived by her soul mate, Denise, her mother Sadie and her brother Steven. Her loving influence will remain and will not be forgotten.

Dr Elizabeth Boge
MBBS FANZCA
June 2008

OBITUARY

Dr Naresh Ramakrishnan
1968–2008

It is with enormous sadness that we report the untimely death of our friend and colleague, Dr Naresh Ramakrishnan. Naresh completed his undergraduate and early medical training in Madras, India, graduating in 1989. Following periods of training in both Tasmania and New Zealand, Naresh undertook his post-basic training at St Vincent's and Royal Melbourne Hospitals in Melbourne completing specialist training in both Internal Medicine and Intensive Care Medicine and achieving Fellowship of both the RACP and the FIC, ANZCA. He was subsequently a Foundation Fellow of the JFICM. Naresh was appointed to the specialist staff of Royal North Shore and North Shore Private Hospitals in April 2002.

In a very short time, Naresh made an enormous contribution to Australasian Intensive Care. He was an active member of the ANZICS CTG and heavily involved in many of the CTG multicentre trials. These included the SAFE, SAFE trips, SAFE TBI, RENAL and NICE studies. Naresh was the RNSH 'PI' for the CAT study, recently published in Intensive Care Medicine and was always looking for new projects into which he could throw his energy. He was passionate about scientific method and methodological rigour, not only completing his own Master of Medicine (Clinical Epidemiology) degree but encouraging and supporting his wife to complete the same degree. Naresh was the current Chairman of the NSW ANZICS committee and was an active member of the Board of ANZICS. As the Board representative he made a major contribution to re-drafting the long awaited ANZICS Guideline on Organ and Tissue Donation.

Naresh was an Associate Lecturer at the University of Sydney and was actively involved in undergraduate teaching. Much of his teaching energy, however, was devoted to Intensive Care vocational trainees. He planned and helped co-ordinate short and long courses for ICU trainees in NSW and was actively involved in all aspects of Intensive Care training. Naresh was a clinical examiner for both the RACP and the JFICM. He helped convene the first JFICM ASM and was solely responsible for the wonderful manual of proceedings that has set the standard for subsequent ASMs.

As a colleague, Naresh's ideas and enthusiasm were almost boundless. He made a huge contribution to quality assurance, almost single-handedly driving our unit's infection improvement program with characteristic enthusiasm and amazingly innovative initiatives. In his clinical work he demonstrated not only all the skills and expertise one expects of a fully rounded intensivist, but also the compassion and commitment to his patients and their families to which we all aspire.

Outside medicine Naresh's other interests were legion and as diverse as cooking, calligraphy, photography and computers. He loved books and was both an avid reader and collector. He was a talented sculptor and had also planned to expand into carpentry and jewellery making when he could find the time. In all his pursuits he was enthusiasm personified and whenever he discovered something that he considered new and good would always want others to share in the pleasure he had found, whether it be a good book or trying to convince his mother-in-law that Apple Mac's operating system was so much better than Windows®. Naresh's undoubted intelligence, thirst for knowledge and enthusiasm for all things make his death that much harder to accept. He leaves behind a wife he admired and loved deeply, a mother-in-law he loved as his own mother and a daughter he adored. His many colleagues and friends from Australia, New Zealand and around the world are that much the poorer for his death. He is sorely missed.

Dr Raymond Raper
July 2008