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THE ANZCA BULLETIN

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

DECEMBER: 2007

JOINT FACULTY OF INTENSIVE CARE MEDICINE
FACULTY OF PAIN MEDICINE

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'To serve the community by fostering safety and quality patient care in anaesthesia, intensive care and pain medicine'

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President's message

2007

DR WALTER THOMPSON

The College and the Council have been very active in 2007. In addition to rebuilding the core infrastructure in information technology and finance, we have:

- Conducted the largest examinations in the College's history
- Introduced a modernised program of Continuous Professional Development
- Completed the Professional Code of Conduct
- Reviewed the College Constitution
- Built staff capability in Government & Media Relations, Policy and Communication
- Introduced a Policy on Intellectual Property
- Introduced a Trainee Performance Review Process
- Reviewed the 'sedation documents'
- Commenced a curriculum review of the Training Program
- Progressed ANZTADC, the tripartite anaesthesia data collection project in relation to incidents and safety, to the stage where the feasibility work can begin.

This month we have commenced a staged roll-out of the new ANZCA website, which will be faster and more effective than the previous website and incorporates enhanced features and functionality that will be of benefit to Fellows and Trainees. I encourage you to visit the site and to feed back your comments to the College.

Research Grants and Awards

This year, 30 applications were received, requesting $1,393,004 for research projects and research fellowships. In October, following review by and recommendations from the Research Committee, the College Council agreed that $512,641 be allocated for research projects in 2008. In addition, $35,000 was made available for Simulation and Education Grants in 2008. The 2007 Academic Enhancement Grant was awarded to Professor Alan Merry of the University of Auckland.

Review of the College Constitution

The Constitution that the College adopted in 1991 was modelled on the Constitution of the College of Surgeons and reflected the legal requirements of the time. Since that time ANZCA has operated under the law as a company limited by guarantee. However, given the changes in the interim to corporate law, the procedural and administrative changes within the College plus changes in technology, it was timely to review the Constitution after 16 years. The principles underpinning the review were:

- To simplify and modernise language and content
- To reflect current legal requirements
- To transfer many powers and functions to Regulations

'This month we have commenced a staged roll-out of the new ANZCA website, which will be faster and more effective than the previous website and incorporates enhanced features and functionality that will be of benefit to Fellows and Trainees.'

- Not to unnecessarily change the governance of ANZCA
- To support and enhance the operations of Council, Faculties and Committees.

The review has been completed and the Council believes that the adoption of the proposed constitution is in the best interests of the College. A postal ballot is in the process of being conducted in order to effect the change to the new constitution. Explanatory documents have been circulated and copies of the new constitution are available on the website or in hard copy on request from the College. I urge you to read and consider the documents and to exercise your vote before the closing date of Tuesday 11 December.

Australian Anaesthesia Workforce Study

I mentioned this in the October 'Bulletin' so I will just take this opportunity to remind Fellows of this study which is being conducted by Access Economics on behalf of the College and the Australian Society of Anaesthetists (ASA). It is an important study and both bodies hope that it will generate a lot of specific and useful information in relation to the anaesthesia workforce. Statistics may not necessarily be power but they are certainly a currency that bureaucrats understand and, as such, are essential in dealings with governments. I trust that all the Fellows who are or have been surveyed will fill in and return the surveys and thereby assist both the College and the ASA.

Director of Professional Affairs (DPA)

As noted in the Report from the June Council Meeting, the Council supported the appointment of a part-time DPA to undertake primarily the Assessor Role and to have responsibility for reviewing and updating Regulations. The position was advertised and on completion of the selection process the Council appointed Dr Steuart Henderson of New Zealand to the position. Dr Henderson is a past ANZCA Councillor and previously held the Assessor position in addition to making extensive contributions to continuing education and the assessment processes of the College. We welcome him to this new role and look forward to his contributions.

Director of Education

The College is pleased to announce the appointment of Ms Mary Lawson as Director of Education. Mary will be joining the College in the New Year and comes from a senior tenured position in Medical Education at Monash University. She has had extensive experience in medical education for both undergraduates and postgraduates over the last 16 years with an emphasis on the professional development of clinicians as educators. We welcome her to the College and look forward to her contributions to education development within the College and in particular her input into the review of the training program and the assessment processes.

Australian and New Zealand Tripartite Anaesthesia Data Collection (ANZTADC)

The ANZTADC Committee has completed an overview of the legislative frameworks in Australia and New Zealand that are relevant to: (1) anonymous data collection, (2) incident reporting and (3) privacy of patient information. The tripartite data collection project has progressed to the stage where extensive feasibility work and testing will be undertaken and a part-time Medical Director has been appointed. We welcome Dr Martin Culwick of Queensland to the project and look forward to his contributions. Dr Culwick has extensive IT and administrative experience and a long standing interest in education, quality and safety.

Professor G A (Don) Harrison AM, FANZCA, FJFICM, MHP Ed.

Fellows will be saddened to hear of the death of Professor Don Harrison in Sydney on October 10th. Don was a well known anaesthetist and a pioneering intensivist in Sydney, a true gentleman and a mentor to many colleagues. He was a Conjoint Professor (Anaesthesia, Intensive Care and Emergency Medicine) at the University of New South Wales and Director of the Cardiothoracic Critical Care Unit at St Vincent's Hospital amongst other appointments. He had been at the forefront of developments and research in Anaesthesia, Intensive Care and Resuscitation within Australia since the 1960s and, despite his retirement and illness, had remained actively involved in medical education, simulation and research up until his death. His current research interests were centred on improving the prediction and management of medical emergencies in hospitals.

Professor Harrison served on the Board of the Faculty of Anaesthetists RACS and was the Chair of Examinations. He also helped develop and refine the examinations of the Faculty of Intensive Care and the G A (Don) Harrison Medal for the final intensive care exam is named in his honour. Don was the first Lennard Travers Professor of the Faculty of Anaesthetists RACS and was also the recipient of the Orton Medal. He was also a Chair of the Resuscitation Council of Australia and he was admitted to the Order of Australia in 1992. I was privileged to attend and speak at a Memorial Service for him on October 24th and was able to pass on the condolences of Fellows to his wife Suzanne and their family.

Intergovernmental Agreement

In my message in the October 'Bulletin', I referred to the uncertain status of the proposed Intergovernmental Agreement (IGA) in Australia in relation to the proposals for National Registration and Accreditation and the concerns that were developing regarding the proposed model that was said to be in the IGA. The concerns proved to be well founded, as the proposed model would have eroded the integrity, professional input and independence of medical registration. However, in the lead up to the Federal Election, the Federal Government decided not to sign the IGA because of concerns expressed by the majority of the health professional groups and in particular the medical profession. The matter will now obviously rest until after the election and the holiday period, but will certainly have to be resolved in 2008 and probably before the funding agreements are negotiated between the Commonwealth Government and the States in mid 2008. It will be incumbent on all medical practitioners to closely study the next version of the IGA and the models proposed for National Registration and Accreditation and then to ensure firstly that professional input to and integrity of the medical registration process is preserved in order to protect patients and secondly that the independence of the Australian Medical Council is maintained.

Demands on the College

Fellows will also be aware of the myriad of issues related to Overseas Trained Specialists in both countries, the shortage of health care workers particularly in nursing, the incessant demands of the jurisdictions at all levels and the increasing expectations of our patients. All of these put pressures not only on Fellows but also on the College and there is a need for our services and capabilities to expand in order to meet that need, both at the headquarters and in the regional offices. There have been major changes to the offices in Brisbane and Wellington this year

President's message continued

and Perth will follow in due course. In 2007, we have rebuilt the core infrastructure in information technology (IT) and finance and have built capacity in Government & Media Relations, Policy and Communication. In 2008, the primary focus will be on education—both for Trainees and Fellows—assessment processes, examinations and communication, in addition to meeting our external challenges. As a result, the College's income needs to keep pace with the increasing demands placed on the College and hence the subscriptions will need to rise in 2008. After careful consideration, Council has resolved that subscriptions will rise by 8 per cent, or 5 per cent in real terms. For 2008, we have budgeted for a 'break even' result, instituted cost reduction programs and have acknowledged that investment returns will almost certainly fall over the course of the year, while seeking to cope with increases in the College's core activities.

2008

2008 will be an interesting and challenging year, not only because of these issues but also because of all the curious promises that have been made regarding health care in the current Federal election. In New Zealand, Fellows will have to contend with the *Review of the Health Practitioners Competence Assurance Act* (2003) and then an election in New Zealand. We anticipate that in both countries there will be a large expansion of activity in relation to the assessment of Overseas Trained Specialists in the workplace due to jurisdictional pressures and changes in the regulatory environments.

The College has been involved with the Joint Standing Committee on Overseas Trained Specialists (JSCOTS) of the AMC and we will be holding a Workshop on OTS Assessment in mid November in order to bed down our plans and policies for 2008. This will be a challenging and logistically demanding problem but it is an area in which the College must maintain its involvement in the interest of patient safety and welfare.

In conclusion, 2007 has been a very active year for the College and the College is positioning itself to meet the challenges of the future while enhancing the core activities of education and training for both Trainees and Fellows. On behalf of the College Council, I wish to convey our thanks to the CEO and the college staff for their sterling work during the year. I and the Council plus the college staff would like to thank you for your support of the College in 2007, and we wish you and your families all of the very best for the Festive Season and for 2008.

DR WALLY THOMPSON
President

'Fellows will also be aware of the myriad of issues related to Overseas Trained Specialists in both countries, the shortage of health care workers particularly in nursing, the incessant demands of the jurisdictions at all levels and the increasing expectations of our patients.'

Adult retrieval moves to Ambulance

The Metropolitan Ambulance Service is set to accept responsibility for Victoria's emergency adult retrieval service, which last year dealt with more than 2000 patients.

The new service, *Adult Retrieval Victoria*, which will operate 24 hours a day, takes over the tasks provided by the Victorian Adult Emergency Retrieval and Coordination Service (VAERCS).

The service will be managed by a medical director, whose appointment will be announced soon. Under the new arrangement, doctors will continue to provide clinical advice over the phone, coordinate the placement of patients in coronary care and intensive care hospital beds, and retrieve critically ill patients from rural areas.

Three specialist adult retrieval services based in rural Victoria will also come under the responsibility of MAS.

In September, the State Government formally asked MAS to take over the service, following a review by the Department of Human Services that identified areas for improvement.

'We have taken over from an effective service and, in the short-term, it will be business as usual,' said MAS General Manager of Operations Keith Young.

'Over the next year, however, we will develop plans to further improve the service and, as such, welcome input from anyone who wants to contribute to the changes,' Mr Young said.

From the first day of operation—set for 20 November 2007—improvements will include a 24-hour 1300 telephone number, the voice-recording of all phone conversations and a more rigorous system of governance.

'This is a natural fit for MAS as we already provide integrated emergency helicopter and plane transport throughout the state,' said Mr Young.

'Combined with our road vehicles and our close relationship with Rural Ambulance Victoria, we believe we can provide an excellent service.'

'Under the new arrangement, doctors will continue to provide clinical advice over the phone, coordinate the placement of patients in coronary care and intensive care hospital beds, and retrieve critically ill patients from rural areas.'

Adult Retrieval Victoria has a new statewide phone number: 1300 368 661.

The website is www.arv.

Letters to the Editor

Recently Dr Richard Barnes, specialist anaesthetist, was part of a volunteer team that visited Atambua Public Hospital, West Timor. This was organised by the Royal Australian College of Surgeons, under the umbrella of the Australian government, to provide humanitarian aid to developing areas of Indonesia. The province of Nusa Tengarra is such an area of need in Indonesia. In a period of 10 days, our Australian team provided specialist general and paediatric surgery to local inhabitants, performing over 70 operations, 200 consultations as well as acute medical care and ward rounds. Our brief was also to impart surgical and anaesthetic skills to the local medical officers.

As a member of the team, I was humbled by both the expertise and humanity shown by Richard in his anaesthetic care. We experienced many difficult and heartfelt cases in our time here. At the end of our time all team members agreed that it was indeed an honour to be associated with Richard. He is a terrific bloke and excellent anaesthetist in every sense.

Richard, on the other hand, would not consider himself different to any other, and is not one to look for praise. Hence the reason for this correspondence.

The picture here is of Richard resuscitating a premature infant (1500g)—a common scenario in a hospital with very limited resources. He is shown calmly resuscitating the infant, and also instructing the attending resident. He donated the resuscitation circuit to the theatre staff, and his stethoscope to a refugee doctor from East Timor.

I often open the Bulletin to see familiar faces, yet again. Perhaps a picture of an Australian anaesthetist offering his expertise to an underdeveloped nation may be of interest to our colleagues.

Sincerely

PAUL SOEDING

I learned somewhat belatedly of the sad passing of Dr David Komesaroff DA (Melb.), FANZCA.

Professor Ross Holland has recently recorded some of the remarkable achievements of this gifted man[1], but I should like to add a personal acknowledgement of David, based upon first-hand experience.

In 1968, several of us began our anaesthesia training careers as Registrars at the Royal Melbourne Hospital. It was there and then that I personally met David for the first time. Over the ensuing, very hard working, clinical year and with our then FFA First Part examinations looming, David not only took a close interest in our clinical welfare and our study preparations, but he gave endlessly of his tremendous basic science knowledge and of his clinical time, to make that year a valuable one for us all. He conducted regular and carefully designed tutorials that were to prove so very helpful. He also, on more than one occasion, took over our respective operating lists to release us for other tutorials or study. It should also be mentioned that he did not hesitate to protect us novice registrars from any inappropriate operating list exposures. Throughout all this time he exhibited the inexhaustibly innovative turn of mind and great courage which is well illustrated by Professor Holland's report, introducing us to (among many other things) the safe applications and limitations of the Goldmann vaporiser, rebreathing circuits and valve and fluid flow physics. He seemed to be everywhere and with good humour and his ready smile—in induction rooms, in theatre, in recovery and in all teaching, quizzing and discussion locations. I also know that a great deal of the time he gave us was in addition to his 'official' hospital time.

The analgesic and unusual vaporisation properties of methoxyflurane were attracting his attention at this stage and his influence upon Victorian and Australian ambulance practice to the benefit of so many patients is now a matter of record.[1]

I am proud to say that from 1968 on, I enjoyed his friendship and ever-available guidance. I feel sure I speak for several colleagues when I say that David's passing fills us with sadness. He is a significant loss from our professional ranks and I shall for ever be grateful for having known him and for his selfless and brilliant influence.

yours sincerely,

JOHN WILLIAMSON

1 Holland R. The Inventors. *Anaesth Intensive Care* 2006;34, Supplement 1:36-38.

This letter supports Rod Westhorpe's excellent article in the ANZCA Bulletin of July 2007 entitled 'The risk of overdoing it', in which he comments upon being increasingly advised by medical indemnity insurers to explain to patients the risks of procedures.

I agree that immediately before an operation is an especially inappropriate time to explain possible serious complications which would be likely to worry a patient, as doing so could increase the likelihood of a complication occurring without achieving any benefit for the patient. What can be explained immediately before surgery without causing harm must depend greatly upon the patient's state of mind at the time.

Surgeons can help, to a degree, by giving patients general information about anaesthetic practices. At the time of advising surgery—or of presenting information which should enable a patient to make an informed decision whether or not to request an elective operation—it is the responsibility of the surgeon to mention, in general terms, all substantive risks (including any anaesthetic risks understood by the surgeon), to discuss any risks specifically asked about to the extent he or she is able to do so and, when appropriate, to refer the patient to an anaesthetist for further information.

For elective procedures which carry significant or specific anaesthetic risks, a pre-anaesthetic consultation with the anaesthetist days before the operation is the ideal, but this may be difficult to arrange in private practice. Perhaps this should change?

I do, occasionally (usually in the presence of a near relative), mention the risk of death resulting from an elective operation—especially when it seems that the procedure may be better deferred or not performed, eg. when advising delay of a procedure on an infant, and also on those rare occasions when a patient asks to be told all risks (an extremely small risk of death may be compared with the risk of a serious car accident on the way home from the consultation).

It is hard to know how to best avoid it, but patients often do not like detailed discussions with anaesthetists about fees immediately before an operation. Again, surgeons may give some helpful advice, such as the telephone number of the anaesthetist's office and surgeons can sometimes provide more detailed information about particular anaesthetists' likely fees for certain procedures. Unhappiness related to fees may cause other complaints to fester.

JOHN A BUNTINE

President
Australian Association of Surgeons

Letters to the Editor continued

Overseas Trained Specialists and the Final ANZCA Examination

The Overseas Trained Specialist (OTS) anaesthetic group has, in general, a significantly lower passing rate in the final examination for the ANZCA College as compared to Australian anaesthetic trainees for several years.

The resultant question of why this occurs with the OTSs who have undergone anaesthetic specialist training in their own countries and successfully completed their respective colleges' examination processes remains unanswered. Several confounding factors, however, may highlight the vastly different circumstances faced by OTSs that have an adverse impact on their examination performance.

One of the most prominent factors is that English may be their second language. Therefore, the candidate will listen or read the question in English, translate it into their native language, process the answer, convert the answer into English and finally give the answer. Depending on the level of the mastery of the English language, this process may be lengthy and erode significantly into the time allocated for both the written and viva examinations. In addition, the degree of accent in the verbal response by the OTS may prove difficult for examiners to understand and may lead to time delays while the answer is clarified. In some cases, the anaesthetic examination may become two examinations for OTS—one in anaesthesia and the other testing the candidate's written and verbal English comprehension.

This group faces many problems, such as their geographical isolation in outlying areas of Australia and inaccessibility to suitable learning resources. A significant number of OTSs are in non-tertiary level hospitals and are therefore not exposed to other final examination candidates who provide an enthusiastic basis for learning as a study group. In these remote areas, it may be difficult for the limited number of ANZCA specialists to provide the OTS with suitable written and oral examination preparation. To overcome these problems, the provision of regular teleconferencing from major teaching centres to these remote located OTS should be considered as a priority.

Anaesthetic trainees often prepare for the examination in small groups who meet at least once a week in the months immediately before the examination. These study groups allow sharing of topical journal articles, gauging one's progress compared to peers and practising exam questions. Of equal importance is the provision of moral support during the examination period. Frequently, the individuals in these groups have known each other from medical school and often during the three to four years of their ANZCA training. Therefore, the groups form rapidly into well lubricated functional entities at an early stage. Unfortunately, the OTS, due to both their geographic isolation as well as the demands of spouses and families, may find joining such groups difficult or impossible. The limited exposure to their peer group and subsequent problems of integrating into small study groups is being currently addressed with the establishment of the OTS network. The 'Overseas Trained Specialist Anaesthetists' Network' (OTSAN) is a self-help group formed by anaesthetists in Australia who have been trained overseas. Their main aim is to allow good anaesthetists to become good examination candidates again. The OTSAN's website is www.otsan.org.

'The 'Overseas Trained Specialist Anaesthetists' Network' (OTSAN) is a self-help group formed by anaesthetists in Australia who have been trained overseas. Their main aim is to allow good anaesthetists to become good examination candidates again.'

The length of time required for examination preparation varies between candidates. Often a twelve to eighteen month period is required; with many candidates continuing to work full-time. The first few months may be spent accessing previous past examination questions and obtaining the required resources for the task ahead. This long preparation process is hard for anyone, let alone the OTSs who

usually have family commitments with settling in a new country at the same time. Equally the spouses of both the OTS and local anaesthetic trainee may find that the amount of time and effort required for their partner to prepare for the ANZCA examination disrupts a tranquil family life. In addition, the pressure that working visas may expire and the possibility that the OTS and their family need to return to their country if failure occurs adds significantly to the stress of the final examination.

Failure may be due to a lack of knowledge or poor presentation skills. The lack of knowledge can be global (ie. insufficient knowledge for the examination) or relative (the examination focused on the candidate's weakest areas). Being at an advanced stage of their career, many OTSs may have specialised in certain aspects of anaesthesia (such as paediatric or cardiac anaesthesia) during their professional development for years and subsequently de-skilled in other areas. Therefore, it is important for them to cover a wide scope of knowledge during the preparation. Clinical rotations of a suitable length (not less than 4 weeks) to other hospitals may assist them in regaining knowledge and experience and should be considered as part of their examination preparation. Frequently it has been several years since most OTSs have sat any examination with the resultant loss of examination techniques. This lack in 'exam-wise' performance contrasts with the more junior anaesthetic trainee who has passed their primary examination within the previous three to four years and are more in-tune with answering written and oral examinations.

Candidates should realise that the examiners are not attempting to fail them but rather objectively assessing their suitability as anaesthetists. In fact, candidates fail themselves during the examination rather than being failed by the examiner. Some OTSs feel that they are more experienced in certain areas than the examiner and this may cause conflict between the examiner and the candidate during the oral examination. It would be wiser for the OTS in these situations to remain calm and provide a logical and well-structured answer while avoiding any feelings of frustration.

Finally, I would like to address the psychological impact of sitting an examination along with more junior anaesthetic trainees. The OTS candidate has not only fulfilled the requirements of the anaesthetic college in their country of origin but has often amassed a significant amount of experience since that time. Sitting another examination along with anaesthetic trainees who have little practical experience in anaesthetic practice will have a humbling effect on some OTSs. The impact of this situation is then magnified if the OTS fails, with a ripple effect onto family and friends. One only has to see its impact on the countless OTSs who walk up to the results display window with their spouses and children only to see them leave with the family in tears as they assess the impact of their failure.

During my time assisting some OTSs in their examination preparation, I have learnt that, though they are a diverse group of individuals, they share a common characteristic—they are willing to face all these hurdles I have mentioned and sit an examination that as Australians we have accepted as our own. To pass the ANZCA final examination is an important achievement for locally born Australians; I tip my hat to those who were born overseas and who attempt this difficult task.

Don't be discouraged by a failure. It can be a positive experience. Failure is, in a sense, the highway to success, inasmuch as every discovery of what is false leads us to seek earnestly after what is true, and every fresh experience points out some form of error which we shall afterwards carefully avoid.

John Keats
(1795 - 1821)

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Obituaries

Professor G A (Don) Harrison AM, MBBS, FANZCA, FJFICM, MHP Ed.

Professor Don Harrison

Professor Don Harrison was a well known anaesthetist and a pioneering intensivist in Sydney, a true gentleman, a gifted physician plus a friend and mentor to many Fellows and colleagues. He contributed greatly to the College and to the specialties of anaesthesia and intensive care for over 40 years. Don graduated from Sydney University (MBBS 1955).

He trained at St Vincent's Hospital in Sydney and was awarded Fellowship of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons (FFARACS) in 1959. Following postgraduate training in Cardiff and Cleveland he returned to St Vincent's in 1964. Don spent the remainder of his working life there and became an integral part of the hospital community; he was beloved and much respected by colleagues, staff and patients.

His many clinical achievements at the hospital have been extensively documented and, particularly his work in cardiac anaesthesia and cardiothoracic intensive care, can best be described as legendary. These achievements, plus his research interests, his pioneering work in anaesthesia and especially intensive care, together with his reputation as a teacher, led to Don being recognised in the late 1960s as both a doyen and a leader in both specialties. In 1972 Don was awarded the First Lennard Travers Professorship by the Faculty in recognition of his contributions to research and education in anaesthesia. In 1973, he travelled and lectured in all states of Australia, New Zealand and the United Kingdom.

It was, therefore, not surprising that he was soon elected as a Member of the Board of the Faculty of Anaesthetists. Don had always believed that 'Education was the key to the best medicine' and as a Board Member, he went on to make major contributions to the training of anaesthetists in the 1970s and later on the training of intensive care specialists. In anaesthesia he collaborated on the development of Objectives in Training and served as the Chair of the Primary Examination Committee and as the Chairman of the

'He contributed to the pioneering work on cardiac bypass surgery and was the anaesthetist for the first heart transplant in Australia.'

Examinations. He went on to develop the initial objectives of Training in Intensive Care Medicine and became the cornerstone which supported the development of the Faculty's Training and Examination program in intensive care—the first such program leading to specialist recognition in intensive care in the world. He did all of this in his own calm, dedicated, gentle, humble and professional way while contributing greatly to the care of patients in St Vincent's and also contributing to many other organisations, such as the Australian Resuscitation Council and the Surf Life Saving Association.

In 1990, he was awarded the Robert Orton Medal by the then Faculty of Anaesthetists for distinguished service to Anaesthesia and Intensive Care through education and research. That occurred just before the Faculty became an independent College and reflected the high esteem in which he was held by both anaesthetists and surgeons of the day.

In 1995, he was recognised by the Faculty of Intensive Care in the establishment of the G A (Don) Harrison Medal for the best performance at the Final Examination in Intensive Care. Don personally presented that medal each year and established a special bond with each of the recipients.

Don also contributed to the teaching and training programs in Singapore, Malaysia and Indonesia, and many of his ex-trainees and friends have asked that their condolences be passed on to the family. Following his own experiences undergoing anaesthetics as a boy, Don had said 'When I grow up I am going to do something about these anaesthetics'. He achieved that and much more. Professor Don Harrison was a remarkable clinician, a gifted researcher, a pioneer and, above-all, a superb teacher who contributed greatly to the specialties of anaesthesia and intensive care. Underlying those achievements was a philosophy that was centred on patient care and safety, that incorporated teaching and research into patient care and which was grounded in a team approach to patient care. That was especially evident in his work in Intensive Care, where he combined empathy and a genuine regard for patients and their families with expert medical care based on research and investigation, facilitated by a team with genuine respect of each other, their capabilities and the needs of the patients and their families. Don admitted that he had 'an obsession with the need to relieve pain and suffering particularly in the critically ill' combined with 'a drive to use his knowledge of the principles of education to help others to better relieve pain and suffering and to resuscitate those dying of potentially reversible conditions'. It is fair to say that he succeeded and that drive and commitment was still evident in his recent endeavours, including the ongoing research related to improving the prediction and management of medical emergencies in hospitals and his teaching role in medical simulation.

Don achieved an enormous amount in his life, which was dedicated to serving the community and his family. He was a true humanitarian, a gifted doctor, a talented teacher and a wonderful mentor. Despite his daunting achievements, he carried others along with his humility, his quiet and unassuming manner and his enthusiasm, which, coupled with his interest in both them and the cause in hand, always encouraged them to seek excellence. He was a truly great man who will be remembered and greatly missed by his family, friends, Fellows and trainees

DR W R THOMPSON
President

Series on past Deans and Presidents

Dr William Moncrieff Crosby

Dr Bill Crosby was the fifteenth Dean of the Faculty of Anaesthetists and served in this role from 1982-1984. He followed Professor Doug Joseph and was succeeded by Professor Ross Holland in this post. As Professor Michael Davies wrote the citation for the awarding of the Orton medal and the obituary for Dr Crosby, I have—with permission—reprinted the obituary here that previously appeared in the Bulletin of August 1991. Dr Terry Loughnan

Dr Bill Crosby died on 28 July 1991, following a long battle with cancer which he had endured with his characteristic determination. His death completed a life that had been dedicated to his family, his friends and to Anaesthesia. Bill graduated from the University of Melbourne in 1954 and completed two years as a resident medical officer at the Alfred Hospital before commencing training in Anaesthesia. He gained his Fellowship of the Faculty of Anaesthetists, Royal Australasian College of Surgeons in 1959 and took up a position as a staff anaesthetist at the Alfred Hospital. Five years later, he was appointed as Deputy Director of Anaesthesia. During this time, Bill developed his great interest in Intensive Care and was responsible for establishing the first intensive care unit in Victoria, at the Alfred Hospital.

In 1964, Bill moved to Geelong, entering private practice with an appointment as Visiting Anaesthetist to the Geelong Hospital. He was appointed Director of Anaesthesia in 1985 and remained in that position until his death. During this time, Bill was tireless in his promotion of anaesthesia and intensive care as a speciality, and recruited many impressive people to the developing discipline. Hospital politics was his forte and many sought his advice in this area. He fought strenuously for many improvements to the practice of medicine and anaesthesia in Geelong and whilst he won many of these, readily accepted decisions that went against his ideas. Bill also had a strong association with the Faculty of Medicine at Monash University. He tutored medical students in Physiology for over 30 years in which post he was able to so effectively relate laboratory experiments to clinical human observations. He also lectured in the Primary FFA course in Melbourne for a long period and tutored many anaesthetic trainees for the Primary FFA at Geelong Hospital, having an excellent record of successful candidates sitting for this most difficult examination.

Bill was appointed an Examiner for the Faculty in 1966 and completed 14 years in that role, becoming Chairman of Examinations in those latter three years. He was elected to the Victorian Regional Committee in 1969 and chaired that Committee from 1973 to 1975. In that same year, he was elected to the Board of Faculty. In 1979, he became the first Faculty Treasurer and completely reorganised the Faculty finances so that they still remain on a solid footing today. He was elected Vice Dean in 1980 and was elected Dean of the Faculty from 1982 - 1984. Following his retirement from the Board of Faculty, Bill was elected to the Court of Honour of Royal Australasian College of Surgeons in 1987. In 1989, the Board of Faculty awarded Dr Crosby the Orton Medal for his distinguished services to anaesthesia and he was presented with this Medal in Wellington, New Zealand at the 1990 GSM. The Orton Medal is the highest award the Faculty may bestow on a practising Fellow and Bill Crosby is the first recipient of the Orton Medal who had in fact worked with the late Dr Orton.

'He fought strenuously for many improvements to the practice of medicine and anaesthesia in Geelong and whilst he won many of these, readily accepted decisions that went against his ideas.'

Bill was a tremendous contributor during his thirty-four years in anaesthesia. He lectured in many parts of Australia, New Zealand and South East Asia and wrote a number of papers published in both the *Medical Journal of Australia and Anaesthesia and Intensive Care*.

Bill Crosby will be missed by a great many people in Anaesthesia—his contributions have enhanced and promoted our speciality significantly during its formative years.

To Jean and her family, Stuart, Helen and Ian, we extend our deepest sympathy. We have lost a wonderful colleague and friend; the Faculty—one of its greatest supporters.

MICHAEL J. DAVIES

August 1991 Bulletin:
Faculty of Anaesthetists
Royal Australasian College of Surgeons

FINAL FELLOWSHIP EXAMINATION (ANAESTHESIA)

Court of Examiners

JULY/SEPTEMBER 2007

The written section of the examination was held in Adelaide, Auckland, Brisbane, Canberra, Hamilton, Hobart, Hong Kong, Kuala Lumpur, Launceston, Melbourne, Newcastle Perth, Singapore, Sydney, Townsville, and Wellington

The oral section of the examination was held at the Prince of Wales and Sydney Children's Hospitals, Sydney.

107 Candidates presented in Sydney and 89 were approved:

Sue Young Ahn	NSW
Stewart Alexander Allan	NZ
Michael Richard Ayling	NSW
Neville Bailey	QLD
Remesh Kumar Balasingam	MYS
Peter Francis Barrett	QLD
Renee Gail Beer	QLD
Aaron Joseph Bellette	NSW
Cambell Gill Bennett	NZ
Philip Michael Black	NSW
Andrew David Cairncross	NSW
Shanel Lei Cameron	NSW
Chin-Wern Chan	WA
Szu-Lynn Chan	WA
Elena Chernova	VIC
Chui Chin Chong	WA
Paul Geoffrey Davies	QLD
Sharon Dempsey	NZ
Sushama Aniruddah Deshpande	NZ
Felicity Ann Doherty	NSW
Daniel Patrick Durack	WA
Christine Maria Edmonds	NSW
Michael James Edwards	QLD
Michael Ehrlich	NSW
Robert James Elliott	QLD
Muhammad Essop	ACT
Aruna Shantha Evana Hennedige	ACT
Richard Galluzzo	ACT
Callum Radford Gilchrist	ACT
Elizabeth Anne Gooch	QLD
Roderick Kenneth Grant	QLD
Shravani Gupta	QLD
Ali Gur	SA
Shivakumar Hampasagar	TAS
Timothy Peter Haydon	VIC
Conrad Hermann Heim	QLD
Anjanette Mariko Hylands	NSW
Patricia Kan Kwok Yee	HKG
Michael Hua-Tsung Kao	QLD
Michael John Keane	VIC
Monica May Korecki	QLD
Michael Zdzislaw Kulisiewicz	NSW
Joshua Ho Pui Lau	WA
Lisa Chih-Mei Lin	VIC
Swee-San Susan Loo	SA
Heather Alicia Matthews	NZ
Timothy Lachlan McIver	VIC
Suzanne Edith Miles	QLD
Jodi Simone Murphy	NSW
Sarvesh Natani	QLD
Hong Jye Neo	SGP
Andrea Maree Noar	QLD
Thomas Michael Alexander O'Rourke	NZ
Cameron David Leigh Osborne	VIC
Darren Pereira	NSW
Senthan Ponniah	ACT
Andrew William Potter	QLD
Priya Rajendra	VIC
Asif Raza	NSW
Scott Craig Robinson	NZ
Johanna Rose	NZ
David Matthew Rusk	NZ
Paul Harold Martin Sadleir	VIC
Jason Matthew Schoutrop	QLD
Matthew Richard Scott	NZ
Tanya Selak	NSW
Marianne M Botross Sidhom	NSW
Vincent Michael Sperando	NSW
Andrew James Stapleton	NZ
Craig Geoffrey Surtees	NZ
Tan Liang Hui	SGP

Jennifer Ann Taylor	NZ
Matthew James Tey	NSW
Emma Janine Thomas	NZ
Jason David Thomas	VIC
Andrew John van der Poll	NZ
Paul Xavier Vella	QLD
Suresh Venu Gobal	VIC
Benedict John Francis Waldron	VIC
Thomas Bruce Walker	NSW
Tony Wei	VIC
Nicola Margaret Whittle	NZ
Christopher Hayden Wong	NZ
Chin Ming David Woo	SGP
Peter William Wright	TAS
John Yang	NSW
Yip Cheng Bee	MYS
Anthony Carl Young	NZ
Simon Anthony Zidar	NSW

The Court of Examiners recommended that the Cecil Gray Prize for the half year ended 31 December 2007 be jointly awarded to:

Suzanne Edith Miles	QLD
Jodi Simone Murphy	NSW

Merit Certificates were awarded to:

Cambell Gill Bennett	NZ
Callum Radford Gilchrist	ACT
Roderick Kenneth Grant	QLD

Dr Peter Gibson, Chair Final Examination and retiring Examiner Dr Maggie Bailey.

OTS Overseas Trained Specialist Results

Twenty two (22) candidates presented for the Overseas Trained Specialist Performance Assessment held in July/ September 2007 and the following thirteen (13) candidates were successful.

Dr Unnikrishnan Chundiran	NT
Dr Hercules De Wet	QLD
Dr Johannes Els	NSW
Dr Paris Hills-Wright	SA
Dr Pushpangadan Janardanan	SA
Dr Piotr Konopka	QLD
Dr Jacob Koshy	NT
Dr Caroline Lake	SA
Dr Thomas Ledowski	WA
Dr Simone Malan-Johnson	QLD
Dr Ravi Tiwary	QLD
Dr Helen Vlachtsis	SA
Dr Konareddy Yatham	QLD

A Certificate of Excellence for Overseas Trained Specialists was awarded to Dr Simone Malan-Johnson.

PRIMARY EXAM

SEPTEMBER 2007

A total of one hundred and twenty four (124) candidates successfully completed the Primary Fellowship Examination at this presentation and are listed below:

Walid Aly	QLD
Agata Ancypa	TAS
Ju Pin Ang	SA
Anna Antonas	NSW
Negar Asadi	NSW
Siu Wah Sylvia Au	HK
Tania Bailey	NZ
Liam Balkin	QLD
Daniel Bartlett	QLD
Timothy Benny	SA
Andrea Bowyer	VIC
Christopher Breen	QLD
Matthew Burke	NSW
David Burton	NZ
Ka Man Carmen Chan	HK
Marianne Chan	NSW
Brett Chandler	VIC
Michael Chappell	QLD
Alex Kuanyu Chen	WA
Yu-Ping Chen	WA
Sandra Chieh Hsiang Cheng	NSW
Suk Kwan Cheung	HK
Ching Pik Candy Chiu	HK
Catherine Chwang	NSW
Nina Civil	NZ
James Craig	QLD
Louisa Crowther	QLD
Jayita De	NSW
Gauri Dhara	VIC
Wayne Edwards	QLD
Catherine Egan	QLD
Islam Elhalawani	SA
Alex Fang	NSW
Thomas Fernandez	NZ
Kate Ferris	QLD
Ingrid Funke	VIC
Jacobus Geertsema	VIC
Nathan Goodrick	QLD
Grace Gunasegaram	VIC
Nathan Harper	NSW
Robert Heavener	NSW
Nicholas Hogan	QLD
Michelle Hughan	NSW
Anthony Jackson	WA
Bryne John	NSW
Vanessa Jones	NSW
Saul Judelman	NSW
Hasher Pallathu Kadavil	NZ
Matthew Keating	WA
Zoe Keon-Cohen	VIC
John Kerdic	NSW
Dale Kerr	QLD
Nicholas Knight	SA
Atlas Ching-Hong Ko	VIC
Steven Koh	NSW
Daniel Kwok	NSW
Zoe Lagana	SA
Ka Wang Alan Lai	HK
Man Ling Lai	HK
Rupert Ledger	WA
Monn Lee	VIC
Igor Lemech	VIC
Malgorzata Lenarczyk	QLD
Leona Yue Peik Leong	NZ
Nina Loughman	TAS
Isabelle Lusk	NZ
Jason Ma	VIC
Hiu Kwan Jannifer Man	HK
Gillian Mann	NZ
Kameel Marcus	VIC
Shane McQuoid	NZ
Luke Mercer	NZ
Rosmiyati Mohammed Zabidi	NSW
Christie Moule	SA
Tracy Murgatroyd	NZ
Luke Murtagh	SA
Rayhaan Mussa	NSW
Joseph Yeuk-Kei Ng	WA
Merlin Nicholas	WA
Toby Nichols	WA
Panya Nipatcharoen	NSW
Martine O'Neill	NSW
Kellie Ovenden	QLD
Timothy Paterson	WA
Pieter Peach	VIC
Andrew Peart	NSW
Anna Pedersen	NSW
Slava Poel	VIC
Rebecca Prentice	NSW
Leah Purcell	QLD
Nayyera Nudrat Rashid	NSW
Peter Reid	QLD
David Reiner	NSW
Jonathan Samaan	QLD
Simon Samoilenko	QLD
Timothy Sampson	QLD
Paul Sherwin	QLD
Tony Shih	NSW
Hon Earn Sim	ACT
Emma Smith	SGP
Melanie Speer	NZ
Georgia Stefanko	NZ
Phoebe Streat	NZ
Sutharshan Sundaram	VIC
Tamsin Supple	VIC
Nathan Taylor	NSW
Derek Kah Wei Teh	NZ
Minh Hai Tran	NSW
Zain Upton	ACT
Khai Tan Van	QLD
Susan Van Duren	WA
Andrew Wallace	SA
Helen Ward	NSW
Katrina Webster	TAS
Brett Wells	NSW
Yasmin Whately	QLD
Carolyn Wills	QLD
Jordan Wood	NZ
David Wright	TAS
Ewan Wright	NT
Melissa Yee	NSW
John Young	NSW
Lilian Yuan	ACT
Chenqu Zhao	TAS

Court of Examiners

PRIZE WINNERS

Renton Prize

The Court of Examiners recommended that the Renton Prize for the half year ended 31 December 2007 be awarded to:

Dr Siu Wah Sylvia Au	Hong Kong

Merit Certificates

Merit Certificates were awarded to:

Dr Andrea Bowyer	VIC
Dr Christopher Breen	QLD
Dr Kate Ferris	QLD
Dr Michelle Hughan	NSW
Dr Vanessa Jones	NSW
Dr Steven Koh	NSW
Dr Igor Lemech	VIC
Dr Luke Mercer	NZ
Dr Yvette D'Oliveiro	Malaysia
Dr Timothy Paterson	WA
Dr Kalmin Senaratne	QLD
Dr Hon Earn Sim	ACT
Dr Georgia Stefanko	NZ
Dr Khai Tan Van	QLD

Noel Roberts at the Examiners dinner receiving a certificate for his retirement as Chairman of Primary Exam

NHMRC Project Grants

ANZCA, JFICM and FPM Fellows were very successful in the recent NHMRC Project Grant Round, with grants totalling $3,475,975.

Successful grants

491226 A multi-site RCT comparing spinal and general anaesthesia on neurodevelopmental outcome and apnoea in infants $490,750.
Dr Andrew Davidson, Dr Rodney Hunt, Dr Robyn Stargatt, Dr Geoffrey Frawley, Ms Pollyanna Hardy.

512307 Predicting the risk of invasive candidiasis in critically ill patients $1,200,350.
Prof Tania Sorrell, Prof Jeffrey Lipman, Dr E Geoffrey Playford, Dr Michael Jones, A/Pr Jonathan Iredell, Prof David Paterson, A/Pr Deborah Marriott.

519702 Antibiotic dosing in the 'at risk' critically ill patient $589,000.
Prof Jeffrey Lipman, Prof Michael Roberts, Prof David Paterson, Dr Carl Kirkpatrick, Dr Peter Kruger, Mr Jason Roberts.

508081 Impact of gastrointestinal dysmotility on enteral nutrition in the critically ill $511,500.
A/Pr Robert Fraser, Dr Marianne Chapman, Dr Christopher Rayner, A/Pr Richard Holloway, Prof Gerald Holtmann, Prof Michael Horowitz.

490966 Hyperbaric Oxygen in lower limb trauma: a randomised controlled clinical trial $684,375.
Dr Ian Millar, Dr Owen Williamson, Prof Peter Cameron, Prof Paul Myles.

The GAS Study

Dr Andrew Davidson was successful in obtaining his first NHMRC Project Grant for his randomised controlled trial of general anaesthesia versus spinal anaesthesia for neonatal inguinal hernia repair. There has been increasing interest in the long term effect of anaesthesia on the developing brain. The GAS study is a multisite randomised controlled trial assessing the neurodevelopmental outcome of infants who have been randomised to receive a general or spinal anaesthetic for hernia repair. This trial will determine if having a general anaesthetic as an infant is associated with long standing neurological damage. 660 babies—from sites in Australia, New Zealand, USA, UK and Canada—will be enrolled into the trial, randomised to receive a general or local anaesthetic, and then followed for five years. The study received seed funding from ANZCA, the Murdoch Children's Research Institute and Boston Children's Hospital. This is one of the first large multinational investigator driven trials to be attempted in paediatric anaesthesia and will answer a crucial question for paediatric anaesthesia. The trial is being co-ordinated from Melbourne, involves nearly all major paediatric centres in Australia/NZ and recruitment has started in several sites. The NHMRC funding will provide sufficient funds for enrolment and assessment across Australia and NZ.

Dr Andrew Davidson

2008 RESEARCH GRANT AWARDS

The following Research Grants for 2008, recommended by the Research Committee, were awarded by Council at the October Council Meeting:

Pollock, Ashley (Neil)
$25,000
Pharmacological characterisation of malignant hyperthermia.

Sleigh, James (Jamie)
$20,625
Dreaming and EEG changes during anaesthesia.

Royse, Colin F
$48,875
Evaluation of left ventricular function using tissue Doppler strain rate with pressure-volume loop analysis.

Brooker, Charles D
$25,000
Radiofrequency neurotomy for chronic lumbar zygapophyseal-joint pain: A randomised double-blinded investigation of diagnostic lumbar medical branch nerve blocks.

Cousins, Michael J
$54,402
Regulation of serotonin receptors by anti-migraine drugs.
$57,099
Experimental strategies for preventing persistent post surgical pain.

Sumpter, Anita L
$40,000
Age related changes in effects of sedatives and analgesics on quantative EEG monitoring in paediatric intensive care.

Davies, Andrew R
$15,000
A multi-centre randomised controlled trial comparing early jejunal feeding and standard feeding in critical illness.

Wrigley, Paul J
$40,000
Cortical and fibre tract changes in subjects with neuropathic pain following spinal cord injury.

McIlroy, David R
$25,000
Can endothelial dysfunction predict perioperative cardiac morbidity?

Bersten, Andrew D
$45,000
lung injury in acute pulmonary oedema: are there peripheral markers of tissue remodelling predictive of clinical outcome?

Finfer, Simon R
$40,000
SAFE TRIPS: An international study of ICU fluid resuscitation practices.

Schug, Stephan A
$27,590
Identifying clinical predictors of long-term pain outcomes among severe physical trauma survivors.

Cohen, Jeremy
$15,000
Tissue cortisol activity in critical illness.

Cooper, David J
$15,000
Permissive Hypercapnia and Alveolar Recruitment with Limited Airway Pressures (PHARLAP): a phase II randomised trial in ARDS patients.

RESEARCH AWARDS

That the **Harry Daly Research Award** be awarded to **Professor Michael Cousins** for his project "Regulation of serotonin receptors by anti-migraine drugs." (08/010)

That the **Mundipharma ANZCA Research Fellowship** be awarded to **Dr Anita Sumpter** for her project 'Age related changes in effects of sedatives and analgesics on quantative EEG monitoring in paediatric intensive care'. (08/011)

That the **Pfizer ANZCA Research Fellowship** be awarded to **Dr Paul Wrigley** for his project 'Cortical and fibre tract changes in subjects with neuropathic pain following spinal cord injury'. (08/014)

That the **ANS ANZCA Research Fellowship** be awarded to **Dr Charles Brooker** for his project 'Radiofrequency neurotomy for chronic lumbar zygapophyseal-joint pain: A randomised double-blinded investigation of diagnostic lumbar medical branch nerve blocks'. (08/009)

That the **Aspect ANZCA Research Fellowship** be awarded to **Professor Stephan Schug** for his project 'Identifying clinical predictors of long-term pain outcomes among severe physical trauma survivors'. (08/030)

That the **Organon Research Award** be awarded to **Professor Michael Cousins** for his project 'Experimental strategies for preventing persistent post surgical pain'. (08/022)

2008 Novice Investigator Grants

Scurrah, Nicholas
$8,000
Postoperative analgesia after liver resection: a clinical trial with intravenous morphine and interpleural analgesia.

Panwar, Rakshit
$11,050
Utility of protein C levels in immunocompromised septic patients.

2007 Academic Enhancement Grant

Professor Alan Merry
$89,282.93
Enhancing the fidelity of modelling in simulation.

2008 Simulation/Education Grant Awards

Fraser, John
$21,650
Practical Simulation of the Human Cardiovascular System for Education and Training.

Pinder, Mary
$13,350
Teaching clinical skills: evaluation of information transfer during medical handover at change of shift in the ICU.

The clinical ethics resource: a free on-line text and educational program

Your comments wanted!

The moral, legal and philosophical issues associated with medicine are widely discussed today in relation to medical practice and research and the formation of social policy. New ethical questions constantly appear which often attract intense community interest.

There is a growing expectation that doctors will possess detailed knowledge about ethical issues and offer reasoned responses. While teaching in ethics is now a universal part of undergraduate medical curricula, however, there are relatively few resources for clinicians who wish to pursue the study of clinical ethics at a higher level.

In response to this need, a collaboration was established in 2005 between various Colleges and Monash University to establish a short postgraduate clinical ethics course. As the project developed, it became apparent that if the course were to serve the needs of clinicians working in many different settings, a complex and flexible approach would be needed. The resource would have to encompass a wide range of issues, incorporate a variety of perspectives, provide access to a wide literature, and be readily updatable, flexible enough to allow individuals to navigate different paths through it (depending on their interests) and able to be used in a manner that could suit busy time schedules.

As a result, we have developed the Clinical Ethics Resource: an expanding on-line resource intended to assist clinicians in their responses to the wide range of moral, legal and philosophical issues that arise in practice. The first version of the resource is now on-line and your comments, suggestions and further contributions are sought. The resource is offered as a service to the medical and wider communities and is presented as a series of modules which aim to provide access to major currents of thought, arguments and resources. The material covers a range of perspectives and is not committed to any one particular point of view.

The ultimate scope of the resource is not limited. At this stage, we have developed modules that cover issues of life and death, consent and confidentiality, legal issues in clinical medicine, ethics of clinical research, relations with industry and conflicts of interest, population health, and organ donation and transplantation. An additional module dealing with ethical issues in genetics is nearly complete and further modules are being planned.

A key feature of the resource will be the incorporation of an expanding 'archive' of case experiences collected in video or text form from clinicians and other health professionals in all areas of practice. This archive is under construction and will be added in the near future.

It is intended that specific learning programs that meet the needs of individual clinicians will be defined within the on-line text. These may be incorporated within advanced training or continuing medical education programs or completed as an accredited course which we will be happy to offer.

At this stage, contributions are sought from interested people to assist with the further development of the resource. Such contributions could take the form of:

- Short articles on particular subjects relevant to any aspect of clinical ethics
- References to the literature or other resources, such as images, short videos or web site addresses
- Descriptions of cases that illustrate ethical issues arising in clinical practice, preferably as 3-5 minute video clips
- Descriptions of experiences of patients or carers that illustrate ethical issues in clinical practice
- Ideas for additional modules or other suggestions about how to develop the resource further
- Identification of error, deficiencies, typos etc within the existing text.

The Clinical Ethics Resource can be found at http://www.cems.monash.org/ or http://mnhs-teaching1b.med.monash.edu.au/Public/Clinical%20Ethics/. Contributions can be sent by e-mail titled 'Clinical ethics resource material' to paul.komesaroff@med.monash.edu.au. We look forward to your comments and suggestions!

PAUL KOMESAROFF

FRACP
Professor of Medicine, Director,
Centre for Ethics in Medicine and Society,
Monash University,
The Alfred Hospital, Commercial Road,
Prahran, Victoria 3181

SIG Combined Education, Simulation, Welfare and Management 2007 SIG Meeting, Sheraton Noosa & Spa

12 – 14 October

The Changing Face of Anaesthetic Careers

The 2007 Combined SIG Conference was held at the Sheraton Noosa Resort & Spa from 12-14 October. A popular annual meeting that regularly attracts Fellows from all over Australia and New Zealand, the conference this year was attended by more than 130 delegates.

The main speaker was Dr David Prideaux, Professor and Head, Department of Medical Education, School of Medicine, Flinders University. Dr Prideaux's research interests include decision making models for change and innovation in medical education, and he brought to the meeting, his expertise in curriculum development and evaluation, which was most valued by members of all four SIGs. The topics of his presentations—'Current Trends in Medical Education' and 'Effective Continuing Professional Development'—were particularly relevant to the meeting's theme.

Other highlights of the weekend included a Hypothetical 'Facing the Public Eye' with a panel discussion moderate by Dr Martin Lum, and a workshop presented by Phil Smith on 'Resolving Conflict through Negotiation' from the IMteam. Together with a number of Free Paper Sessions, delegates had a wide range of sessions to attend as well as the time to meet and mix with colleagues.

On Saturday night, a Conference Dinner was held at the award-winning restaurant, Berardo's, and was a great success. The delegates enjoyed an excellent meal with beautiful wines in a relaxed tropical atmosphere.

The next Combined SIG Meeting will be held in Queenstown in August 2008 in a very different climate, but with an equally stimulating program.

Obituaries

Raymond Arthur Chapman
College Secretary 1962 – 1989
4 March 1928 – 9 August 2007

Ray Chapman

Judy (Ray's widow) has asked me to speak about Ray's career as Secretary of the Royal Australasian College of Surgeons. It is a privilege to do so on behalf of a host of surgeons whom Ray has helped and befriended in his role as chief executive of the College.

Ray came to the College as a Certified Practising Accountant and an Administrative Cadet from CSIRO. In mid-1961, the position to which he was first appointed was Assistant Secretary.

The President in 1962 was Julian Ormond Smith—a swash-buckling, warm-blooded surgeon of the older school, who is credited with having filled every position on College committees, although not all at the same time. Viewed in retrospect, perhaps his master-stroke in 1962 was to appoint, as Secretary, Raymond Arthur Chapman who was at the ripe age of 34 years.

I think Julian Smith recognised his intelligence, initiative, energy and enthusiasm, and that is what he wanted in his lieutenant and adjutant. Little did he bargain for the versatility, loyalty, sound judgement and affable personality which Ray brought to the job, and to all his dealings with his surgeons.

For many, first contact with the College was made through Ray Chapman. Moreover, entry to Fellowship of the College is preceded by a stiff but fair Part II exam. Ray organised those examinations like clockwork. After each, there would be those who were happy, and those who were sad. Ray was the first to contact each category—no easy task with the latter. Ray, who knew his scriptures, was able to comply with the exhortations of St Paul the Apostle to the Romans to 'Rejoice with them that do rejoice, and weep with them that weep'.

So began a bond with new Fellows of the College—some of whom enter at their first attempt, some at their second, and others taking longer.

Ray was not one to raise spurious hopes by false optimism. One applicant, with several unsuccessful attempts, wished to try again. In his application, he made the proviso that he did not wish to be examined again by Mr D R Leslie. Mr Chapman, in sending him his exam number, acknowledged the proviso, but felt it was only fair to indicate that of the ten examiners the applicant had faced at previous attempts, the only one who had passed him was Mr D R Leslie.

Ray maintained contact with Fellows and was a personal friend of many of them throughout Australia and New Zealand. Many were surprised when they telephoned the College that he could recognise the voice before they had introduced themselves. In Singapore, Hong Kong and Kuala Lumpur he was very much the face of the College. He was held in high regard at the headquarters of the surgical colleges in the United Kingdom and Ireland and in the United States of America, where his deep knowledge of surgical affairs, his efficient approach to business, and his collegiate manner were deeply appreciated.

'He was a very enthusiastic teacher and showed an interest in registrars by giving them tutorials at a time when formal in-service teaching was rare.'

To my knowledge, there was only one occasion on which he was paraded before higher authority—to explain his actions and for reprimand. I know because I was paraded with him. It came about this way:

In preparation for the Golden Jubilee General Scientific Meeting in 1977, the command was issued by the Vice-President, impending President and former naval officer D'Arcy Sutherland that the College Headquarters were to be cleaned up. Much had accumulated in the vaults at Spring Street, and had been put there during the war when the College building had been occupied by the Red Cross and National Authorities. The task was given to Chapman and Macleish, who had just been appointed to the House Committee. Our solution was to put everything from the vaults in a removal van and take the lot to an empty ward at Heidelberg Repatriation Hospital. We spent a weekend in boiler suits separating the wheat from the chaff. Old telephone books, unused toilet rolls, out-dated stationery, etc were thrown out and anything bearing a hint of archival significance was put in the van and brought back to the College.

In Memory

Associate Professor G A (Don) Harrison
3 November 1931 - 10 October 2007

Teacher
Innovator
Worker
Carer
Family man

Thereafter, it was found that certain records were missing, including the colourful Grant of Arms issued by the College of Heralds in London. We were summoned to face the Archives Committee, which comprised past surgical Office-bearers of impressive stature and imperious nature. The dressing down was merciless. All we could do was to maintain that we had sifted wheat from chaff. It carried little weight. A substitute Grant of Arms had to be obtained from the College of Heralds—through the good offices of Wyn Beasley.

Fortunately, shortly afterwards, an official of the ANZ Bank called Mr Chapman to state that in the vaults of the bank there had been found a red box labelled 'Surgeons', and 'was he interested?'. He was. It contained the missing original Grant of Arms. Chapman and Macleish received no formal apology, but were not dismissed.

In 1984, Ray was awarded the RACS Medal 'For singularly valuable and dedicated contributions to the College'. He had contributed to the well-being of all aspects of College activity. It is not my role or intention to make odious comparison. I know that times change and the College has grown. But the simple mathematical fact is that all the portfolios that Ray Chapman carried are now carried by seven different individual people.

In 1987, after 25 years as Secretary, he was elected to Fellowship of the Royal Australasian College of Surgeons—a most unusual honour for someone who has not studied anatomy. As a rule, the anaesthetist commences manoeuvres before the surgeon, but in this case, two years later he was elected to Fellowship of the Faculty of Anaesthetists, in recognition of all the work he had done for the Faculty in its earlier days. He thus became both a surgeon and an anaesthetist, but being the good administrator that he was, he did not enter into competition with his clinical colleagues.

The College Office was a happy place, and his supportive secretarial staff were fond of him. The nature of his approach was reflected in their enthusiastic work for the betterment of the College. In the age of acronyms, RACS became interchangeable for R A Chapman Secretary and Royal Australasian College of Surgeons.

Had he been CEO of Telstra, he would have received greater remuneration. He was not highly paid, but as Shakespeare has put it, he was 'wealthy in his friends'.

When he retired from the College in 1989 after 28 years service, he left 'with friends and admirers aplenty, and without an enemy of consequence'. His Headmaster's report card would have read: 'Could not have done better'.

Though it is difficult to be certain of more than a few predictions, I think the College will not see his like again.
May I close by paraphrasing Kipling but slightly:

'Wherefore praise we famous men—
Men of little showing,
For their work continueth
Broad and deep continueth,
Great beyond their knowing.'

D G (SCOTTY) MACLEISH
15 August 2007

College Library

The following services are offered to all Fellows and Trainees of the College, the Joint Faculty of Intensive Care Medicine and the Faculty of Pain Medicine.

- **Loan of books and videos**
- **Supply of journal articles**
- **Literature searches**

ONLINE JOURNALS
To access online journals go to:
http://www.anzca.edu.au/infocentres/library/journals/index.htm
A website username and password is required to access the online journals.
To apply for a website username and password go to:
http://www.anzca.edu.au/reg/anzca_reg.cfm

CONTACT THE LIBRARIAN
Phone (03) 8517 5305
Fax (03) 8517 5381
Email: libanzca@anzca.edu.au

NOTICE 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 http://www.anzca.edu.au/libcatalogue/index.htm
for books held in New Zealand.

Contact details for the New Zealand office are as follows:
New Zealand National Committee (ANZCA)
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Fax (04) 385 3950
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New additions to the College Library

NEW BOOKS

1. **Acute pain management: a practical guide** / PE Macintyre and S Schug – 3rd ed. – Edinburgh: Saunders-Elsevier, 2007.
2. **AMA manual of style: A guide for authors and editors** / C Iverson et al – 10th ed. – Oxford: Oxford University Press, 2007.
3. **Anaesthesia and the practice of medicine: historical perspectives** / Keith Sykes and John Bunker – London: Royal Society of Medicine Press, 2007.
4. **Anesthesia in cosmetic surgery** / ed by BL Friedberg – Cambridge: Cambridge University Press, 2007.
5. **Anaesthesia science** / ed by NR Webster and HF Galley – Mass. Blackwell Publishing, 2006.
6. **The Australian health care system** / S J Duckett – 3rd ed. – Victoria: Oxford University Press, 2007.
7. **Better: A surgeon's notes on performance** / Atul Gawande – New York: Metropolitan Books, 2007.
8. **Cardiopulmonary bypass: principles and practice** / ed by GP Gravlee, RF Davis, AH Stammers and RM Ungerleider – 2nd ed. – Philadelphia: Wolters Kluwer – Lippincott Williams and Wilkins, 2008.
9. **Cardiothoracic critical care** / ed by D Sidebotham, A McKee, M Gillham and JH Levy – Philadelphia: Butterworth Heinemann Elsevier, 2007.
10. **Clinical examination: A systematic guide to physical diagnosis** / NJ Talley and S O'Connor – 5th ed. – Sydney: Churchill Livingstone Elsevier, 2006.
11. **Core topics in operating department practice: anaesthesia and critical care** / ed by B Smith, P Rawling, P Wicker and C Jones – Cambridge: Cambridge University Press, 2007.
12. **Essentials of anaesthetic equipment** / Baha Al-Shaikh and Simon Stacey – 3rd ed. - Edinburgh: Churchill Livingstone Elsevier, 2007.
13. **Evidence-based anaesthesia and intensive care** / ed by Ann Moller and Tom Pedersen – Cambridge: Cambridge University Press, 2006.
14. **Examination medicine: a guide to physician training** / NJ Talley and S O'Connor – 5th ed. – Sydney: Churchill Livingstone Elsevier, 2006.
15. **How doctors think** / Jerome Groopman – Boston: Houghton Mifflin Co. 2007.
16. **Inquiry into the misuse / abuse of bezodiazepines and other forms of pharmaceutical drugs in Victoria: interim report** / Drugs and Crime Prevention Committee – Victoria. Parliament. Drugs and Crime Prevention Committee. – Melbourne: Government Printer, 2006.
17. **Irwin and Rippe's intensive care medicine** / ed by RS Irwin and JM Rippe – 6th ed. – Philadelphia: Wolters Kluwer - Lippincott Williams and Wilkins, 2008.

18. Manual of office-based anesthesia procedures / ed by FE Shapiro – Philadelphia: Wolters Kluwer - Lippincott Williams and Wilkins, 2007.

19. Medical emergency teams: Implementation and outcome measurement / ed by MA DeVita, Ken Hillman and R Bellomo -- New York: Springer, 2006.

20. The objective structured clinical examination in anaesthesia: Practice papers for teachers and trainees / C Mendonca and S Balasubramanian – UK: tfm Publishing Limited, 2007.

21. Peripheral regional anesthesia: An atlas of anatomy and techniques / ed by G Meier and J Buettner – 2nd ed. – Stuttgart: Thieme, 2007.

22. A practical approach to cardiac anesthesia / ed by FA Hensley, DE Martin and GP Gravlee – 4th ed. – Philadelphia: Wolters Kluwer - Lippincott Williams and Wilkins, 2008.

23. Rang and Dale's pharmacology / HP Rang, MM Dale, JM Ritter and RJ Flower – 6th ed. – Edinburgh: Churchill Livingstone, 2007.

24. Safety and ethics in healthcare: a guide to getting it right / Bill Runciman, Alan Merry and Merrilyn Walton – Hampshire, England: Ashgate, 2007.

25. Transoesophageal echocardiography: Study guide and practice questions / A Roscoe – Cambridge: Cambridge University Press, 2007.

26. Yao and Artusio's anesthesiology: problem-oriented patient management / ed by Fun-Sun F Yao, Vinod Malhotra and Manuel L Fontes – 6th ed. – Philadelphia: Lippincott Williams and Wilkins, 2008.

POPULAR BOOKS

1. Anaesthesia OSCE / G Arthurs and KM Elfituri – 2nd ed – London: Greenwich Medical Media, 2002.

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

3. Benumof's airway management: principles and practice / ed by CA Hagberg – 2nd ed. – Philadelphia: Mosby Elsevier, 2007.

4. The clinical anaesthesia viva book / Simon J Mills; Simon Maguire and Julian M Barker – London: Greenwich Medical Media, 2002.

5. Clinical teaching: a guide to teaching practical anaesthesia / ed by J David Greaves; Chris Dodds; Chandra M Kumar and Berend Mets – Lisse: Swets and Zeitlinger, 2003.

6. Concise anatomy for anaesthesia / Andreas G Erdmann – London: Greenwich Medical Media, 2002.

7. Crisis management in anesthesiology / David M Gaba; Kevin J Fish and Steven K Howard – New York: Churchill Livingstone, 1994.

8. Equipment for anaesthesia and intensive care / WJ Russell – 2nd ed – Adelaide: W J Russell, 1997.

9. Evidence-based practice of anesthesiology / ed by Lee A Fleisher – Philadelphia: Saunders, 2004.

10. Foundations of anesthesia: basic sciences for clinical practice / ed by HC Hemmings and PM Hopkins – 2nd ed. Philadelphia: Mosby Elsevier, 2006.

11. Laryngeal mask anaesthesia: principles and practice / JR Brimacombe – 2nd ed. – Philadelphia: Saunders, 2005.

12. Ophthalmic anaesthesia / ed by Chandra M Kumar; Chris Dodds and Gary L Fanning – Netherlands: Swets and Zeitlinger, 2002.

13. Peripheral regional anesthesia: an atlas of anatomy and techniques / Gisela Meier and Johannes Buettner – New York: Thieme, 2005.

14. Pharmacology for anaesthesia and intensive care / TE Peck; SA Hill and M Williams – 2nd ed – London: Greenwich Medical Media, 2003.

15. A practical approach to cardiac anesthesia / ed by Frederick A Hensley; Donald E Martin and Glenn P Gravlee – 4th ed – Philadelphia: Lippincott Williams and Wilkins, 2008.

16. Practical perioperative transesophageal echocardiography / ed by David Sidebotham; Alan Merry and Malcolm Legget – Edinburgh: Butterworth Heinemann, 2003.

17. Regional anesthesia: an atlas of anatomy and techniques / ed by Marc B Hahn; Patrick M McQuillan and George J Sheplock – St Louis: Mosby, 1996.

18. Regional nerve blocks and infiltration therapy: textbook and colour atlas / Danilo Jankovic – 3rd ed. – Mass.: Blackwell Publishing, 2005.

19. Statistical methods for anaesthesia and intensive care / Paul Myles and Tony Gin – Oxford: Butterworth-Heinemann, 2000.

20. Yao and Artusio's anesthesiology: problem-oriented patient management / ed by Fun-Sun F Yao, Vinod Malhotra and Manuel L Fontes – 6th ed. – Philadelphia: Lippincott Williams and Wilkins, 2008.

Q & S

Report on Standards for the Year 2007

The major activity for standards has been internationally due to the retirement of the project manager for the main Australian standards committees dealing with anaesthesia and intensive care.

International Standards

ISOTC121—which is the international standards technical committee for anaesthetic and intensive care equipment—met in San Diego in June. Four subcommittees, **SC1**, **SC2**, **SC3** and **SC6** met.

This meeting heard a report from the Italian delegation on the death of 8 patients due to a pipeline error. In 2002, this hospital was opened with pipelines for air, oxygen, suction and nitrous oxide. In 2004, a new building with an intensive care ward was built. It included four pipelines. The pipelines were tested but not connected as the building was not put into use because of staff shortages. To this point, the pipeline construction appears to have been correct and there is clear documentation of the system.

In 2007, this second building was opened and the pipeline put into use. There is no record of who connected the pipeline into the building or how it was connected.

Supposition is that the connection was made by hospital staff. This connection crossed the oxygen and the nitrous oxide. Because it affected the coronary care unit, it is uncertain exactly how many were killed by the error. From an Australian point of view, could this accident have occurred here? I believe not because the Australian pipeline standard, AS2896, requires final testing by an anaesthetist. The standard states 'Final operational tests. Where non-respirable medical gases, eg. nitrous oxide, nitrogen are piped, tests shall be performed by the anaesthetist-in-charge or a delegated anaesthetist'. This testing would have identified the cross connection. Generally in New Zealand, installers use the British standard HTM2022. This does not involve a member from the anaesthetic department of the hospital, so the error could go undetected.

ISOTC121 SC1 WG9 discussed low pressure hose assemblies and agreed to include the Australian Sleeve Index System (SIS) as a recognised index. Whiplash from 'quick connections' was identified as a problem if the connection is at head height. Nitric oxide/nitrogen mixtures were removed from the standard and the maximum working pressure for hoses for driving gas was separated from the normal gas supply. The main SC1 committee met in the latter part of the week and discussed ISO DIS26825—user applied labels for use on syringes containing drugs used during anaesthesia.

This draft will be a final draft international standard and will create a uniform environment in anaesthesia for drug labeling across the world. The standard was originally proposed by Australia, using AS/NZS 4375 1996, our syringe labelling standard, as a basis.

ISO TC121 SC2 discussed aerosol nebulizers. At present, the calibration of nebulizers is very variable. The standard proposes a series of fine meshes to collect various size particles. This is an expensive but reliable system. This approach will reduce the variability and improve the accuracy of delivery into certain regions of the airways.

ISO TC121 SC6 reviewed, at Germany's request, the maximum allowable pressure for vacuum. The current value is difficult to achieve within some ceiling pendants. A proposal for the inclusion of stainless steel piping for medical gas systems was made. After much discussion, it was accepted that this is not excluded by the current standard. The committee considered a proposal to develop a standard for oxygen conserving devices. Canada suggested that there should be a standard for the extraction of laser plumes which is to be a new work item.

ISOTC121 SC 3 accepted the standard for CPAP devices. This standard should help the performance of devices such as those for sleep apnoea. This committee also spent a day considering the ramifications of the explosion of medical terminology to assist communication and interoperability. At present, SNOMED would appear to have the lead and although it is a private venture both the FDA and UK Health have purchased the system.
Because much of the equipment we use is imported, and indeed much of it has no manufacture in Australia or New Zealand, we can only influence manufacturers by having an international standard to specify. These standards will also be used across the world which increases the compliance incentive for manufacturers.

Australian Standards

Activity over the past 12 months has been subdued on the Australian/ New Zealand scene.

One committee which has met is HT021 to review AS3003. This revision has clarified which areas should be cardiac protected and hopefully this will reduce unnecessary areas of cardiac protection with associated cost reduction. The committee also identified that two 10 mA Residual current devices are available across the world. Only one, the type 1 RDC, reacts within the 40 msec window and is therefore suitable for protection with medical equipment.

Conclusion

Finally I would once again like to express my appreciation to those members who have contributed to standards. In most of the committees where we have representation, ours is the only medical input and this input is vital if workable practical ways are to be found to achieve a safe and functional environment.

JOHN RUSSELL

Adelaide

‘Can’t intubate, can’t ventilate’

‘Can’t intubate, can’t ventilate’ situations are amongst the most terrifying faced in anaesthetic practice.

This problem was highlighted in a recent coronial report which followed the death of a young woman, who died while being anaesthetised for elective abdominal surgery. After administration of a paralysing dose of atracurium, it became apparent that her trachea was not easy to intubate, and that effective ventilation by face mask or laryngeal mask was not possible. Eventually intubation of the trachea was achieved by the blind nasal route, but too late to save the patient’s life.

The patient suffered from torticollis, and had undergone a cervical spinal fusion 15 years earlier. She had undergone anaesthesia on at least one other previous occasion, but no attempt was made to access her past anaesthetic record. When the patient was asked about these preoperatively, she said she had not had problems. In fact there had been some difficulty with her airway, but of a relatively minor nature, and it was said in evidence that this was not severe enough to warrant informing the patient or general practitioner, or to justify arranging a medic alert bracelet.

The Coroner’s recommendation was as follows:

I recommend that anaesthetists be encouraged to adopt a practice of reporting difficulties with the ventilation or intubation of patients during anaesthesia to their referring physician and the patient in writing and to place a copy of the letter in the patient’s medical record.

We endorse the Coroner’s recommendation, recognising that there are many lessons from this tragic case. Adequate preoperative assessment of the airway is critically important in avoiding or preparing for such situations. Several excellent advanced airway management courses are available in Australia and New Zealand, and all anaesthetists should participate in these from time to time. In addition, regular practice in simulation centres in handling crises of this type should be undertaken by all anaesthetists.

ANZCA would assure the community of its commitment to avoiding this sort of tragedy in the future and to this end the Quality and Safety Committee is convening a meeting in early 2008 to review guidelines for emergency equipment for difficult intubations.

ALAN MERRY
New Zealand
PATRICIA MACKAY
Victoria

ALERT: Dantrolene dosage

The College has been advised by experts in the field that the recommended initial dose of intravenous Dantrolene for the treatment of Malignant Hyperthermia is 2.5mg/kg, not 1mg/kg. It is suggested that old posters displaying the lower dosage should be removed, and that a poster with the higher dosage be sought from the supplier.

The Australian and New Zealand Prospective Audit of Peripheral Nerve and Plexus Blockade

The Australian and New Zealand prospective audit of peripheral nerve and plexus blockade aims to determine the incidence of permanent neurological complications following peripheral nerve/plexus blockade. In addition, non-neurological side-effects and quality markers of clinical practice including efficacy, patient satisfaction and recovery are recorded. This project has full support from the Regional Anaesthesia Special Interest Group.

Large scale studies such as the one by Auroy indicate that the incidence of neurological complications following peripheral nerve/plexus blockade are rare[1]. However clinical practice is evolving with the increasing use of ultrasound to locate and block nerves/plexuses and with that new operators and procedures. The audit aims to collect data from tens of thousands of patients so that rare complications may be determined, and also so that precursors to adverse events may be detected. It has clear methodology, well defined follow-up procedures and uses standardised definitions[2] all of which were of variable quality in previous studies[3].

Data entry is via an online database **www.regional.anaesthesia.org.au**. Registering as a test user and entering test data (which will later be deleted) facilitates familiarity with this project. A test user can later be converted to a full registered user. The web-based interface facilitates ease of data entry, multi-centre collaboration and capture of other data so that the incidence of non-neurological complications can also be established[2]. The initial data entry takes two minutes and it is recommended that it occurs online in the intraoperative period, facilitating accurate data collection. It is also recommended that the local coordinator(s) have a hands-on approach and ideally have some non-clinical time allocated to this project. An alternative method of validating the denominator data should be established at each site. Postoperative follow-up occurs at 24-48 hrs (efficacy and block recession data) and for potential neurological complications at 7-10 days using a standardised online questionnaire. Reminders regarding follow-up are received via email. An important requirement is a commitment to the provision of a quality data collection process such that all relevant data from all patients are collected.

A clinical pathway for neurological assessment and investigation has been established following a recent study[4]. Triggers for referral, the referral pathway, and the standardised neurological questionnaire are located at **www.regional.anaesthesia.org.au**. A collaborative approach with a neurologist with expertise in peripheral neuropathies and nerve conduction studies is essential.

This project offers a unique opportunity for anaesthetists from Australia and New Zealand to collect data following peripheral nerve/plexus blockade. When completed, it should be of value to anaesthetists worldwide. Anaesthetists from Anaesthesia groups and departments (public, private, large or small) are invited to participate in this project. To learn more visit **www.regional.anaesthesia.org.au**.

DR MICHAEL BARRINGTON

Project Coordinator
Department of Anaesthesia
St Vincent's Hospital, Melbourne
michael.barrington@svhm.org.au

1 Auroy Y, Benhamou D, Bargues L, Ecoffey C, Falissard B, Mercier FJ, Bouaziz H, Samii K. Major complications of regional anesthesia in France: The SOS Regional Anesthesia Hotline Service. *Anesthesiology* 2002;97:1274-80.
2 Schulz-Stubner S, Kelley J. Regional Anesthesia Surveillance System: first experiences with a quality assessment tool for regional anesthesia and analgesia. *Acta Anaesthesiol Scand* 2007.
3 Brull R, McCartney CJ, Chan VW, El-Beheiry H. Neurological complications after regional anesthesia: contemporary estimates of risk. *Anesth Analg* 2007;104:965-74.
4 Watts SA SD. Long-term neurological complications associated with surgery and peripheral nerve blockade: outcomes after 1065 consecutive blocks. *Anaesth Intensive Care* 2007;35:24-31.

Dean's message

Dr Richard Lee

Avocation

- a calling or occupation
- a hobby or pastime

DR RICHARD LEE

A common theme can be discerned in recent changes to the intensive care scene. These developments include:

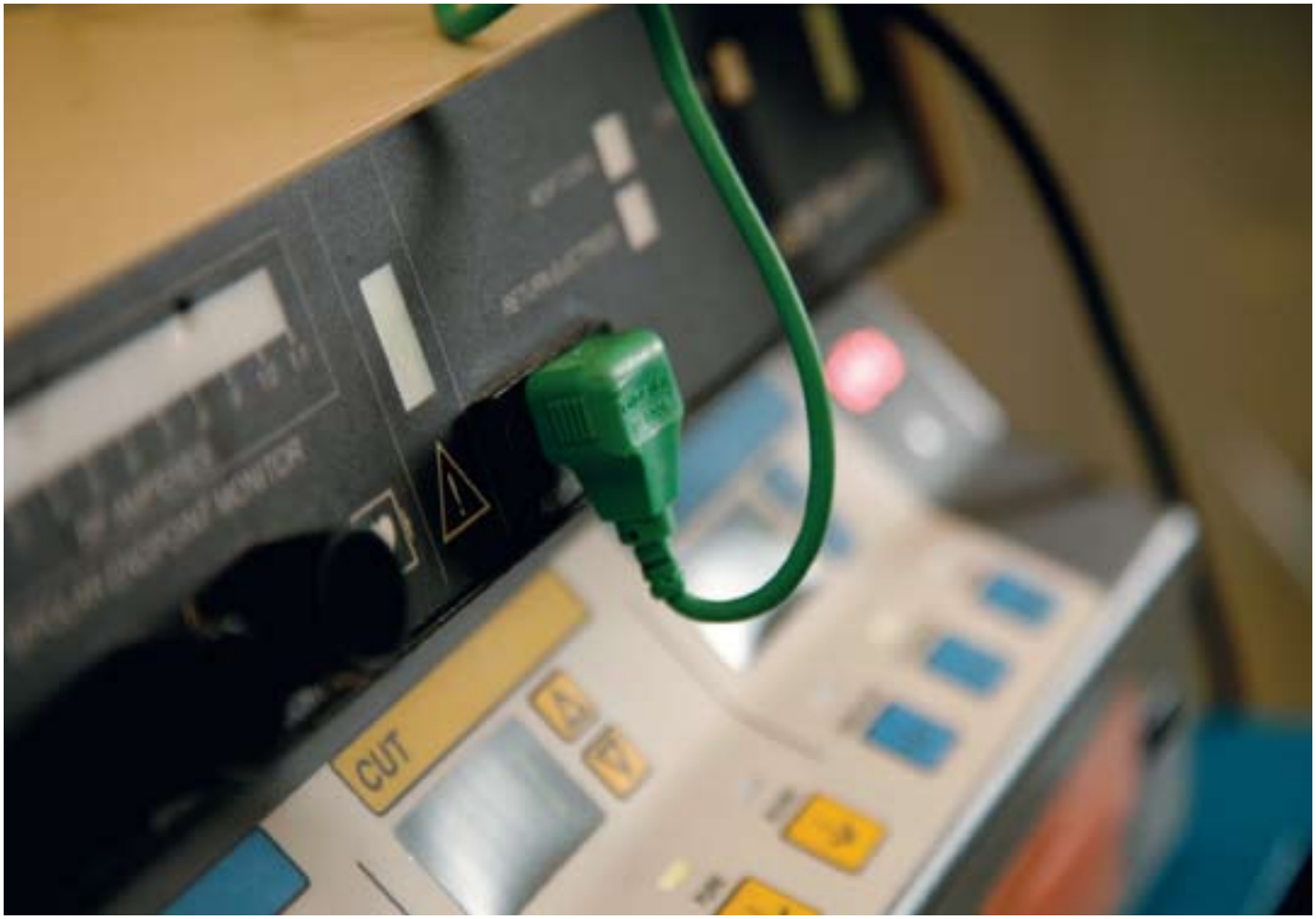
- Sadly, the death of Don Harrison after a most productive career. Don, aged 75, was still working to improve patient care as a teacher in the simulation centre now named after him.
- The appointment of Rinaldo Bellomo as Editor-In-Chief of Critical Care and Resuscitation. Tub Worthley spawned and grew the Journal and Vernon van Heerden has taken it on to indexation and professional production. Rinaldo's appointment moves the JFICM Journal into the next phase of development as a high impact journal in the world of intensive care medicine.
- The presentation of 61 candidates at the latest Fellowship Examination and passing of 40. It was an exhausting process for all involved. The resources of two major Perth hospitals and 33 examiners were needed to complete the task very successfully.
- The latest NHMRC Grant round results. Members of the intensive care community were very successful. The total grants to the group approached $5M.
- ANZCA Foundation Grant results. Fellows were also successful in this round receiving approximately 30% of the grants.
- The notice of retirement of several key board members. This will lead to a Board Election and search for the next generation of fellows interested in Joint Faculty affairs, training, assessment and continuing education.
- The shifting of some assessments into training time and the associated increase in work for Supervisors of Training.
- The commencement of planning for several mega units in Australia with greater than 50 beds and needing perhaps more than 20 specialists with diverse non-clinical portfolios.

The theme revolves around the commitment of intensivists as volunteers to specialty affairs. I don't believe that we should try to dissect or excessively analyse why highly talented and hardworking doctors give of their time unpaid. Whether the desire to volunteer is driven by altruism, sense of debt or sense of duty to the specialty, desire for personal growth, continuing education or professional development or the enjoyment of the social mix, it appears to be driven internally. Often called intrinsic motivation by psychologists; whatever the impetus, it is clear that the specialty is dependent on and indebted to these workers.

'JFICM will need an understanding of the particular intrinsic motivation and areas of interest of future generations to harness their skills. It will require facilitation more than external motivation.'

The question arises as to how we sustain this effort into the future.

It has been suggested that we should pay volunteers for their time, but simple maths would suggest that it would be impossible. A straightforward addition—even neglecting travel and preparation time—shows that in a year, the time worked by JFICM Board members and examiners would total more than 4,200 hours. For ANZICS, it would also mean funding hours of diverse work provided by Board members, database committees, PRICE Committee, Foundation executive and members of the CTG. Paid at even minimum rates, this would financially cripple organisations such as ours.



The literature also suggests that providing external motivation—such as financial incentives or rewards—minimalises or trivialises the work, removes or distracts from the true incentives and discourages continuing the effort. Researchers identify the effect and liken it to that of attempting to pay your friends for dinner at their house.

It has also been suggested that future generations will be less inclined to volunteer. I do not believe this is true. Members of generation X will be our next leaders. They have grown up in a unique environment of technological innovation. Members are often characterised as individualistic or even, in Wikepedia, as 'apathetic, cynical, disaffected, streetwise loners and slackers [sic]'. These simplifications have no inherent truths and in no way suggest that the desire to help has been bred out of doctors belonging to generation X. In fact, the belief that generations are divided by values and attitudes is not supported by evidence, which actually suggests the differences are due more to varying life stages.

As one of the fathers of modern economics, Adam Smith, wrote in 1759, 'How selfish soever man may be supposed, there are evidently some principles in his nature, which interest him in the fortunes of others, and render their happiness necessary to him, though he derives nothing from it, except the pleasure of seeing it.' He must have been observing a Supervisor of Training with trainees.

Nonetheless, JFICM will need an understanding of the particular intrinsic motivation and areas of interest of future generations to harness their skills. It will require facilitation more than external motivation. JFICM will assess ways, as well as reimbursing costs, to help make it possible for the next group of fellows to continue to give a part of their busy lives, without unreasonable sacrifice, by:

- Valuing non-patient contact work in regulations and documents;
- Stressing to hospitals the provision of non-clinical time during accreditation inspections;
- Providing backfill salaries to hospitals to cover office bearers with busy portfolios; and
- Employing professional officers to support more roles.

We do not know that we will be successful, but we do know that JFICM is, and will be, dependent on volunteers for the support of the systems, which maintain the structure of our specialty (accredited hospitals, training schemes, research, examinations, courses, CME, conferences) and justify our processes to bodies such as the ACCC, AMC and the jurisdictions.

DR RICHARD LEE
Dean

Joint Faculty of Intensive Care Medicine

Dean's message

Dr Roger Goucke

On Friday the 19th of October, Access Economics, along with the MBF, launched a report outlining the economic impact of Persistent Pain in Australia 2007.

DR ROGER GOUCKE

Many of you will not be surprised at the enormous dollar value that can be attributed to persistent pain. Pain has been ranked fourth in prevalence order after visual disorders, musculoskeletal conditions and cardiovascular disorders, and third in health expenditure order following cardiovascular and musculoskeletal conditions.

Following an extensive review and using, among others, AIHW data, Access Ecomomics have estimated (for 2007) that the total cost of chronic pain will be over 34 billion dollars. In this fascinating report, there are useful estimations of who bears this enormous cost, with just over 50% being borne by individuals themselves and over 25% via Federal and State governments.

Fellows are urged to read this report and bring it to the attention of hospital administrators and State and Federal politicians. It should be useful at all levels, to easily justify and hopefully argue strongly for more funding to address the needs of our patients with pain.

The report may be accessed at: http://www.accesseconomics.com.au/publicationsreports/showreport.php?id=142&searchfor=2007&searchby=year

October saw the conclusion of the 'Global Year Against Pain in Older Persons'. With the increase in Australia's population together with the changing demographics relating to age, it is predicted that by 2050 there will be over 5 million Australians experiencing chronic or persistent pain with a significant number (>10%) over the age of 80 years. So, although the year to bring the plight of elders with pain to our attention has passed, the issue will remain and continue to require our input.

As Pain in Older Persons closes, the Global Year Against Pain in Women, subtitled 'Real Women, Real Pain', opens. This IASP campaign aims to empower women and raise awareness of pain issues affecting women world-wide.
The IASP website (www.iasp-pain.org) has a number of excellent fact sheets covering all the significant issues. In the western world, apart from pain related conditions specific to women, several other common painful conditions are much more common. Migraine has a 2.5 to 1, chronic widespread pain syndrome (fibromyalgia) has a 4 to 1 and irritable bowel syndrome also a 4 to 1 increased prevalence in women.

The Faculty will take the opportunity during this year to develop links with our Gynaecological colleagues, to develop more multidisciplinary services for female chronic pelvic pain.

With the data provided by Access Economics and the excellent information provided by the IASP, I hope that Fellows of our Faculty can continue to lead the way in developing better preventative and treatment services for our patients.

DR ROGER GOUCKE
Dean

Highlights from the Board Meeting

Held on 11 October 2007

HIGHLIGHTS FROM THE BOARD MEETING

Fellowship

In October, Drs Michelle Tan and David Chung were admitted to Fellowship by training and examination.

FINANCE

2008 Subscriptions and Fees

The Board acknowledged a need for an 8% increase in annual subscriptions and an increase in fees for 2008 in line with ANZCA's, reflecting the increased activity within the Faculty and the need to provide adequate resources to meet initiatives arising from committee activity and the strategic planning process.

EDUCATION AND TRAINING

Australian Curriculum Framework for Junior Doctors – PGY1&2

Professor Ted Shipton and Dr Jane Trinca will represent the Faculty at the inaugural meeting of the Institute for Medical Education and Training (IMET) in Sydney. IMET will be driving the development of the PGY1 and 2 educational program. A document has been developed for circulation to the CPMEC outlining desired minimal skills to be used as a basis to develop the PGY1 and 2 curriculum.

Undergraduate Medical Curriculum

A document on *Pain and the Undergraduate Medical Curriculum*, outlining the learning objectives for medical undergraduates, was accepted for circulation to Curriculum Committee Chairs. This information will also be made available to Fellows through the Faculty website.

Responses from medical schools to recent communications indicate a raised awareness of pain medicine in the undergraduate curriculum.

Blueprinting

The multidisciplinary Blueprinting Sub-committee will continue to progress the development of a blueprint of the Fellowship program. A recent meeting focused on the conceptual frameworks of what defines a Pain Medicine specialist. The process is expected to take approximately 12 months with a face-to-face meeting planned during the ASM in May 2008.

FPM Training Program

The Board considered drafts of a *Training Agreement*, outlining the responsibilities of both the Trainee and the Faculty, and a *Trainee Performance Review* document, outlining the process for independent review of a trainee with difficulties. It was agreed that input be sought from Supervisors of Training to the *Training Agreement* and further revisions were suggested to the *Trainee Performance Review*.

A Trainee Newsletter has been developed and it is hoped this will develop into a more substantial communication and will encourage trainees to interact.

The Board discussed exposure to Paediatric Pain and it was noted that there are not currently many Faculty-accredited paediatric facilities to provide this training. The possibility of a Paediatric Pain Medicine training program was raised and it was agreed that further consideration be given on how to move this forward.

Supervisors of Training

A Supervisor of Training Workshop was convened during the inaugural Spring Meeting focusing on the development of a trial Mini-CEX (Clinical Evaluation Exercise) on Neuropathic Pain and a marking guide. Mini-CEX is a formative in-training assessment which provides a snapshot of doctor/patient interaction designed to assess the clinical skills, attitudes and behaviours of trainees essential to providing high quality care.

Continuing Professional Development

The revised ANZCA/FPM CPD Program will be launched in January 2008. Documentation associated with the new CPD Program is available on the Faculty website. Fellows are encouraged to explore these documents. A randomly selected audit of 5% of the Fellowship's 2006/2007 MOPS returns has been undertaken.

EXAMINATION

Sixteen trainees attended the pre-examination Workshop at the Royal Adelaide Hospital in September and seventeen candidates have registered for the examination to be held in Geelong, 28-30 November 2007.

TRAINING UNIT ACCREDITATION

The Royal Hobart Hospital was reaccredited for Pain Medicine training for a period of 5 years and an individual joint training program between Axxon Health/ Greenslopes Private Hospital and the Royal Brisbane Hospital was approved for one trainee for 2008.

RESEARCH

The Dean's Prize/FPM Free Papers session will be held on Sunday 4 May 2008 during the ASM. In addition to the Dean's Prize for the Fellow/Trainee judged to have presented the most original Pain Medicine/Pain Research Paper of sufficient standard, a Best Free Papers Prize in the form of a certificate will be presented to the best Free Paper for those not eligible for the Dean's Prize.

At the Melbourne ASM workshop, participants had been strongly in favour of developing a minimum dataset and to develop outcome measures. A sub-committee has been formed to progress this initiative and further consultation with the Fellowship is anticipated. The Research Committee will make contact with the Australasian Rehabilitation Outcomes Centre (AROC) and seek their input to quality outcome measures.

Admission to Fellowship of the Faculty of Pain Medicine

By training and examination:

- Dr Michelle Tan - WA
- Dr David Chung - QLD

Professor Stephan Schug was nominated to represent the Faculty on the ANZCA Research Committee.

PROFESSIONAL

PM1 (2006) Policy for Trainees Seeking Faculty Approval of Programs for Training in Multidisciplinary Pain Medicine

The Board moved that this document be rescinded and that the Administrative Instructions be revised and used as the reference source for entry into training and Fellowship of the Faculty.

Opioid Prescribing

The Board noted the RACP/AChAM working group's interim draft recommendations with regard to the management of pain in people with drug dependence and prevention of drug dependence in management of CNMP. Recommendations include a uniform system for monitoring prescriptions and tracking diversions. The working Group is looking at existing guidelines and attempting to standardise them. Further input is being sought locally and from New Zealand.

Interdisciplinary Opioid Taskforce

A recommendation made to the CPMC and AMA that the Faculty attempt to coordinate an Interdisciplinary Opioid Taskforce to address issues relevant to the Faculty has met with a positive response. It was hoped that this would also find some political support. The need to engage GPs in the process was acknowledged. It will be a natural successor to the RACP/AChAM working group and be able to work on the application or their recommendations.

Recognition of Pain Medicine as a Specialty – New Zealand

The Board reviewed the latest draft and, following input from New Zealand Board Members and the Chairman and Executive Officer of the NZNC, it was anticipated the application would be submitted before the end of the year.

CONTINUING EDUCATION

2008 ASM Sydney and Refresher Course Day

The Faculty's 2008 Annual Scientific Meeting Program is in the final planning stages and will be published on the ASM website http://anzca2008asm.com. The FPM Foundation Visitor is Professor Quinn Hogan (USA), who will undertake a regional visit to Western Australia following the ASM. Dr Linda Watkins (USA) is the NSW Visitor (Pain Medicine). The Refresher Course Day Theme is 'Pain and Opioids'. Registration brochures will be circulated early in the new year.

2010 ASM Christchurch

Professor Ted Shipton was appointed Faculty Convenor for 2010.

Inaugural Spring Meeting 12-14 October 2007

The Faculty's inaugural Spring Meeting, in conjunction with the Medico-Legal Society of Queensland attracted 128 delegates, 3 major sponsors and 6 exhibitors. Professor Atkinson and Dr Moore and Mr David Tait were praised for their efforts in convening this very successful inaugural meeting. Ms Christine Gill, Conference Secretariat, was commended on her organisation of the event.

Spring Meeting 2008

The venue and time were confirmed as the Uluru Meeting Place, Ayers Rock, 18-20 September 2008. The meeting will be held in conjunction with the ANZCA/ASA Acute Pain SIG and the IASP Acute Pain SIG.

American Academy of Pain medicine Meeting – Hawaii 2009

The Board is keen to expand the relationship with the AAPM and there was support to accept the opportunity for involvement in the AAPM 2009 meeting in Hawaii.

CORPORATE AFFAIRS

Board Restructure

In further discussion of the Board restructure, to take effect from May 2008, it was agreed that not all committee Chairs were required to be Board Members. The Faculty's Administrative Instructions will be amended to reflect the new structure. The role of 'Censor' will be changed to 'Assessor' from May 2008.

2008 Board Election

There will be four vacancies on the Board in the 2008 election. One vacancy must be filled by a FANZCA FFPMANZCA and one vacancy by a FRANZCP FFPMANZCA. The remaining two vacancies may be filled by FFPMANZCAs from any of the five participating specialties. Nomination forms will be circulated to Fellows by mail and must be in the hands of the Executive Officer before 5.00pm on Friday 1 February 2008.

Visitors to the Board

Mr Ian Dickinson, Chair, Professional Development and Standards Board, RACS, met with the Board and discussion focused on progressing an MoU between RACS and the Faculty. It was reported that, in considering the draft MoU, Presidents of the specialty societies had been supportive of a Pain Medicine module or theories of pain management and a number of synergies were evident in the training of surgeons and the professional development area. Opportunities for interaction were discussed, including examination tools and processes, delivery of a Pain Module and opportunities to advertise CPD activities.

Dr Christine Tippett, President of the RANZCOG has been invited to the February 2008 Board Meeting.

2007 Spring Meeting

Waves of Change in Pain and Suffering

The inaugural Spring Meeting of the Faculty of Pain Medicine in association with the Medico-Legal Society of Queensland was held at the Sheraton Mirage Resort and Spa, Gold Coast from 12-14 October 2007. The event was highly successful, with 129 delegates in attendance over the three days.

Entitled 'Waves of Change in Pain and Suffering', this meeting featured a number of outstanding medical and legal speakers, including Professor Dan Carr, Tufts University, Boston, USA; The Hon. Cecil William Pincus QC, Professor of Law, Queensland; Alastair Lynch, Former Captain, Brisbane Lions and Nikki Hudson, Captain of the Australian Hockeyroos. We would like to thank all the presenters for their contribution and expertise.

The meeting focused on advances and new developments for Pain Physicians and lawyers and explored topics such as the 'Clinical Assessment of Neurpoathic Pain'; 'Pain and Sport Injuries'; 'Chronic Pain and Recovery' and much more.

The social program included the Conference Dinner at L'Esprit on the Water which allowed delegates the chance to unwind with colleagues in a relaxed atmosphere. The meeting also acknowledges the generous support of all the sponsors and exhibitors.

On behalf of the Organising Committee, we encourage all Fellows and Trainees to attend the 2008 Spring Meeting of the Faculty of Pain Medicine, the Acute Pain SIG of ANZCA, ASA and NZSA and the Acute Pain SIG of IASP. This will be held at the Voyages Resort, Ayers Rock, from 18-20 September. The theme of the meeting is 'Pain at the Centre'.

A/PROF LEIGH ATKINSON
DR BRENDAN MOORE

Co-Convenors, 2007 Spring Meeting

Top to bottom, left to right:
> Dr Roger Goucke and Dr Michael Butler
> Delegates enjoying the Conference Dinner
> Presentation by A/Prof Leigh Atkinson on 'Pain and Western Art' at the Conference Dinner
> Dr Roger Goucke and Professor Dan Carr
> Alastair Lynch, Nikki Hudson and Dr Brendan Moore
> Delegates form a rapt audience during a lecture session

Below:
> Delegates enjoying the Conference Dinner

Faculty of Pain Medicine Professional Documents

PM2	(2005)	Guidelines for Units Offering Training in Multidisciplinary Pain Medicine
PM3	(2002)	Lumbar Epidural Administration of Corticosteroids
PM4	(2005)	Guidelines for Patient Assessment and Implantation of Intrathecal Catheters, Ports and Pumps for Intrathecal Therapy
PM5	(2006)	Policy for Supervisors of Training in Pain Medicine
PM6	(2007)	Guidelines for Longterm Intrathecal Infusions (Analgesics/Adjuvants/Antispasmodics)
PS3	(2003)	Guidelines for the Management of Major Regional Analgesia
PS38	(2004)	Statement Relating to the Relief of Pain and Suffering and End of Life Decisions
PS40	(2005)	Guidelines for the Relationship Between Fellows and the Healthcare Industry
PS41	(2007)	Guidelines on Acute Pain Management
PS45	(2001)	Statement on Patients' Rights to Pain Management
PS48	(2003)	Statement on Clinical Principles for Procedural Sedation
PS49	(2003)	Guidelines on the Health of Specialists and Trainees

ANZCA Professional Documents adopted by the Faculty:

PS4	(2006)	Recommendations for the Post-Anaesthesia Recovery Room (Adopted February 2001)
PS7	(2003)	Recommendations on the Pre-Anaesthesia Consultation (Adopted November 2003)
PS8	(2003)	Guidelines on the Assistant for the Anaesthetist (Adopted November 2003)
PS9	(2007)	Guidelines on Conscious Sedation for Diagnostic, Interventional Medical and Surgical Procedures (May 2002)
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 with amendment to the title to read Recommendations for the Perioperative Care of Patients Selected for Day Care Procedures (Adopted February 2001)
PS18	(2006)	Recommendations on Monitoring During Anaesthesia (Adopted February 2001)
PS20	(2006)	Recommendations for Responsibilities of the Anaesthetist in the Post-Operative Period (Adopted February 2001)
PS31	(2003)	Recommendations on Checking Anaesthesia Delivery Systems (Adopted July 2003)
T1	(2006)	Recommendations on Minimum Facilities for Safe Anaesthesia Practice in Operating Suites (Adopted May 2006)

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	(2005)	Recommendations for Hospitals Seeking College Approval for Vocational Training in Anaesthesia
TE2	(2006)	Policy on Vocational Training Modules and Module Supervision (interim review)
TE3	(2006)	Policy on Supervision of Clinical Experience for Vocational Trainees in Anaesthesia
TE4	(2003)	Policy on Duties of Regional Education Officers in Anaesthesia
TE5	(2003)	Policy for Supervisors of Training in Anaesthesia
TE6	(2006)	Guidelines on the Duties of an Anaesthetist
TE7	(2005)	Guidelines for Secretarial and Support Services to Departments of Anaesthesia
TE8	(2003)	Guidelines for the Learning Portfolio for Trainees in Anaesthesia
TE9	(2005)	Guidelines on Quality Assurance in Anaesthesia
TE10	(2003)	Recommendations for Vocational Training Programs
TE11	(2003)	Formal Project Guidelines
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	(2006)	Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations
T3	(2006)	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 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	(2003)	Recommendations on the Pre-Anaesthesia Consultation
PS8	(2003)	Guidelines on the Assistant for the Anaesthetist
PS9	(2007)	Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical Procedures
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	(2001)	Statement on the Standards of Practice of a Specialist Anaesthetist
PS18	(2006)	Recommendations on Monitoring During Anaesthesia
PS19	(2006)	Recommendations on Monitored Care by an Anaesthetist
PS20	(2006)	Recommendations for Responsibilities of the Anaesthetist in the Post-Operative Period
PS21	(2003)	Guidelines on Conscious Sedation for Dental Procedures
PS24	(2004)	Guidelines on Sedation for Gastrointestinal Endoscopic 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	(2002)	Statement on Anaesthesia Care of Children in Healthcare Facilities without Dedicated Paediatric Facilities
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	(2001)	Statement on Patients' Rights to Pain Management
PS46	(2004)	Recommendations for Training and Practice of Diagnostic Perioperative Transoesophageal Echocardiography in Adults
PS47	(2002)	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	(2003)	Guidelines on the Health of Specialists and Trainees
PS50	(2004)	Recommendations on Practice Re-entry for a Specialist Anaesthetist

PROFESSIONAL DOCUMENTS UNDER REVIEW

In line with College policy, the following Professional Documents are due for review in 2008:

TE4	Policy on Duties of Regional Education Officers in Anaesthesia
TE5	Policy for Supervisors of Training in Anaesthesia
TE8	Guidelines for the Learning Portfolio for Trainees in Anaesthesia
TE10	Recommendations for Vocational Training Programs
TE11	Formal Project Guidelines
TE13	Guidelines for the Provisional Fellowship Program
TE17	Policy on Advisors of Candidates for Anaesthesia Training
PS3	Guidelines for the Management of Major Regional Analgesia
PS7	Recommendations on the Pre-Anaesthesia Consultation
PS8	Recommendations on the Assistant for the Anaesthetist
PS21	Guidelines on Conscious Sedation for Dental Procedures
PS31	Recommendations on Checking Anaesthesia Delivery Systems
PS39	Minimum Standards for Intrahospital Transport of Critically Ill Patients
PS48	Statement on Clinical Principles for Procedural Sedation
PS49	Guidelines on the Health of Specialists and Trainees

Council will welcome any input or suggestions relating to these documents which will be considered during the review.

PS9

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GUIDELINES ON SEDATION AND/OR ANALGESIA FOR DIAGNOSTIC AND INTERVENTIONAL MEDICAL OR SURGICAL PROCEDURES

This document is intended to apply wherever procedural sedation and/or analgesia for diagnostic and interventional medical and surgical procedures are administered, especially where sedation and/or analgesia may lead to general anaesthesia. The Australian and New Zealand College of Anaesthetists recognises that practitioners with diverse qualifications and training are administering a variety of medications to patients to allow such procedures to be performed. This document addresses pertinent issues for all practitioners involved in such activities.

1. DEFINITIONS

1.1 Procedural sedation and/or analgesia implies that the patient is in a state of drug-induced permissiveness of uncomfortable or painful diagnostic or interventional medical or surgical procedures. Lack of memory of distressing events and/or analgesia are desired outcomes, but lack of response to painful stimulation is not assured.

1.1.1 Conscious Sedation is defined as a drug-induced depression of consciousness during which patients are able to respond purposefully to verbal commands or light tactile stimulation. No interventions are usually required to maintain a patent airway, spontaneous ventilation or cardiovascular function. Conscious sedation may be achieved by a wide variety of techniques and may accompany local anaesthesia. All conscious sedation techniques should provide a margin of safety that is wide enough to render loss of consciousness unlikely.

1.1.2 Deep levels of sedation, where consciousness is lost and patients only respond to painful stimulation, are associated with loss of the ability to maintain a patent airway, inadequate spontaneous ventilation and/or impaired cardiovascular function. Deep levels of sedation may have similar risks to general anaesthesia, and may require an equivalent level of care.

1.1.3 Analgesia is reduction or elimination of pain perception, usually induced by drugs which act locally (by interfering with nerve conduction) or generally (by depressing pain perception in the central nervous system).

1.2 General Anaesthesia is a drug-induced state characterised by absence of response to any stimulus, loss of protective airway reflexes, depression of respiration and disturbance of circulatory reflexes. General anaesthesia is sometimes indicated during diagnostic or interventional medical or surgical procedures and requires the exclusive attention of an anaesthetist (see College Professional Document T1 – *Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations*).

2. AIMS AND RISKS OF PROCEDURAL SEDATION AND/OR ANALGESIA

The aims of procedural sedation and/or analgesia are to ensure patient safety and comfort, and to facilitate completion of the planned procedure. In order to achieve these aims, a range of sedation options may be required during any one procedure, with a continuum from no medication, through conscious sedation and deep sedation, to general anaesthesia. While no sedation or conscious sedation with small doses of drugs such as benzodiazepines and opioids are options for some patients and proceduralists, many patients and proceduralists want deep levels of sedation or general anaesthesia to be an option during each procedure.

Practitioners authorised or credentialled to administer procedural sedation and/or analgesia should be aware that the transition from complete consciousness through the various depths of sedation to general anaesthesia is a continuum and not a set of discrete, well-defined stages. The margin of safety of drugs used to achieve sedation and/or analgesia varies widely between patients and loss of consciousness with its attendant risk of loss of protective reflexes may occur rapidly and unexpectedly. Therefore practitioners who administer sedative or analgesic drugs that alter the conscious state of a patient must be prepared to manage the following potential risks:

2.1 Depression of protective airway reflexes and loss of airway patency.

2.2 Depression of respiration.

2.3 Depression of the cardiovascular system.

2.4 Drug interactions or adverse reactions, including anaphylaxis.

2.5 Individual variations in response to the drugs used, particularly in children, the elderly, and those with pre-existing medical disease.

2.6 The possibility of deeper sedation or anaesthesia being used to compensate for inadequate analgesia or local anaesthesia.

2.7 Risks inherent in the wide variety of procedures performed under procedural sedation and/or analgesia.

2.8 Unexpected extreme sensitivity to the drugs used for procedural sedation and/or analgesia which may result in unintentional loss of consciousness, respiratory or cardiovascular depression.
Over-sedation, airway obstruction, respiratory or cardiovascular complications may occur at any time. Therefore, to ensure high standards of quality safe patient care, the following guidelines are recommended.

3. PATIENT PREPARATION

3.1 The patient should be provided with written information which includes the nature and risks of the procedure, preparation instructions (including the importance of fasting), and what to expect during the immediate and longer term recovery period, including after discharge.

3.2 Informed consent for sedation and/or analgesia and for the procedure should be obtained (see College Professional Document PS26 – *Guidelines on Consent for Anaesthesia or Sedation*).

4. PATIENT ASSESSMENT

4.1 All patients should be assessed before procedural sedation and/or analgesia. Assessment should include:

4.1.1 Details of the current problem, co-existing and past medical and surgical history, history of previous sedation and anaesthesia, current medications (including non-prescribed medications), allergies, fasting status, the presence of false, damaged or loose teeth, or other evidence of potential airway problems.

4.1.2 Examination, including that relevant to the current problem, of the airway, respiratory and cardiovascular status, and other systems as indicated by the history.

4.1.3 Results of relevant investigations.

4.2 This assessment should identify those patients with special risks, such as patients in ASA Grades P-3 to P-5 (see Appendix I), including the elderly and those with severely limiting heart disease, cerebrovascular disease, lung disease, liver failure, acute gastrointestinal bleeding with cardiovascular compromise or shock, severe anaemia, morbid obesity, and previous adverse events due to sedation/analgesia/anaesthesia. In addition, the potential for aspiration of gastric contents must be considered and prevented, if necessary by endotracheal intubation. An anaesthetist should be present to administer sedation in the patients identified in this section. See also College Professional Document PS7 – *Recommendations on the Pre-Anaesthesia Consultation*.

5. STAFFING

5.1 There must be a minimum of three appropriately trained staff present: the proceduralist, the practitioner administering sedation and monitoring the patient, and at least one additional staff member to provide assistance to the proceduralist and/or the practitioner providing sedation as required.

5.2 The assistant to the practitioner administering sedation/anaesthesia must be exclusively available to the practitioner at induction of and emergence from sedation/anaesthesia, and during the procedure as required. If general anaesthesia is intended, and especially in emergency situations where endotracheal intubation is planned, a fourth person to specifically assist the practitioner throughout the procedure is required. (See College Professional Document PS8 *Guidelines on the Assistant to the Anaesthetist*)

5.3 The practitioner administering procedural sedation and analgesia requires sufficient training to be able to:

5.3.1 Understand the actions of the drugs being administered, and be able to modify the technique appropriately in patients of different ages, or in the case of concurrent drug therapy or disease processes.

5.3.2 Monitor the patient's level of consciousness and cardiorespiratory status.

5.3.3 Detect and manage appropriately any complications arising from sedation.

PS9 continued

(2007)

5.4 A medical practitioner who is skilled in airway management and cardiopulmonary resuscitation must be present whenever procedural sedation and/or analgesia are administered.

5.5 Techniques intended to produce deep sedation or general anaesthesia must not be used unless an anaesthetist is present (see College Professional Documents PS1 *Recommendations on Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia*, PS2 *Statement on Credentialling in Anaesthesia*, PS8 *Guidelines on the Assistant to the Anaesthetist*, PS16 *Statement on the Standards of Practice of a Specialist Anaesthetist*, TE3 *Policy on Supervision of Clinical Experience for Trainees in Anaesthesia*, T1 *Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations*).

5.6 In situations other than those when an anaesthetist must be present (noted in 4.2 and 5.5), administration of sedation and/or analgesia and monitoring of the patient should be performed by an appropriately trained medical practitioner other than the proceduralist.

5.7 If an appropriately trained medical practitioner is not present solely to administer sedation and/or analgesia and monitor the patient, there must be an assistant to the proceduralist present during the procedure, who is appropriately trained in observation and monitoring of sedated patients, and in resuscitation, and whose sole duty is to monitor the level of consciousness and cardiorespiratory status of the patient. This person may, if appropriately trained, administer sedative and/or analgesic drugs under the direct supervision of the proceduralist, who must have advanced life support skills and training (see 5.4). If loss of consciousness, airway obstruction or cardiorespiratory insufficiency occur at any time, all staff must devote their entire attention to monitoring and treating the patient until recovery, or until such time as another medical practitioner becomes available to take responsibility for the patient's care.

6. FACILITIES AND EQUIPMENT

The procedure must be performed in a location which is adequate in size, and staffed and equipped to deal with a cardiopulmonary emergency. This must include:

6.1 Adequate room to perform resuscitation should this prove necessary.

6.2 Appropriate lighting.

6.3 An operating table, trolley or chair which can be tilted head down readily.

6.4 An adequate suction source, catheters and handpiece.

6.5 A supply of oxygen and suitable devices for the administration of oxygen to a spontaneously breathing patient.

6.6 A means of inflating the lungs with oxygen (e.g. a self-inflating bag) together with a range of equipment for advanced airway management (e.g. masks, oropharyngeal airways, laryngeal mask airways, laryngoscopes, endotracheal tubes).

6.7 Appropriate drugs for cardiopulmonary resuscitation and a range of intravenous equipment and fluids (See Appendix II).

6.8 Drugs for reversal of benzodiazepines and opioids.

6.9 A pulse oximeter.

6.10 A sphygmomanometer, or other device for measuring blood pressure.

6.11 Ready access to an ECG and a defibrillator.

6.12 A means of summoning emergency assistance.

6.13 Within the facility there should be access to devices for measuring expired carbon dioxide.
(See College Professional Documents T1 *Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations*, PS15 *Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery*.)

7. TECHNIQUE AND MONITORING

7.1 Reliable venous access should be in place for all procedures when procedural sedation and/or analgesia are used.

7.2 As most complications of sedation are cardiorespiratory, doses of sedative and analgesic drugs should be kept to the minimum required for patient comfort, particularly for those patients at increased risk.

7.3 Monitoring of the patient's response to verbal commands must be routine. Loss of patient response to verbal commands indicates that loss of airway reflexes, respiratory and/or cardiovascular depression are likely.

7.4 All patients undergoing procedural sedation and/or analgesia must be monitored continuously with pulse oximetry and this equipment must alarm when appropriate limits are transgressed.

7.5 There must be regular recording of pulse rate, oxygen saturation and blood pressure throughout the procedure in all patients.

7.6 According to the clinical status of the patient, other monitors such as ECG or capnography may be required (see College Professional Document PS18 *Recommendations on Monitoring During Anaesthesia*).

8. OXYGENATION

Hypoxaemia may occur during procedural sedation and/or analgesia without oxygen supplementation. Oxygen administration diminishes hypoxaemia during procedures carried out under sedation /or analgesia, and must be used in all patients. Pulse oximetry enables the degree of tissue oxygenation to be monitored and must be used in all patients during procedural sedation and/or analgesia.

9. MEDICATIONS

A variety of drugs and techniques are available for procedural sedation and/or analgesia. The most common intravenous agents used are benzodiazepines (such as midazolam) for sedation and opioids (such as fentanyl) for analgesia. Even small doses of these drugs may result in loss of consciousness in some patients. Special care is required when local anaesthesia of the larynx and/or pharynx has been administered to facilitate the procedure.

Intravenous anaesthetic agents such as propofol or thiopentone must only be used by a medical practitioner trained in the use of anaesthetic agents and techniques, because of the risk of unintentional loss of consciousness. These agents must not be administered by the proceduralist.

10. DOCUMENTATION

The clinical record should include the names of staff performing sedation and/or analgesia, with documentation of the history, examination and investigation findings. A written record of the dosages of drugs and the timing of their administration must be kept as a part of the patient's records. Such entries should be made as near the time of administration of the drugs as possible. This record should also note the regular readings from the monitored variables, including those in the recovery phase, and should contain other information as indicated in the College Professional Document PS6 *The Anaesthesia Record. Recommendations on the Recording of an Episode of Anaesthesia Care*.

11. RECOVERY AND DISCHARGE

11.1 Recovery should take place under appropriate supervision in a properly equipped and staffed area (see College Professional Document PS4 *Recommendations for the Post-Anaesthesia Recovery Room*).

11.2 Adequate staffing and facilities must be available in the recovery area for managing patients who have become unconscious or who have suffered complications during the procedure.

11.3 Discharge of the patient should be authorised by the practitioner who administered the drugs, or another appropriately qualified practitioner. The patient should be discharged into the care of a responsible adult to whom written instructions should be given, including advice about eating and drinking, pain relief, and resumption of normal activities, as well as about making legally-binding decisions, driving, or operating machinery.

11.4 A system should be in place to enable safe transfer of the patient to appropriate medical care should the need arise.

12. TRAINING IN PROCEDURAL SEDATION AND/OR ANALGESIA FOR NON-ANAESTHETIST MEDICAL PRACTITIONERS

It is recommended that non-anaesthetist medical practitioners wishing to provide procedural sedation/analgesia should have received a minimum of 3 months full time equivalent supervised training in procedural sedation and/or analgesia and anaesthesia. They should participate in a process of In-Training and Competency Assessment.

Training should include completion of a crisis resource management simulation centre course.

Annual certification in advanced cardiac life support, and evidence of relevant Continuing Professional Development are highly desirable for credentialling.

Such trained medical practitioners should receive oversight from nominated anaesthetists in the hospital or centre.

13. REFERENCES

The following references provide evidence to support the recommendations made in this document.

1 American Society of Anesthesiologists Task Force on Sedation and Analgesia by Non-Anesthesiologists Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. Anesthesiology 2002; 96: 1004-1017

2 Faigel DO, Pike IM, Baron TH et al. Quality Indicators for Gastrointestinal Endoscopic Procedures: An Introduction. Gastrointestinal Endoscopy 2006; 63: (4 Suppl.) S3-S9

3 Godwin SA, Caro DA Wolf SJ et al. ACEP Clinical Policies Subcommittee on Procedural Sedation and Analgesia Clinical Policy: Procedural Sedation and Analgesia in the Emergency Department. Ann Emerg Med 2005; 45: 177-196

4 Harrington L. Nurse-Administered Propofol Sedation: A review of Current Evidence. Gastroenterology Nursing 2006; 29: 371-383

5 American College of Radiology. ACR Practice Guideline for Adult Sedation/Anesthesia. www.acr.org 2005

6 Clarke AC, Chiragakis L, Hillman LC, Kaye GL. Sedation for Endoscopy: the safe use of propofol by general practitioner sedationists. Med J Aust 2002; 176: 159-162

7 Ward DA, Bell GD, Gray A, Quine A, Bowles J et al. Sedation for Gastrointestinal Endoscopic Procedures in the Elderly: Getting Safer But Still Not Safe Enough. www.gsg.org.uk/clinicalprac/guidelines/sedation/htm 2006

PS9 continued

(2007)

8 American Society of Anesthesiologists Statement on Granting Privileges to Nonanesthesiologist Practitioners for Personally Administering Deep Sedation or Supervising Deep Sedation by Individuals who are not Anesthesia Professionals. www.asahq.org 2006
9 Sauterau D. La sedation en endoscopie: qui fera quoi et comment? Gastroenterology Clinical Biology 2005; 29: 1087-1089

All College Professional Documents must be complied with, but particular note should be taken of the following:

PS1 *Recommendations on Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia*
PS2 *Statement on Credentialling in Anaesthesia*
PS4 *Recommendations for the Post-Anaesthesia Recovery Room*
PS6 *The Anaesthesia Record. Recommendations on the Recording of an Episode of Anaesthesia Care*
PS7 *Recommendations on the Pre-Anaesthesia Consultation*
PS8 *Guidelines on the Assistant to the Anaesthetist*
PS15 *Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery*
PS16 *Statement on the Standards of Practice of a Specialist Anaesthetist*
PS18 *Recommendations on Monitoring During Anaesthesia*
PS26 *Guidelines on Consent for Anaesthesia or Sedation*
T1 *Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations*
TE3 *Policy on Supervision of Clinical Experience for Vocational Trainees in Anaesthesia*

APPENDIX I

The American Society of Anesthesiologists' classification of physical status:

P-1 A normal healthy patient
P-2 A patient with mild systemic disease
P-3 A patient with severe systemic disease
P-4 A patient with severe systemic disease that is a constant threat to life
P-5 A moribund patient who is not expected to survive without the operation
P-6 A declared brain-dead patient whose organs are being removed for donor purposes
E Patient requires emergency procedure

Excerpted from American Society of Anesthesiologists Manual for Anesthesia Department Organization and Management *2003-04. A copy of the full text can be obtained from ASA, 520 N Northwest Highway, Park Ridge, Illinois 60068-2573*

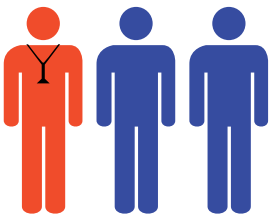
APPENDIX II

Emergency drugs should include at least the following:
adrenaline
atropine
dextrose 50%
lignocaine
naloxone
flumazenil
portable emergency O2 supply

APPENDIX III

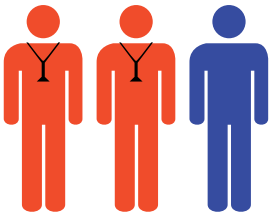
Personnel for Procedural Sedation and Analgesia

Scenario 1: Three practitioners – Sedation by Proceduralist



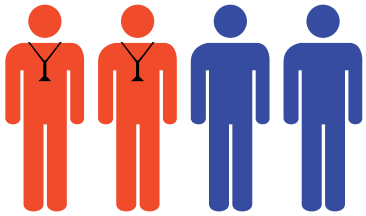
- Medical practitioner proceduralist with airway and resuscitation skills, and training in sedation
- Practitioner with training in monitoring sedation
- Assistant to assist both
- Conscious sedation in ASA 1-2 patients
- Propofol, thiopentone and other intravenous anaesthetic agents must not be used

Scenario 2: Three practitioners – Sedation by Medical Practitioner



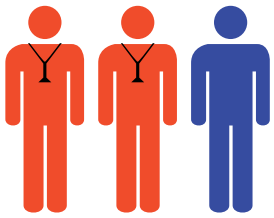
- Proceduralist
- Medical practitioner with airway and resuscitation skills, and training in sedation
- Assistant to assist both
- Conscious sedation in ASA 1-2 patients
- Propofol, thiopentone and other intravenous anaesthetic agents may only be used by a medical practitioner trained in their use

Scenario 3: Four practitioners – Sedation by Medical Practitioner



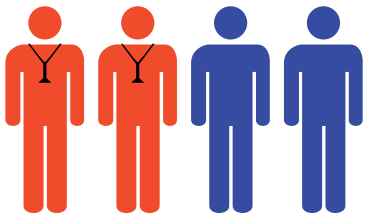
- Proceduralist
- Medical practitioner with airway and resuscitation skills, and training in sedation
- Assistant to assist each*
- Conscious sedation in ASA 1-2 patients
- Propofol, thiopentone and other intravenous anaesthetic agents may only be used by a medical practitioner trained in their use

Scenario 4: Three practitioners – Sedation by Anaesthetist



- Proceduralist
- Anaesthetist
- Assistant to assist both
- Conscious, deep sedation or general anaesthesia in all patients
- All approved anaesthetic drugs may be used

Scenario 5: Four practitioners – Sedation by Anaesthetist



- Proceduralist
- Anaesthetist
- Assistant to assist each*
- Conscious sedation, deep sedation or general anaesthesia in all patients
- All approved anaesthetic drugs may be used

* *Recommended if assistance is likely to be required for the majority of the case (e.g. complex or emergency patients)*

COLLEGE PROFESSIONAL DOCUMENTS

College Professional Documents are progressively being coded as follows:

TE Training and Educational
EX Examinations
PS Professional Standards
T Technical

POLICY – *defined as 'a course of action adopted and pursued by the College'. These are matters coming within the authority and control of the College.*

RECOMMENDATIONS – *defined as 'advisable courses of action'.*

GUIDELINES – *defined as 'a document offering advice'. These may be clinical (in which case they will eventually be evidence-based), or non-clinical.*

STATEMENTS – *defined as 'a communication setting out information'.*

This document has been prepared having regard to general circumstances, and it is the responsibility of the practitioner to have express regard to the particular circumstances of each case, and the application of this document in each case.

Professional documents are reviewed from time to time, and it is the responsibility of the practitioner to ensure that the practitioner has obtained the current version.

Professional documents have been prepared having regard to the information available at the time of their preparation, and the practitioner should therefore have regard to any information, research or material which may have been published or become available subsequently.

Whilst the College endeavours to ensure that professional documents are as current as possible at the time of their preparation, it takes no responsibility for matters arising from changed circumstances or information or material which may have become available subsequently.

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