

THE  
**ANZCA**  
**BULLETIN**

- Council reports
- Training in private
- Coronor's investigation
- Quality and safety
- Kind Cuts for Kids Foundation

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

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JOINT FACULTY OF INTENSIVE CARE MEDICINE  
FACULTY OF PAIN MEDICINE



**THE ANZCA BULLETIN EDITORIAL**

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



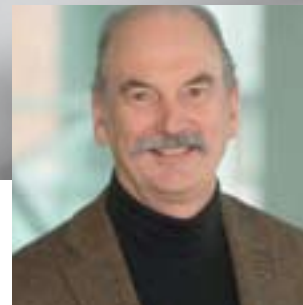
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# Letter from the editor

## THE RISK OF OVERDOING IT



DR ROD WESTHORPE

**We are increasingly being advised by medical indemnity insurers to explain the risks of procedures with patients.**

**A well known insurer states, in a brochure on informed consent, that 'if an adverse outcome is likely to impact a patient's way of life in any way, then the patient should be informed about it', and in a poster directed to patients, advises them to ask 'What are the risks of anaesthesia?'**

Adverse outcomes can vary from nausea and sore throat to severe brain damage and death. The former are relatively common, and not particularly related to adverse events or poor clinical performance. The latter are rare, and are only likely to follow a major adverse event, and are not usually related to negligent clinical practice.

In Australia and New Zealand, we have achieved a level of safety in the practice of anaesthesia that is the envy of most other countries of the world. This is in no small measure due to the training and accreditation program developed by the College; to the active encouragement of practitioners to engage in ongoing education; and to the work of the Australian Patient Safety Foundation in identifying and promulgating information on risk minimisation.

What is the benefit of informing an otherwise healthy patient that the anaesthetic they are about to undergo may result in their death or serious disability? Is the discussion of that information going to lessen the likelihood of such an outcome?

Further, is the discussion of death or serious disability during the preanaesthesia consultation of any benefit to the patient, unless they particularly request such a discussion? In the case of children, is such a discussion of any benefit to the child or to the parents?

Fear and anxiety are common in patients and families presenting for anaesthesia and surgery, especially on the day of surgery.

The preanaesthesia assessment provides the opportunity to tell patients, or their families, how good and safe anaesthesia is, and how well we do our job. It is the opportunity to gain their confidence and to allay the fear and anxiety.

Yet, our medico-legal advisors tell us that we should inform patients of any adverse outcome likely to impact on their way of life!

They implore us to tell our patients how disastrous anaesthesia can be!

Significant additional stress may be added by the discussion of serious and unlikely adverse outcomes—and for what purpose? The additional stress may have detrimental psychological or physiological effects on the patient with potential effects on the anaesthetic process, and the chance of an adverse outcome will not be diminished.

Where a choice of technique carries greater risk of adverse outcome in return for greater benefit, then some discussion is appropriate. We should, however, be confident in our expertise in advising the patient of the best treatment option, and be careful to not overstate the marginal increase in risk.

The legal profession has taken the meaning of 'risk' to new heights in our community. There is an expectation that whenever an adverse outcome occurs, someone is responsible and someone must pay. In Australia, we have seen huge payouts after accidents where most of the community would have previously accepted 'bad luck' or 'being in the wrong place at the wrong time' as an adequate explanation. There is no question that whenever an adverse outcome

follows a negligent or criminal act, then blame and compensation is appropriate. New Zealand, with its accident compensation scheme, has a more rational approach to the problem.

It has to be said that the safety record for anaesthesia in Australia and New Zealand is at least partly due to the efforts of the legal profession. It was the veiled threat of legal action in 1987 against local anaesthetists who had experienced an adverse outcome, but who had not followed to the letter, the anaesthesia monitoring guidelines published in the U.S.A., in 1986. Professor Bill Runciman convened a focus group of some 60 anaesthetists from Australia and New Zealand, who met in Adelaide in May 1987, to discuss patient safety and monitoring. The shortcomings of the American guidelines were recognised and three important initiatives resulted from the meeting: the publication of local monitoring standards (refined and promulgated by the Faculty of Anaesthetists, RACS); the establishment of the Australian Patient Safety Foundation; and the Anaesthesia Incident Monitoring Study.

In Australia, anaesthetists and other medical practitioners have been gently pushed down a path where patterns of practice are increasingly being dictated by lawyers who neither treat patients nor comprehend medical practice and doctor-patient relationships.

As anaesthetists, we must take control of the informed consent process, and provide information in an appropriate context for the individual patient and family. The prime objective of the preanaesthesia consultation is to assess the patient and formulate an anaesthesia plan, with discussion of options when appropriate. The second objective is to secure the trust and confidence of the patient in our ability to care for them. We should not allow the insurers or the legal profession to tell us how to do it.

**Rod Westhorpe is retiring as editor of The Bulletin following the publication of this issue.**



# President's message

2007: What does the year hold in store?



DR WALTER THOMPSON

In my message in the March edition of 'The ANZCA Bulletin' there were comments related to national registration and accreditation, training in extended environments, examinations, the ANZCA Foundation and Continuing Professional Development (CPD). How have these issues progressed?

**The CPD has undergone further development following input from Fellows and the 'final' version is due to be considered by Council in June. The corporate launch of the ANZCA Foundation was well received and to date we have secured three 5 year Fellowships each worth \$50,000 per year. In May the College held the largest ever Final FANZCA Examination. There were 185 candidates of whom 151 were successful. This was a major logistic exercise and we are grateful to the Court of Examiners and the College staff for the enormous effort that they put into the examination.**

As regards the other matters, Australia is now well and truly in election mode and the messages coming out of Canberra are very mixed. On issues such as National Registration and Accreditation, things have gone very quiet following the COAG Meeting on April 13 and no one seems to want to discuss Federal Funding for Health despite the fact that the Australian Health Care Agreements (AHCAs) are due for renegotiation next year. On issues such as 'training in extended environments', the Federal Government is 'forging' ahead, seeking to get something in place before the Federal election.

After extensive lobbying by the AMA, health professional groups, the Colleges and the CPMC, the Council of Australian Governments (COAG) decided to scrap the idea of having a single national registration and accreditation body for all nine health professional groups in favour of having a separate National Registration and Accreditation body for each of the nine groups. The AMC will fulfill those roles in relation to medicine, but the logistics and the administrative structure for doing that have yet to be finalised by the jurisdictions. The role of the current medical boards is also being clarified but they will have a role as the 'shop fronts' for a national registration body in each state in the first instance.

On training in extended environments, the Federal Government is pushing ahead and seeking to facilitate meetings, change funding and to get something in place before the election. So far they have been talking to different groups with a view to getting some pilot sites working and have placed some \$60 million on the table for the next four years. ANZCA recognises the need for training to occur in these alternate environments and has in the past, accredited Private hospitals. We will continue to pursue these issues where (a) there is an educational imperative; (b) the hospitals are prepared to support training and meet the College accreditation standards; and (c) the arrangements put in place do not disadvantage trainees.

**'The role of the current medical boards is also being clarified but they will have a role as the 'shop fronts' for a national registration body in each state in the first instance.'**

In New Zealand there is concern that the Government has been trying to use debate on the Trans Tasman Therapeutic Goods Legislation to obtain supplementary orders to prescribing regulations under the Therapeutic Products and Medicines Bill without adherence to due process for revisions to the Bill. Nursing Groups and the Midwives had approached the Government seeking approval for unlimited prescribing rights for nurse practitioners. Previously nurse practitioners were excluded from prescribing muscle relaxants and anaesthetic induction agents. The College — through the New Zealand National Committee — is working earnestly to maintain the current situation and to ensure that due process is adhered to. The New Zealand Society has also conveyed its views to the Government.

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### **INFORMED FINANCIAL CONSENT**

In March, the Chief Medical Officer for Australia (Professor John Horvath) approached the College asking for a meeting to discuss informed financial consent (IFC). We met with him and indicated IFC was generally the province of the ASA and the AMA. He accepted that, but also stated that the Health Minister and the Department considered that it was, in part, an issue of professionalism and, given the results of the initial IPSOS survey, they wondered if there were ways that ANZCA could assist in improving the rate of IFC.

We noted that there was mention of IFC in some College documents and that in the past there had been an article on IFC in the Bulletin. There was a discussion on the problems faced by anaesthetists and the issues involved. As a result of discussions, I undertook to liaise with the ASA on this matter and indicated that the College would (a) consider making reference to IFC in the proposed Code of Conduct and in the next revision of PS26; (b) include IFC in relevant CME meetings; (c) consider the inclusion of IFC in educational modules for trainees; and (d) consider publishing a further article in the Bulletin.

### **ANNUAL REPORT**

The Annual Report was released prior to the ASM and is available to Fellows on the website and in printed format. The report was accepted at the AGM on 28 May, and details the developments in 2006; reports on the major activities of the College and the Faculties; plus it includes the financial report. The developments included the necessary increases in capability in the areas of education, finance, information technology, and finance plus strategy and policy development in order to cope with the continuing expansion of activities by the College and the Faculties. The College remains in a sound financial position due to the commitment of Fellows in Australia, New Zealand and South East Asia, College staff, Committee Members, Councillors, community representatives and the advisers to Council.

# President's message continued



‘1,800 delegates attended and they were treated to a scientific program that was both challenging and stimulating while providing evidence and practical guidelines for aspects of pre-operative care, intra-operative care and post-operative care.’

## ANNUAL SCIENTIFIC MEETING

This was held in Melbourne from 26-29 May and the theme was ‘Perioperative Medicine: Evidence and Practice’. Some 1,800 delegates attended and they were treated to a scientific program that was both challenging and stimulating while providing evidence and practical guidelines for aspects of pre-operative care, intra-operative care and post-operative care. The meeting was very well organised and had an excellent social program. An enormous vote of thanks is due to Dr Rowan Thomas and the Regional Organising Committee plus A/Professor David Story and the Scientific Program Committee.

## RACS

On a matter related to postoperative care it was a pleasure in May to receive a letter from the President of the Royal Australasian College of Surgeons thanking Fellows of ANZCA for their involvement as instructors and course directors for the ‘Care of the Critically Ill Surgical Patient’ (CCrISP) Course since 1999. ANZCA has also had representation on the CCrISP Committee, which oversees the curriculum and the running of the courses. The CCrISP is an important contribution to surgical training and is producing improvements in the surgical postoperative care that is provided by surgical trainees. Fellows who are interested in instructing on CCrISP Course should contact the Skills Training Department at RACS.

## COUNCIL MATTERS

I would like to congratulate and welcome Dr Genevieve Goulding and Dr Peter Cook, both of Queensland, who were elected to Council at the recent election. Drs Margie Cowling, Lindy Roberts, Wally Thompson and Tony Weeks were all re-elected to Council. I look forward to their contributions to Council.

Dr Di Khursandi and Dr Rod Westhorpe are retiring from Council. They are much respected by College staff, Fellows and councillors and will be missed. Their wisdom, integrity, diligent thought, hard work and attention to detail have assisted them in both the governance of college affairs and their many contributions to the wider anaesthesia community.

Dr Khursandi served as a co-opted member of Council from Queensland in the period 1995-1998 and was first elected as a councillor in 1998. Her particular interests have included doctors’ health, gender issues, rural anaesthesia and workforce matters. Di has made extensive contributions to issues related to the welfare of anaesthetists, rural anaesthesia, clinical indicators, workforce and education. Di has chaired the Continuing Education and Quality Assurance Committee and the Educational and Training Committee.

Dr Westhorpe has served on the Council for 12 years and has also been the Honorary Curator of the Geoffrey Kaye Museum since 1987. He has chaired the Clinical Indicators Working Party, the House Committee, the Library Committee, the Continuing Education and Quality Assurance Committee, and has served on the Council Executive. Rod was instrumental in the establishment of the Anaesthesia Continuing Education Coordinating Committee and has nurtured the progress of the Special Interest Groups. In addition to the museum and the library he has also had particular interests in Fellowship Affairs and communication and has been the Editor of ‘The ANZCA Bulletin’. Rod was the Lennard Travers Professor and delivered the Australian Visitors Lecture in 1991 and in 2007 he delivered the Gwen Wilson Memorial Lecture.

On behalf of the Fellows, the Council and the staff of ANZCA, I would congratulate them both and thank them for all their efforts. We would also like to thank their families for all the generous support that they have given to them and the College over the years.

DR WALLY THOMPSON  
President

# Education report

## Ideal best practice within examinations



PROF RUSSELL JONES

As part of the ongoing iterative process of improvement, ANZCA, JFICM and FPM are continuously considering current and potential methods to optimise the examination of trainees.

This report describes best practice for a hypothetical ideal examination with regard to the four major characteristics by which examinations are evaluated: validity, reliability, generalisability and practicality. Readers interested in additional information about examinations are referred to the recent article in *Anaesthesia and Intensive Care* entitled 'Medical specialist examinations: Item format types and minimising error'<sup>1</sup>.

### VALIDITY

Essentially, validity is the extent to which an examination measures what it is supposed to measure. For example, in the case of the ANZCA Primary and Final examinations, that these examinations actually measure candidate knowledge, skill and ability in basic science or anaesthesia. There are numerous forms of validity.

**Content validity** is the extent to which an examination assesses an adequately representative sample of the content the examination purports to measure. The ideal tool to establish content validity is to map examination content against the content specified in course curricula documents. Such a process is called 'blueprinting'.

**Criterion validity, or more correctly criterion-related validity**, is the extent to which examination marks or scores are related to one or more external measures (known as criteria). Concurrent validity and predictive validity are two subsets of criterion-related validity.

**Concurrent validity** considers the strength of the relationship between performance on one examination and performance on another designed to assess the same underlying abilities. For example, the strength of the correlation between an oral examination and a short-answer examination if both are purported to assess intensive care or pain medicine.

**Predictive validity** measures the strength of the relationship between candidate results on an examination and their future performance. That is, the extent to which an examination is able to predict future performance.

**Construct validity** is the degree to which an examination measures the underlying 'construct' the examination is designed to measure. That is, how closely does the examination measure real world performance. Such validity acknowledges that examinations are indirect indicators of true ability, skill and knowledge and measure 'theoretical attributes' or 'hypothetical constructs'. Despite this characteristic of examinations, they remain one of the best available methods for providing information to estimate true ability, skill and knowledge. Construct validity is typically demonstrated if it can be shown that experts in, for example, basic science or anaesthesia perform well on the respective examinations and people with varying lower degrees of expertise perform correspondingly worse.

**Face validity** is what an examination appears to assess at first glance. That is, what the untrained eye would suggest an examination measures 'on the face of it'. Although it may be argued that face validity is not of equal importance to other forms of validity, face validity is essential in order that an examination be perceived as appropriate by examiners, candidates, the Australian Medical Council (the organisation responsible for accrediting ANZCA as a training and accreditation institution) and others interested in the examination process. Face validity is strongly influenced by choice of examination

format. Descriptions of some current formats used within the ANZCA, JFICM and/or FPM examination are summarised below, together with a synopsis of their strengths and weaknesses.

### MULTIPLE-CHOICE QUESTIONS

Multiple-choice questions (MCQs) commence with a stem which sets the scene for the question and may include text, diagrams, tables or illustrations. The stem is typically followed by a series of three to five answer choices or options; the greater the number of options, then the better the MCQ. These options include the correct answer and the remaining options are termed distractors. There are two answer types for MCQs: single correct answer and best answer. Of these, the single correct answer is more desirable as it does not allow for ambiguity or judgement by either the candidate or examiner. In this regard this form of MCQ is entirely objective. That is, there is no judgement as to whether the answer is correct or incorrect. Conversely, it may be argued that an MCQ which requires a best answer includes an element of subjectivity because more than one answer is potentially correct and the question requires a candidate to decide which option is not correct. Of course, the examiner must also judge which answer is most correct. When comparing single correct and best answer MCQs, the single correct answer approach is optimal. If a best correct MCQ is used it is important to ensure that answer options can be placed on a homogeneous continuum. The correct answer is that which is considered to be the option that a group of subject area experts would consider to be the best option. The best answer MCQ may be used to assess judgement or rationalisation. For example, the best method for a specific course of action, the best method for a procedure, or the best application of a principle.





‘It is possible for examiners to assess an entire course of study by carefully writing questions to match each objective or outcome.’

#### Advantages of MCQs

- > MCQs can be written to assess a wide range of curricula and ability levels.
- > MCQs can be used to assess many educational outcomes or objectives quickly and easily.
- > It is possible for examiners to assess an entire course of study by carefully writing questions to match each objective or outcome. After marking the examination the examiner can instantly identify those items candidates do not answer correctly.
- > Examiners can obtain instant feedback as to which parts of a course candidates have mastered and which parts (as well as which candidates) require attention. This knowledge can be used to promptly feedback to candidates and therefore improve their learning.
- > The feedback can also be forwarded to instructors to allow them to identify which parts of the course are being taught successfully and which may need to be reviewed.
- > MCQs are able to be marked quickly, easily and accurately.
- > MCQs are highly reliable and, if well written, have high validity.
- > A sound body of educational assessment research has produced sound statistical tools for analysing, equating and scaling MCQs.
- > MCQs can be marked by a non-content area expert or via computer and therefore marking does not require specialist input from an examiner.

#### Disadvantages of MCQs

- > Good MCQs take longer to write than items using many other item formats.
- > Some higher order cognitive skills and abilities are difficult to assess using MCQs.
- > The requirement that individuals merely select an answer from several options does not allow candidates to readily demonstrate creativity or innovative thinking.
- > Guessing is possible with the probability of guessing a correct answer inversely proportional to the number of answer options.
- > MCQs do not allow candidates to provide additional information beyond the answer choice.

#### SHORT ANSWER QUESTIONS

Short answer questions (SAQs) vary considerably in their format, though many are brief essays. Ideally these questions should be phrased to elicit a structured or semi-structured written response and facilitate marking. These types of questions are called ‘constructed response’, because candidates must construct their answers, in contrast to ‘selected response’ where candidates select their answers from a series of options (e.g., MCQs or true-false questions). Candidates have less chance of guessing a correct answer using constructed response item formats.

#### Advantages of SAQs

- > SAQs can be structured to allow candidates to be examined on many educational objectives and outcomes.
- > SAQs are easy to write compared with most other item formats.
- > SAQs can be written to readily assess higher order cognitive skills beyond knowledge including application of knowledge, interpretation of data, problem solving and clinical reasoning.

#### Disadvantages of SAQs

- > Unless carefully structured, SAQs can incorporate considerable ambiguity.
- > SAQs must be marked by a content area expert.

- > SAQs may take considerable time to mark, especially if double marking is used where answers are marked by two markers to improve reliability. If these two markers disagree on the value of the allocated mark, then a third marker may need to be used.
- > It may be tempting for some writers of SAQs to expect more detailed answers than can be realistically provided by candidates within time limits provided for completion of SAQs.
- > Large numbers of questions are needed to accurately reflect a large curriculum and to minimise sampling error.

#### Viva Questions

The viva is a common traditional format for medical examinations. The power of the viva as an assessment device arises from its capacity to assess a great deal of knowledge, skill and ability relevant to a broad spectrum of medicine and associated basic science.

#### Advantages of the viva

- > The viva can be used to assess significant breadth and depth of knowledge, skill and attitude including assessment of a candidate’s ability to problem solve, communicate, display knowledge, clinically reason, employ clinical judgement, evaluate clinical situations, choose treatments and justify choices, deal with changing situations and make decisions.
- > Vivas offer examiners considerable flexibility to explore the strengths and weaknesses of a candidate.
- > Vivas have undeniable face-validity.

#### Disadvantages of the viva

- > The subjectivity of viva marking has led to their being criticised for poor reliability. Structured marking schemes or global rating scales may improve reliability.
- > Different candidates may be asked substantially different questions by examiners which may adversely affect both reliability and validity.



> Results may be influenced by factors extraneous to the candidate's knowledge, skill or ability relating to curriculum content such as verbal and non-verbal communication skills, halo effects, candidate nervousness and examiner fatigue.

**Effect on learning** of an examination is increasingly being used as a measure of validity. That is, does the examination have a desirable influence on learning? Examinations may introduce invalidity if their procedures, structure or content encourage inappropriate learning. Trainees seek to learn what they believe will be assessed. Thus the **content** of an examination becomes extremely important as a motivator of what trainees will learn. The method trainees choose to study is also strongly influenced by examination **format and structure**. Thus, for example, examination formats which encourage checklists should only be used to assess basic science or clinical material best suited to the application of check lists in real life.

## RELIABILITY

Essentially reliability is the extent to which an examination or examination process is consistent over time, on different occasions, with different candidates or using different questions. There are several different forms of reliability.

**Alternate forms, or test-retest, reliability** is the extent to which an examination produces consistent results over several administrations to the same candidates. Hypothetically, an ideal examination would produce identical results over each administration. However, in reality, this ideal is almost impossible to achieve in an exam measuring cognitive constructs because a candidate's cognition is modified each time they sit an exam and by experiences that occur between examination administrations.

Ideally, **intra-rater reliability** is the extent to which an examination produces consistent results over different administrations using the same examiner to assess the same individual who performs at the same level. From a practical perspective, the definition of intra-rater reliability usually focuses upon the extent to which the same examiner awards consistent marks for candidates who provide similar responses.

'... reliability is the extent to which an examination or examination process is consistent over time, on different occasions, with different candidates or using different questions.'

**Inter-rater reliability** is the extent to which different examiners award the same mark for the same answer during an examination. Whereas this is not an issue for objective tests (eg, MCQs), it may become an issue for tests marked subjectively (eg, SAQs and vivas).

**Inter-case reliability** is the extent to which different cases presented to different candidates may introduce variability into examination results.

**Internal consistency** is the extent to which the different questions comprising an examination consistently measure the same attribute. Typically this may be estimated by calculating the correlation between candidate performance on an individual question and their performance on the total of the remaining questions.

## GENERALISABILITY

One of the fundamental purposes of most examinations is to provide information about candidate mastery of the underlying examination construct to enable generalisation from their performance on the examination to their likely performance on the underlying construct overall. Generalisability is closely associated with validity and reliability. Generalisability of a candidate's performance on an examination to their likely performance related to basic science, anaesthesia, intensive care or pain medicine can be optimised by minimising threats to validity and reliability within examinations.

## PRACTICALITY

The practicality of designing, administering and marking an examination varies according to numerous factors including the specific content to be measured; the depth and breadth of the knowledge, skill and abilities to be assessed; number of candidates; number of questions; and available personnel, resources and funds. Another important practical consideration is the available time commitment of all personnel including:

- > Examiners
- > Collaborators (eg, timekeepers, 'bulldogs', administrative staff)
- > Data compilers/analysers
- > Adequate range of real, simulated and/or standardised patients.

Examinations also require significant physical resources including rooms, time keeping equipment, record keeping tools and computers as well as (possibly) mannequins and props. Logistical considerations are important and include: the opportunity for examiners to optimally communicate when setting examinations; for examiners, candidates and, where appropriate, examination patients (ie, all exam participants) to be brought together at the correct time and place; timing considerations; security; marking; and record keeping.

When considering the structure and format of an examination, it is important to first consider validity, reliability and generalisability in the design of a desired optimal examination and then to modify this hypothetical examination according to practical constraints. If the converse process is applied, whereby practical considerations are used as the initial priority, then the resulting examination (although practical) will include far from optimal examination characteristics relating to validity, reliability and generalisability.



# New CPD Program

The proposed CPD Program is available for viewing on the ANZCA website under the CE&QA section. The CPD Committee would like to thank all of those who provided us with feedback on the draft program.

**The general consensus was that the new CPD Program is an improvement on the current MOPS Program, whilst also being 'something that we will need to get used to'.**

A number of queries were received regarding how specific activities that participants complete will fit into the new program. Several Fellows commented that they are unsure of how to embark on the planning and reflection components of the program and this has been taken on board by the CPD Committee in planning how the program will be implemented. Toolkits to guide participants in these and other components have been developed and will be further added to.

Many suggestions have been incorporated into the program. These varied from small grammatical changes, through to clarification of concepts within the program. The core elements of the CPD Program have not been changed.

With the review stage nearing completion, in the coming months we will be finalising the new CPD Program. This will include everything from fine-tuning the Framework of Activities; designing the 'look and feel' of the program; through to developing the process of participation.

Towards the end of 2007 we will be sending out a communication to all MOPS Participants, reminding them of the cessation of the MOPS Program and inviting them to begin their participation with the CPD Program. Full information on the process of participating in the CPD Program will be sent out in due course.

Please note that the current MOPS Program will continue for 2007 as before. This means that we will still be asking for Returns for 2007 to be sent to us by the end of February 2008. These Returns will be processed and Statements of Participation will be sent by mail as usual.

CPD Committee

# Research report

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



ORNELLA CLAVISI

The ANZCA Trials Group together with the Department of Anaesthesia and Perioperative Medicine Alfred Hospital has started recruiting for the ENIGMA II Study (Nitrous Oxide Anaesthesia and Cardiac Morbidity after Major Surgery a large simple multicentre randomized controlled trial (RCT) to definitively evaluate the efficacy of removing nitrous oxide from the anaesthetic in moderate and high risk patients undergoing non cardiac surgery.

### Box 1

#### ENIGMA II INVESTIGATORS

Trial Steering Committee and Chief Investigator

Prof Paul Myles

A/Prof Kate Leslie

A/Prof Phil Peyton

A/Prof Andrew Forbes

A/Prof Brendan Silbert

Prof Mike Paech

Prof Matthew Chan

Prof PJ Devereaux (Canada)

Prof Dan Sessler (USA)

Research Team

Ornella Clavisi

Sophia Wallace

Marg Quayle

### Background

There are about 20 million anaesthetics given each year in the US (1:10 of the population), with the majority receiving N<sub>2</sub>O. Approximately 25% of patients undergoing major surgery have known coronary artery disease (CAD) or risk factors for CAD. In 1990, approximately 1 million of the 25 million Americans who underwent noncardiac surgery suffered a perioperative cardiac event, resulting in \$20 billion in costs.

N<sub>2</sub>O interferes with vitamin B12 and folate metabolism. This impairs production of methionine (from homocysteine), used to form tetrahydrofolate and thymidine during DNA synthesis. It has been repeatedly demonstrated that N<sub>2</sub>O anaesthesia increases postoperative homocysteine levels. Chronic hyperhomocysteinaemia is associated with cardiovascular disease, and acute

hyperhomocysteinaemia is known to cause endothelial dysfunction. One small trial has demonstrated an increased incidence of postoperative myocardial ischaemia in patients receiving N<sub>2</sub>O anaesthesia. Reducing postoperative myocardial infarction and death are important aims for those with CAD undergoing major surgery.

### ENIGMA I

The ENIGMA I study randomised 2,050 patients undergoing non cardiac surgery to receive oxygen 80-100% in nitrogen 0-20% or nitrous oxide 70% in oxygen 30%. This study found that nitrous oxide increased the risk of wound infection (OR 1.3, p=0.03), severe vomiting (OR 2.5, p<0.001), atelectasis (OR 1.5, p=0.001), and pneumonia (OR 2.0, p=0.002). Additionally, nitrous oxide patients had a greater length of stay in the ICU (p=0.02), indicating an increased incidence of more serious complications

However, the ENIGMA trial was not designed (sample size/power) to detect a difference in the less common, but serious complications of MI or death. Nevertheless, the study identified a non-significant increased risk of confirmed myocardial infarction and postoperative death.

ENIGMA I was done in an unselected group of surgical patients, but the findings suggest that N<sub>2</sub>O may be particularly detrimental in those at risk of cardiac events. Also the trial did not equalise the inspired oxygen concentrations in both groups, so it is possible that some of the benefits of avoiding N<sub>2</sub>O could be attributed to supplemental oxygen. The ENIGMA-II trial aims to address some of these issues. For those who are interested, the results of ENIGMA I study will be published in the August edition of Anaesthesia.

**'Reducing postoperative myocardial infarction and death are important aims for those with CAD undergoing major surgery.'**

### ENIGMA II

Box 2 provides a synopsis of the ENIGMA II Research Plan.

### Box 2

#### Hypothesis

Avoidance of N<sub>2</sub>O will reduce the incidence of a composite endpoint of death, MI, cardiac arrest, PE and stroke from 8% to 6% at 30 days.

#### Study Design

Large, multi-centre, randomised, blinded, clinical trial. 7,000 high risk cardiac patients undergoing major non-cardiac surgery will be randomly allocated to either a N<sub>2</sub>O-containing (70% N<sub>2</sub>O in oxygen) or N<sub>2</sub>O-free (nitrogen in oxygen) anaesthetic; both groups FiO<sub>2</sub> 0.3. Patients, surgeons, and nursing staff, and all individuals responsible for all outcome assessments will be blinded.

#### Primary endpoint

The primary endpoint is a composite of death and cardiovascular events (clinical and silent MI, cardiac arrest, pulmonary embolism, and stroke) measured at 30 days after surgery.

#### Trial Update

ENIGMA II commenced recruiting in late May (2007) with two sites currently recruiting patients: The Alfred Hospital and Prince of Wales Hospital (Hong Kong). If you would like further information regarding the trial or are interested in being a site investigator please contact Ornella Clavisi, email: oclavisi@anzca.edu.au Ph: 03 8517 5326. You can also find further information about the trial on the ENIGMA II website: [www.enigma2.org.au](http://www.enigma2.org.au). Also the Trial has adopted the NHMRC's National Ethics Application Form (NEAF) as a way of reducing the time and effort required by site investigators to complete their own ethics application. Just let us know if your hospital is happy to accept the form and we'll do all the legwork.



# Series on past Deans and Presidents

Maurice James Wilson Sando

1930-1984

Maurice James Wilson Sando, OBE MBBS FFARACS FFARCS was past Dean of the Faculty of Anaesthetists, born in Cumnock, New South Wales on January 23 1930. Maurice Sando was educated at Sydney Church of England Grammar School and the University of Adelaide where he graduated in medicine in 1953. He passed away in Adelaide on 24 February, 1984.



‘Maurice was known by his colleagues as a gifted clinician, teacher and organiser who always made time to discuss problems with those who sought his guidance and help.’

After serving in resident posts at the Royal Adelaide Hospital Maurice Sando travelled to England, taking up a career in anaesthesia and being awarded the Nuffield Prize for the highest marks in the Primary Examination of the Faculty of Anaesthetists of the Royal College of Surgeons of England. He returned to Australia, obtained the Fellowship of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons in 1957 and entered private anaesthetic practice in Adelaide.

In 1962, Maurice was appointed Director of the Department of Anaesthesia at the Royal Adelaide Hospital, and during the years that followed, established it as a Department of Anaesthesia and Intensive Care. He was responsible for the establishment of the rotational anaesthetic training program in South Australia and many of those who practice the specialty in the state trained under his watchful eye.

He soon established the need for intensive care facilities and was able to organise his department so that the Intensive

Care Unit was run by suitably trained specialists in that field. In 1966 Maurice was awarded the Churchill Fellowship to study developments in intensive care overseas and was always a strong supporter of that specialty.

Maurice was elected to the South Australian Branch Council of the Australian Medical Association. became its President in 1973-74, was elected a Fellow of the AMA in 1974 and was on the Federal Council in 1974 and 1975.

He served as a member of the Medical Board of South Australia from 1974 until 1982 and was Chairman of the Blood Transfusion Service of the South Australian Division of the Red Cross Society from 1978 until his death.

In his own hospital he played a leading role as a member of many committees and was Chairman of the Royal Adelaide Hospital Staff Society from 1976 to 1978.

In 1982 he was elected to Fellowship of the Faculty of Anaesthetists of the Royal College of Surgeons of England, an honour conferred on few Australians.

Maurice served the Faculty of Anaesthetists R.A.C.S. with distinction in a number of positions. He was a member of the south Australian Regional Committee from 1961 to 1980, serving both as Secretary and Chairman. He was appointed a Final examiner in 1965, moved to the Primary examination in

1968 as an examiner in Physiology and was Chairman of the Primary Examination from 1970 to 1974. He was a member of the Board of Faculty from 1967 to 1980 and served as the first Chairman of Examinations in 1974 and 1975 becoming Chairman of the newly formed Faculty Executive Committee. In 1976, he was elected Vice Dean and in 1978 Dean. All those who had the privilege of serving with him on the Board learnt to respect his opinions and wise counsel.

During his period on the Board, Maurice stimulated a review of the role of the Faculty within the College and was Chairman of the Working Party of the Council and the Board which ultimately resulted in the change, of the Articles of Association to give the Faculty autonomy within the College.

In 1980, he was made a member of the Court of Honour by the College Council.

Maurice was known by his colleagues as a gifted clinician, teacher and organiser who always made time to discuss problems with those who sought his guidance and help. It is a tragedy for all of us that this strenuous effort took toll of his health and forced his early retirement.

At his funeral the eulogy was given by J.E. (Fred) Gilligan. whose words in part, summarise the feeling of many who knew him.



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There is a passage in the book of Ecclesiasticus which perhaps describes my feelings for him today:  
'let us now praise famous men ... giving a counsel by their understanding. Leaders of the people, in their deliberations. They were the glory of their times. and their name lives to all generations.'

I believe his memory will live, perpetuated by his achievements, but especially by the traditions of service and patient care that he believed in and pursued with single mindedness, and which lives on in those he taught and inspired.

He is survived by his wife Margaret and son Jonathon to whom I believe all Fellows would send their sincerest sympathy.

.....  
WM. CROSBY Dean  
March 1984 Bulletin  
.....



# Provisional Fellows in Private Practice

The Central Victorian Anaesthetic Service is the first private practice in Australia to have the Provisional Fellowship Year (PFY) funded by Medicare.



**The Practice is comprised of ten consultants in Bendigo, providing anaesthetic services, such as Visiting Medical Officers to various public and private hospitals in the central Victorian area.**

Over the years, we have grown from a group of two to the current number. We often found it difficult to obtain locum cover for leave, and to recruit new members to join the group. From time to time we have been able to get registrars who have completed their exams and training, to work with us, and some of them included their time with us as part of their PFY. Once the ten year rule for Medicare provider numbers filtered through, those registrars no longer had provider numbers and could not access Medicare.

We felt that a worthwhile experience in a supportive provincial city was denied to these anaesthetists because of the provider number problem.

The task of obtaining provider numbers for trainees was a difficult one. Paul Woodhouse of the AMA was very helpful in negotiations with the Department of Health and Ageing. He suggested that other Colleges, such as the College of General Practice, had

**‘Dr Peter Mazur and his colleagues in the central Victorian city of Bendigo have established a successful model of anaesthesia training in the private sector.’**

registrars funded by Medicare. The DHA agreed to give PFY location specific provider numbers as long as the College of Anaesthetists considered it as part of their training.

Many members of the College Council were very supportive, especially Dr Anthony Weeks, Professor Michael Cousins and Dr Rod Westhorpe. A process was worked out where we were approved for PFY training and the College signed off for the registrar’s provider numbers.

In September 2003, we received notification that the Central Anaesthetic Service had been approved by the Australian and New Zealand College of Anaesthetists for PFY training.

The Fellows work in their own theatres, with supervision as required on a daily basis. They rotate through the various specialties so that they get a varied experience in country anaesthetic practice. We organise suitable accommodation, list rotation and full secretarial support.

Under the new system, we have had only two PFYs so far. However, our secretary, Margaret Stephens has diligently collated all the details, so that sorting out arrangements for future PFYs will be routine.

Both Trainees so far have had a positive and worthwhile experience working and living in a provincial city. We feel we have a system which enables Trainees to experience private anaesthetic practice in a supportive rural frame work. It also enables our practice to gain leave time for holidays and conferences. We also hope that this scheme will help us recruit new anaesthetists to Bendigo.

DR PETER MAZUR

Left to right: Margaret Stephens, Peter Mazur and Brad O’Connor, our current PFY.



# Refining the Art of Day Care Anaesthesia

The first combined meeting of the Day Care and Regional Anaesthesia Special Interest Groups of ANZCA, the ASA and NZSA was held on Friday 25 May 2007 at the Sofitel Melbourne.



The meeting was a huge success with close to 250 delegates in attendance. The meeting was well supported by the Health Care Industry particularly by our major sponsors B. Braun and Pfizer. Our international speaker was Dr Susan Steele from the Duke University Medical Center in North Carolina.



# Final Fellowship Exam (Anaesthesia)

April/May 2007

The written section of the examination was held in Adelaide, Auckland, Brisbane, Cairns, Canberra, Christchurch, Darwin, Dunedin, Hamilton, Hong Kong, Kuala Lumpur, Launceston, Newcastle, Perth, Singapore, Sydney, Townsville, and Wellington.

The Clinicals were held at the Alfred and Royal Melbourne Hospitals, Melbourne. 164 candidates presented in Melbourne and 144 were approved.

## SUCCESSFUL CANDIDATES

Sudhanshu Agarwal	VIC	Mark A. Fairley	QLD	Thomas J Main	NZ
Yasir Al-Tamimi	WA	Daniel J Faulke	NZ	Shannon J Matzelle	WA
Kara J Allen	VIC	Nicholas S Ford	NSW	Heather R McDonald	QLD
Lance D Anderson	NSW	Nga Yin Fung	HK	Rebecca E McIntyre	VIC
Harmeet S Aneja	VIC	Katrina C Gelhaar	VIC	Maree H Meier	QLD
Viktor Avramov	SA	Robert Gotmaker	VIC	Shane Merriman	WA
Alexander R Baker	VIC	Andrew B Green	VIC	Andrew R Middleton	VIC
Sally L Barlow	NZ	Robert J Greenberg	VIC	Christopher H Mitchell	WA
David Belavy	QLD	Timothy C Grice	NZ	Pedram Naderi	SA
Erez Ben-Menachem	NSW	Steven A Gubanyi	QLD	Kenneth Y Nam	NSW
Kerry A Benson-Cooper	NZ	Su Yuan Stephen Han	NSW	Wai L Ng	NZ
Owen P Bourne	NZ	Elizabeth C Hessian	VIC	Julie L Ng	NSW
Tobias Robert Bown	SA	Jeremy M Hickling	NZ	Kar Peng Ng	SA
Ralf Brachold	VIC	Justin P Holborow	NZ	Suzi L Nou	VIC
Liesel Bredenkamp	NZ	James P Houghton	NZ	Poh Loong S Ong	VIC
Angela K Brothers	NSW	Stephen P Hur	VIC	Caroline Padget	NSW
Justin A Burke	VIC	Nicholas J Hutton	NZ	Angela J Palumbo	WA
David Cardone	SA	Angela Jerath	VIC	Ling Te Terry Pan	SIN
Matthew D Chacko	NZ	Owen A Keet	NZ	Shivashankaran Panchacharavel	NSW
Karen Chan	NSW	Geraldine L Khong	WA	Tuong D Phan	VIC
Chan Chi Wing	HK	Charles C Kim	VIC	Stephenie Ven Nee Phong	SIN
Mui Khoon Chang	NZ	Dae S Kim	NSW	Timothy M Porter	SA
Chee Yong Choo	SIN	Roni B Krieser	VIC	Justin M Porter	SA
Edwin K Choong	NSW	Emile F Kurukchi	QLD	Malarvizhi Ramesh	NZ
Steven P Cook	QLD	John Lau	ACT	Lorna G Rankin	NZ
Nicholas M Courtney	QLD	Andrew P Lavender	SA	Maivili M Raveenthiran	QLD
Joanne L Cowan	NSW	Thien Le Cong	SA	Maria M Rhodes	WA
Daniel Dallimore	NZ	Jong C Lee	NSW	Angelo A Ricciardelli	SA
Alison J Davies	NZ	Wai J Lee	NZ	Barbara A Rodriguez	VIC
Annick I Depuydt	NZ	Richard M Lees	NSW	Maira N Rush	NSW
Pedro A Diaz	SA	Martyn I Lethbridge	WA	Pamela Salerno	NSW
David S Dolan	QLD	Benjamin S Lloyd	QLD	Andrea S Santoro	NSW
Alexandra E Donaldson	QLD	Heather Loane	VIC	Erich B Schulz	QLD
Sam M Duncan	VIC	Francis Ling Loh	VIC	Anil J Sen Gupta	NSW
Robert J Edwards	QLD	Meng Woei Loh	SIN	John Sestan	NSW
Agata D Errera	NZ	Frances Lui	HK	Sanjeev K Sharma	NSW
		Maria Mackintosh	NSW	Mark A Shulman	VIC



Gabriel S Shuster	TAS
Joanne N Silverton	NSW
Amar A Singh-Jangi	VIC
Lyndon W Siu	VIC
Poobalan Sivasubramaniam	NZ
Reuben J Slater	VIC
Ian J Smith	NZ
Timothy J Smith	NSW
Amanda J Smith	QLD
Catherine E Smyth	NSW
Marcus D Soo	QLD
Anthony J Stark	VIC
Kate L Stephens	SA
Penelope A Strickland	SA
Mark B Suss	VIC
Alexander David Swann	WA
Robert M Thomas	QLD
Lara J Tickell	VIC
Kam C Tong	HK
Luke E Torre	WA
Alpha M Tung	HK
Rod M Van Twest	QLD
Ivan Ward	SA
Andrew J Watson	NZ
Andrew D Weatherall	NSW
Diana Webster	QLD
David E Whybrew	NZ
Hannah W Wong	NSW
Lai Yee Belinda Wong	HK
Grace L Wong	HK
Jeremy K D Wong	VIC
Duncan M Wood	NZ
Warrick G A Wrightson	NZ
William J Young	NZ

#### **CECIL GRAY PRIZE**

The Court of Examiners recommended that the Cecil Gray Prize for the half year ended 30 June 2007 be awarded to Dr Daniel Faulke, New Zealand.

#### **Merit certificates were awarded to:**

- Dr David Belavy, Queensland
- Dr Justin Burke, Victoria
- Dr Matthew Chacko, New Zealand
- Dr David Dolan, Queensland
- Dr Sam Duncan, Victoria
- Dr Jeremy Hickling, New Zealand
- Dr Andrew Weatherall, New South Wales



# NSWACE CME: CODE ORANGE!

## Anaesthetic Complications: their management and prevention

Over the weekend of Saturday 21 and Sunday 22 April, in the NSW rural centre of Orange, the NSWACE Committee held the above conference. As our conference coincided with 'Food Week' and the finish of school holidays in NSW it was fortunate that delegates heeded our advice and made their accommodation arrangements early. With over 200 participants (registrants, presenters, trade), the Orange community certainly knew the Anaesthetists were in town.

The NSWACE Committee is indebted to the anaesthetists in Orange for their input and energy, particularly Dr Tsung Chai (scientific program), Dr Ming Chan (social program) and Dr Frank Moloney (for allowing our conference to interrupt his department's staff for several months).

The plenary sessions were well attended and appreciated and the workshops, as usual, were particularly popular with excellent attendance at them all. For those registrants who were able to travel to Orange on the Friday, a Degustation dinner had been arranged at the Lolli Redini Restaurant, Orange, and with 60+ diners it was certainly a drawcard. The Saturday evening Conference Dinner at the Tonic Restaurant, Millthorpe, was also well attended with 100+ diners—the Karaoke machine was a big hit and organised coach transfers saved diners from getting lost in the Orange countryside. The city folk certainly learnt the meaning of 'country comfort' with the array and supplies of home cooking for breakfast and morning teas, not to mention the good old-fashioned size of the lunchtime meal in the hotel which was a casual stroll across the park from the conference venue.





# Quality and Safety Committee Report

## ACUTE PAIN MANAGEMENT MEASUREMENT TOOLKIT

In 2002, representation was made to the Victorian Quality Council (VQC) of the State Government by the Victorian Consultative Council on Anaesthetic Mortality and Morbidity (VCCAMM), expressing concern at the number and increasing incidence of reported adverse events, both mortality and morbidity, associated with acute pain management. As a result of this initiative a widely representative one day acute pain management workshop was conducted in February 2003.

Subsequently a working party under the chairmanship of Dr Tony Weaver was appointed by the VQC to review the appropriate measures that could be instituted in Victorian hospitals to ensure consistency in measurement of pain and related parameters in an attempt to obtain better pain relief, standardise procedures and so minimise adverse events. The project to develop this toolkit was funded and managed by the VQC and awarded to St Vincent's Health under the leadership of A/Prof David Scott.

The Toolkit encompasses evidence-based subjective and objective measurement of pain, in a broad range of patients as well as indications for intervention. Consistent strategies for assessing and recording both *pain intensity* and the *functional impact* of pain are proposed. Detailed attention is given to standardising monitoring for side effects (eg sedation scores, Bromage scale etc), accompanied by suggestions for documentation for pain management, including trigger points for intervention. It is envisaged that all these components would be represented on every hospital's frequent observation chart, such that all modalities of analgesia can be managed on the same form.

Finally, there is a suggested proforma for a hospital-wide analgesia treatment summary form to aggregate data and facilitate wider audit and research activity in acute pain management.

The Toolkit was taken to a further representative workshop in February 2006 and consensus obtained to proceed with its publication. It is hoped that this toolkit will be adopted widely in Victorian hospitals to achieve uniformity in the measurement and management of acute pain for individual patients and provide a consistent approach for staff moving from one hospital to another.

To promulgate the Toolkit, the VQC has funded a Project Officer and will be running a series of workshops in Metro and Regional health areas and will then be asking for expressions of interest to roll out the Toolkit in individual institutions with funding assistance to the successful applicants.

The toolkit is a valuable publication that could well be followed in other states. It can be viewed at <http://www.health.vic.gov.au/qualitycouncil>

DR PATRICIA MACKAY, VIC



DR CHRISTINE JORM

## Is practising Evidence Based Medicine (EBM) too hard?

There is no doubt that the use of the best available evidence is essential for the provision of safe quality patient care (and 74% of Australian doctors think EBM improves patient care). Last month, Professor Myles discussed the need to practise EBM in anaesthesia. He listed a number of evidence based practices. One omitted, that is worthy of consideration, is the establishment of minimum volume standards for performing discretionary surgery. It is well recognised that hospitals and surgeons with higher volumes have lower case fatality rates following surgery<sup>1-4</sup>. The practical re-arrangements such data would support are rarely comfortable. For Australia, distance may sometimes provide a competing consideration (eg for coronary angioplasty), but the relative safety implications of such considerations should be tested, not assumed.



Even simple changes in practice are hard. For example, let us consider the recommendation for the subclavian route and use of ultrasound guidance for central line insertion. For an experienced anaesthetist to change their method and site of central line insertion may be difficult (for instance a colleague's assistance may be required). Worse, patients may be subject to a high rate of complications while the anaesthetist is in this learning period. (It is even possible that difficulties with the subclavian route during training have resulted in an individual's current preference for the internal jugular.)

As well as the practical difficulties of any new learning or change, there are two other major issues that make it hard to practise EBM. These are: the uncertain and case-based nature of most medical knowledge, and the difficulty of determining what might be current best practice.

### Uncertainty

Uncertainty exists in all forms of responsible human action, but doctors' actions have profound and directly observable consequences for their patients resulting in doctors being particularly prone to anxiety about their decisions.<sup>5</sup> Important types of uncertainty relate to:<sup>5</sup>

- > incomplete mastery of available knowledge;
- > limitations in current medical knowledge; and
- > the difficulty of distinguishing between personal ignorance and the limitations of current knowledge.

Doctors are not scientists, although they have a rational science using practice<sup>6</sup>. It is the use of the interpretative and narrative that defines clinicians. This is:

'... particularly evident in clinicians' habitual scepticism, in their refusal to generalise, and, above all in their pedagogical and mnemonic use of single particular, chronological accounts of illness.'<sup>7</sup>

It has been suggested that context specific application of sets of medical knowledge and experience (which would include procedural skills) that are individual to each doctor are the only way that medicine is able to be practised.<sup>5</sup> If this is so, it may explain why 85% of UK doctors would ignore a guideline if they disagreed with it.<sup>8</sup>

### What is current best practice?

Production of guidelines has been a popular approach to increasing the practise of EBM. Guideline implementation is difficult and much literature attests to the difficulty of changing medical practice. Opinion though 'often fills in gaps in the evidence base related to a chain of reasoning that underlies a clinical guideline'.<sup>9</sup> It is estimated that 50-80% of all medical treatments have never been validated by trials and this absence of evidence does not

mean a treatment is not safe or effective.<sup>9</sup> When Australian doctors were recently surveyed on their views about EBM,<sup>10</sup> 40% agreed that 'there is not enough evidence relevant to my specialty'. If evidence is fragmentary, it is not surprising that doctors may disagree with an evidence based guideline (and 75% of UK doctors disagree with at least one national guideline).<sup>8</sup>

What is regarded as 'best practice' changes over time, as new evidence is produced and considered. The issue of peri-operative beta blocker therapy forms a good example. In 2002, this was strongly recommended.<sup>11</sup> Yet in 2005, it was suggested that '...not only does it fail to improve outcomes, it may in fact worsen them'.<sup>12</sup> The basis for this change in recommendation was a Canadian systematic review<sup>13</sup>, but at the same time, a US review supported beta blocker use in high risk patients<sup>14</sup>. Meanwhile in the UK, patients on chronic beta blocker therapy were shown to suffer increased rate of peri-operative myocardial infarction<sup>15</sup>, and in the same time period, a paper demonstrated under-utilisation (based on the previous recommendations) of beta blockers<sup>16</sup> in peri-operative patients. The ephemeral nature of 'best practice' is made evident by this example.

### The way forward

There are no easy answers, but I suspect the best solution will come from medical colleges assuming a greater role in the development of guidelines. These new guidelines though need to 'live' in a way that has not been usual in the past. The guideline development groups need to be permanent, and permanently scanning the literature and assessing the need for change. A guideline should never have a fixed revision date, but rather a well informed group should be responsible for making sure it is appropriate for the current state of the evidence. Further, all guidelines need to be linked to key performance indicators for clinical care (and have implementation pilots). In the case of central line insertion, perhaps study of the complications associated with changing practice in Australia might need to be made. In the case of peri-operative beta-blockers, the process difficulties with appropriate prescription may require solutions to be developed (while at the same time, a closer analysis of deaths due to myocardial infarction in the first week post-surgery could be performed). These changes would make it much less likely that a professional will 'disagree' with an evidence based guideline and make it easier to actually practise EBM.

DR CHRISTINE JORM, NSW

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# Open Afternoon

at ANZCA House and Ulimaroa

As part of the Annual Scientific Meeting held in Melbourne, the ANZCA Head Office decided to open its doors to Fellows who may not have had the opportunity to visit the College before. The Open Afternoon was held on 25 of May from 2 to 4pm.

**Initiated by Drs Rod Westhorpe and Ian Rechtman, the Open Afternoon was an opportunity for visiting Fellows to view the historic Ulimaroa and the award-winning architecturally designed ANZCA House.**

The event was designed to give Fellows an opportunity to become familiar with the College and its facilities.

Dr Westhorpe designed a straightforward, yet informative, self-guided tour encompassing the Ulimaroa Board Room, the DJ Room, Library, Auditorium, Council Room and Museum. Other areas of interest and various gifts made to the College were also on exhibition, including the legendary Hippocrates–Latin Translation by Janus Cornarius. The book was printed in 1558 and presented to the College in 1994 by Professor Bernard Brandstater.

Dr Ian Retchman and Dr Peter Lowe—who both have an interest in the history of the College—were on hand to guide visitors through the stately rooms of Ulimaroa, imparting their knowledge on everything from how the building was sourced to information about Past Presidents, the various art works and other gifts donated to the College.



Dr Westhorpe, Elizabeth Triarico and their many volunteers, including Dr Christine Ball, worked tirelessly to make sure the Museum (which was to be launched the following Monday) was ready for visitors to explore. With its many fascinating exhibits, the Museum proved to be a point of conversation for all.

Afternoon tea in the foyer provided an opportunity for Fellows to mingle with the President, Vice President and other Councillors and to catch up with colleagues they may not have seen in a while. Approximately 40 to 50 Fellows, their families and friends visited the College and from the feedback received it was a positive afternoon for all. Many thanks to all staff involved in the project. Your assistance was invaluable.

ROMANY AMARASINGHAM  
Project Coordinator



Top, from left: Dr Barrie McCann, Dr Rod Westhorpe and Dr Walter Thompson

Middle, Left, Dr Ian Rechtman and Prof Garry Phillips

Bottom, from left: Ms Lynda Patullo of Green Poles Design, Dr Rod Westhorpe and Dr Christine Ball

Left: Dr John Williamson, Noel Sheales and Dr Peter Lowe

# Perioperative medicine and you

## What is Perioperative Medicine?

Exploring the boundaries of anaesthesia practice as individuals and collectively was the theme of the ANZCA ASM Monday afternoon session.



**Professor Alan Merry, Chair ANZCA Quality and Safety Committee spoke of the importance of a sound grounding in the practice of Internal Medicine as a core component of what it means to be an anaesthetist and doctor.**

Professor Susan Steele from Duke University, North Carolina—a recognised expert in regional anaesthesia—outlined her experience in developing a service framework and anaesthesia led multidisciplinary team for day-only surgery and procedures, including at home care.

Fellows heard an echo when Dr Vanessa Beavis—representing the Perioperative Medicine Taskforce<sup>1</sup>—gave feedback on what 500 randomly selected Fellows, and Department Heads associated with the FANZCA teaching program thought of Perioperative Medicine.

It is agreed (>90% support) that Perioperative Medicine may be defined as 'the continuum of patient care involving pre-operative evaluation and preparation, pre-anaesthetic assessment, intra-operative care, post-operative care and the management of systems and personnel supporting these activities.' Current practice prioritises and concentrates resources in order, in the

operating theatres, recovery room, pre-admission clinics and acute pain round. Whilst there was over 70% support for developing Perioperative Medicine across the whole spectrum, with over 50% of Fellows personally prepared to contribute time, the identified barriers to Perioperative Medicine are significant—particularly in regard to postoperative care in the wards, including lack of resources for a 24/7 service, lack of buy-in by hospital administration, medicolegal and political implications and a perceived need for further medical knowledge and skills.

The work of the ANZCA Perioperative Medicine Committee<sup>2</sup> is to:

1. Address the needs of Fellows and Trainees by incorporating Perioperative Medicine in Continuing Professional Development (CPD) and the review of the FANZCA program;
2. Establish research (pilot) sites to explore the development of a potential Perioperative Medicine service for high risk patients in an evidence based manner with the ANZCA Clinical Trials Group.

PLEASE JOIN US if you are interested in either of our two areas of work by contacting the Perioperative Medicine Committee via [cwilkinson@anzca.edu.au](mailto:cwilkinson@anzca.edu.au)

Also in keeping with the philosophy behind

ANZCA's many Taskforces—to bring in Fellows to refresh and inform ANZCA's work—there is opportunity for leadership in Perioperative Medicine. Every two years the position of Chair will be handed on as we continue to refresh and explore Perioperative Medicine. Please feel welcome to join us in this initiative.

DR SU-JEN YAP  
Chair ANZCA  
Perioperative Medicine Committee

**1 Members of the Perioperative Medicine Taskforce (2005):** Vanessa Beavis (NZ), Vic Callanan (Qld), Mark Colson (Vic), Rick Horton (Vic), Ross Kerridge (NSW), Ross Macpherson (NSW), Roger Traill (NSW), Su-Jen Yap (Chairperson) (NSW).

**2 Members of the Perioperative Medicine Committee (2006):** Vanessa Beavis (NZ), David Broadbent (Vic)\*, Vic Callanan (Qld)\*, Don Harrison (NSW) #, Ross Kerridge (NSW), Di Khursandi (Qld)\*, Kate Leslie (Vic), Garry Phillips (SA), Lindy Roberts (WA), Wally Thompson (President) (WA), Leona Wilson (NZ)#, Su-Jen Yap (Chairperson) (NSW).

\* retiring members

# new members (2007)



# Obituaries

## Alan Guibal Bradford

19.10.1923 – 10.04.2007



DR ALAN BRADFORD

● Dr Alan Bradford, universally known as Brad, Nelson's first and long-serving specialist anaesthetist, died on 10 April, aged 83.

Brad was born in and grew up in Sheffield UK, where his father held professorial posts in Education and Psychology. His unusual middle name derived from Channel Islands maternal antecedents. He was educated at Netheredge School, then studied medicine in Sheffield during the staff depleted wartime years, graduating MBChB in 1947. He then served his two years National Service in the RAF in Berlin and Northern Scotland. He was awarded a Fullbright Scholarship for 1949, spending the year in the USA in hospitals in Elizabeth, New Jersey, and Bute, Montana.

On his return to England, his thoughts were towards general practice on the South Coast, however he kept finding, as he would later say with Yorkshire succinctness, 'Bart's men preferred'.

He came to NZ in 1952, working his passage as ship's doctor. He had spells in general practice in Collingwood, Ranfurly & Plimmerton, then in 1954 took a registrar post in obstetrics at National Women's Hospital Auckland. However, with obstetrics he found 'I saw the sunrise too often for my liking', so resolved to return to England at the completion of the year. Four weeks prior to Brad's scheduled departure, final year Otago medical student Kay Johnstone began her obstetrics attachment. In what must have been a whirlwind six weeks they became engaged,

'Brad had infinite patience, and unflinching tact, courtesy and equanimity, making him a reassuring presence for surgeons, theatre staff and patients.'

Kay sat her finals, then they married. They remained in Auckland, Brad switching to anaesthesia, Kay training in child psychiatry.

Brad completed his anaesthesia training in Auckland, one of the early trainees of the recently structured Faculty of Anaesthetists, Royal Australasian College of Surgeons. He qualified FFARACS in 1960, was secretary/treasurer of NZSA in 1960-61.

They then spent four years in Melbourne, Brad having an appointment at the Royal Victorian Eye & Ear Hospital, plus private practice involving ever increasing time spent travelling between various hospitals with the resultant long hours away from home.

Looking for a smaller centre lifestyle (and perhaps with Brad nostalgic for the earlier time he spent in Collingwood), in 1965 they both accepted positions in Nelson—Brad as the city's first specialist anaesthetist, Kay as the Superintendent of Braemar Psychopaedic Hospital.

The Braemar Superintendent's residence, with its lawns, tennis court and treed backdrop, became the centre of a social round hitherto not experienced by the Nelson Medical community. Brad, tall, tweeded, every inch the English country gentleman, contrasted with Kay's exuberant and edgy fashion style.

Anaesthesia in Nelson in 1965 was provided on a sessional basis by visiting general practitioners, of varying seniority, whose expertise was acquired on the job and who used a very limited range of drugs and techniques. To quote the then hospital superintendent, 'Brad proceeded to gently elevate the standard of general practice anaesthesia'. Being the town's first specialist

meant acquiring the operating sessions associated with the most demanding clinical cases and the more demanding surgical personalities.

One visitor enchanted by the Bradfords' hospitality was Professor Eckenhoff of Chicago, touring in 1968 as the ASA/NZSA visitor. At his invitation, Brad spent 1970 in Eckenhoff's department at Northwestern University, returning to Nelson with new expertise in regional techniques, not then commonly used in NZ.

Brad had infinite patience, and unflinching tact, courtesy and equanimity, making him a reassuring presence for surgeons, theatre staff and patients. He considered that Nelson Hospital's best interests were served if it could attract as house surgeons the most confident and ambitious of new graduates (who might return to specialist posts), and that the absence of a registrar tier allowed early responsibility for these young doctors. Arguably this was valid reasoning in the far off days before student loans and shift work for juniors. Thus Brad declined approaches to include Nelson in registrar training schemes, the consequence being that he spent his entire career up to retirement at 65 taking first call at nights and weekends. The demands of call evolved considerably, becoming more onerous as surgical throughput expanded beyond the daytime capacity of the 1950s design theatre suite. On the other hand, as the older generation of GP anaesthetists progressively retired, the load became shared by specialist colleagues, a second in 1972, third in 1980, fourth in 1984.

After Brad's retirement, Kay continued working, latterly as Nelson Hospital Chief Medical Officer. On her retirement from this post, they moved to Hamilton where Kay continues to work in child psychiatry. Sadly, Brad's retirement was marred by the onset of Parkinson's disease.

Brad is survived by Kay, sons Charles and George, and daughter Polly, a medical officer in Psychiatry in Wellington.



# Report following the Council Meeting

Of the Australian and New Zealand College of Anaesthetists held on 14 April 2007

## DEATH OF FELLOWS

**Council noted with regret the death of the following Fellows:**

- > Professor Sir Gordon Robson (UK) – Hon FFARACS 1968, Hon FANZCA 1992
- > Dr Alan Guibel Bradford (NZ) – FFARACS 1960, FANZCA 1992

## HONOURS, APPOINTMENTS AND HIGHER DEGREES

The admission of Dr Nicholas A Jansen (Vic) to The Most Venerable Order of the Hospital of St John of Jerusalem as a Serving Brother (SBStJ) was recorded by Council.

## EDUCATION AND TRAINING

### Membership of Regional/National Trainee Committees

Council endorsed the membership of the Trainee Committees from each State of Australia, New Zealand, Hong Kong, Singapore and Malaysia.

### Distance Education Clinical Teaching Course

Council supported the recommendations of the Clinical Teaching Course (CTC) Working Party pertaining to the Distance Education Clinical Teaching Course. This course is planned to run in parallel with the current CTC model (in which one Module is run in each Region and New Zealand per year).

The course will consist of four Modules which participants will be able to complete in a one year time frame. The course will be repeated, initially on an annual basis, but frequency will be determined by participant levels of interest. The course will include pre- and post-workshop activities provided via distance education and a face-to-face component provided at a two day workshop.

## Review of Module 11 – Education and Scientific Enquiry

A Working Party has been established to review Module 11.

### anzMET – Australian Postgraduate Medical Education and Training Forum (incorporating the 12th National Prevocational Medical Education Forum) – October 2007.

Council nominated Prof Barry Baker, Dr Lindy Roberts and Prof Russell Jones to attend this forum.

## INTERNAL AFFAIRS

### Regulations

The following Regulations were updated:

- > Regulation 2.9 – CPD Committee
- > Regulation 6.3 – Election to Fellowship

Regulation 33 – Trainee Performance Review – was promulgated following approval of the process documentation.

### Council Election

Congratulations were extended to recently re-elected standing Councillors, Drs Margaret Cowling, Lindy Roberts, Walter Thompson, and A/Prof Tony Weeks. Drs Peter Cook and Genevieve Goulding (both Qld) were elected to the two vacant positions and will join Council following the AGM in May.

### Retiring Councillors

Drs Diana Khursandi and Rod Westhorpe are retiring from Council in May. The President recognised their contributions and thanked them for their input and efforts during their time on Council.

### Retiring RACS Representative

B Waxman is retiring from the RACS Council and will be standing down as the representative to ANZCA Council. The value in having cross-representation between the two Colleges was recognised, and Prof Waxman was thanked on behalf of Council for his input over the years.

## PROFESSIONAL

### RANZCOG/ANZCA/RACGP/ACRRM Position Statement on the Provision of Obstetric Anaesthesia and Analgesia Services

This document has now been approved by the four parent bodies and is in the process of being formatted for promulgation.

### Draft Position Statement on Sedation

Following consideration by the Sedation Working Party, revision of PS—Guidelines on Conscious Sedation for Diagnostic, Interventional Medical and Surgical Procedures—will be undertaken. The first step will be to clarify the principles the College wishes to have included in the document, and then to consider them in parallel with the other sedation documents.

### Malignant Hyperthermia – Australia and New Zealand (MHANZ)

Subject to positive feedback from the Regional/NZ Committees, Council agreed to endorse the MH Resource Kit put together by MHANZ. It is intended to advertise the kit and make it available electronically on the College website via a link to the MHANZ website.

## WORKFORCE

### Workforce Survey

Council approved investigating a joint survey with the ASA on issues related to the Australian anaesthesia workforce. Terms of Reference are to be drafted and the use of an external agency to undertake the survey is under consideration. A New Zealand workforce survey will be undertaken at a later stage.

## RESEARCH

### ANZCA Foundation

The Corporate Launch of the ANZCA Foundation took place on 12th April, and was officially launched by the Governor of Victoria, Professor David de Kretser.

DR WALTER R THOMPSON President  
DR LEONA F WILSON Vice President

# Simulation: The hunt and the campfire?

Without prior similar experience, it is likely that our response to a crisis or stressful situation will be far from optimal. Confronted by a crisis, our minds dramatically curtail the range of information presented for audit.<sup>1-3</sup>



**This inattentional blindness<sup>3</sup> (the 'gorilla effect') may have atavistic survival value. It is possible that imposing limitations on sensory information is a survival mechanism honed by hundreds of millennia of exposure to stressful situations, both in escaping predators, and in pursuit of prey — 'a dog in the hunt doesn't stop to scratch its fleas'.<sup>4</sup> However, problems with situational awareness are responsible for many aviation mishaps,<sup>1</sup> and the same is likely to be true for medicine.<sup>2</sup>**

Can we address the problem of inattentional blindness? Psychologist Keith Payne has researched the issue in depth, and come to the conclusion that when forced to act quickly, we stop relying on the actual evidence of our senses and fall back on a rigid and unyielding system, a stereotype or heuristic that we may not even endorse.<sup>5</sup> For example, online Implicit Association Tests<sup>6</sup> easily demonstrate how people who show little explicit racial bias are more likely to associate negative words with images of black people than white people, when under time pressure. The solution Payne found was to encourage people to wait before answering.

Practice is important. In an observational study of police officers in Dade County, Florida officers did the 'right thing' 92% of the time in the 'face-to-face' confrontation of a subject, but in the less familiar and less practised 'approach to the scene', their success fell to a dismal 15%.<sup>7</sup> Training in situational awareness has a beneficial effect in such circumstances.<sup>8</sup>

Given such studies, it seems highly appropriate to practise crisis skills, familiarising learners with stressful situations and ways to deal with them. But there is a problem—such an approach seems to fly in the face of safe or comfortable methods of teaching. Abraham Maslow, for example, described a hierarchy of needs ascending from basic needs, such as hunger and thirst, through safety and social needs, culminating in 'self actualisation'. Who can argue with the proposition that a hungry child cannot be expected to learn? It seems reasonable that all modern educators should tailor a teaching environment that is seen to be safe and that learners should not feel threatened nor should the teacher be perceived as hostile. The perception is that learning takes place 'around the campfire' where everyone is warm, well-fed and contented.

The simulation environment is considered dangerous by many. Factors which appear to compromise our own safety in the simulated operating room include:

1. We're being watched by our peers, and even videotaped. Despite working in teams, we are not normally scrutinised and judged in routine performance, let alone when things go wrong.
2. Bad things happen. Participants who are engaged in the simulation may feel very real grief and distress about 'adverse' outcomes; they may even reject lessons learnt from simulation because of the discomfort experienced.

How can we reconcile the apparent necessity for a safe, non-threatening environment with the simulation-supported need to immerse learners in a stressful environment?

The danger of avoiding simulation is that in a crisis, stereotyped or dysfunctional behaviour is likely. We can argue that in a crisis the individual has no time to think, and must just act, that errors are inevitable, and that we must deal with the errors that result. Such an approach is unsatisfying. There is no evidence that the extreme arousal encountered in difficult simulations and the consequent mind-blindness are inevitable, and there is considerable evidence to the contrary<sup>10-13</sup>

‘All I’m interested in during the first month is that the young anaesthetist becomes aware how easy it is to kill a patient. The rest—caution, knowledge and expertise—will follow naturally.’

One approach is to bowdlerise simulation, making it safe, but removal of all dangerous components from simulation introduces two major problems. The first and biggest problem is that in the safe environment, participants do not encounter the stresses they will encounter in real life, and do not develop appropriate responses. An allied problem is that the modified environment may well promote negative learning.

A more robust approach is the full mission simulation approach.<sup>14</sup> Here we strive to recreate real life, with all its knocks and bruises—in contrast to a fireside chat, we pursue the hunt. The fundamental thesis of the full mission simulation approach is a program of stress inoculation. We strive for fidelity, a composite of environmental fidelity, patient physiological fidelity and fidelity in terms of human interaction and participant psychological stress.

It should be emphasised at this point that the key component in realism is not absolute ‘naturalistic’ fidelity, but the participant’s perception that the situation is real, and consequent engagement of the participant. A ‘disengaged’ learner might be confronted by an extremely realistic scenario and still fail to ‘buy in’. Conversely, a keen learner might participate and engage with minimal props, particularly if other participants are similarly enthusiastic.

In using full mission simulation we should not be afraid of confronting extreme situations, even those involving unanticipated behaviour by participants that results in extreme harm to or death of the ‘patient’. It is here reasonable to go through normal processes including:

1. Realistic death of the mannequin;
2. Following the usual processes associated with the death of a patient;
3. Correct debriefing of the learner; and
4. Suitable resolution, often with scenario re-enactment.

In such circumstances it may be appropriate to forego the planned educational objectives in deference to the greater good of showing the candidate the severity of their error. An old, wise Professor of Anaesthesia

was heard to comment ‘All I’m interested in during the first month is that the young anaesthetist becomes aware how easy it is to kill a patient. The rest—caution, knowledge and expertise—will follow naturally’. Simulation can help to flatten the associated learning curve.

It can be argued that a true, realistic and no-holds-barred approach to simulation allows the learner to develop an appropriate approach to the deaths which they are likely to encounter several times during a lifetime of practice. Although rare, death is not always avoidable during anaesthesia. It might be that the anaesthetist who is too cautious and refuses to anaesthetise many ASA 4 or ASA 5 patients will avoid being exposed to deaths, but will also fail to save lives in consequence.

If we accept the full mission simulation approach, then what price Maslow? Fortunately, the two approaches are, despite appearances, not mutually exclusive. Both human society and the human brain have doubtless been conditioned over the past several hundred thousand years by their ‘operating environment’. Let us draw an analogy between this conditioning and modern approaches to education. Simulation is ‘the hunt’ with all of its dangers, excitement, and frenzied activity; the warm Maslow-like approach is the post-hunt debrief around the camp fire.

Learning from the analogy, it is conceivable that modern simulation would benefit from several modifications. Firstly, ‘the hunt’ will be more realistic when it takes place in the actual workplace, rather than in a dedicated, identified simulation centre. Secondly, ‘the campfire’ might be made even more congenial, with a warm Maslow-like environment containing coffee and food, rather than a stark room adjacent to the ‘scene of the hunt’. Repetition of ‘simulation stories’ over subsequent days in a similar non-threatening environment (the anaesthetic tea-room) will naturally reinforce learning and disseminate appropriate messages.

DR LARA HOPLEY

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# Geoffrey Kaye Museum of anaesthetic history

The Museum on show during the 2007 ANZCA ASM

The Museum held a number of very successful activities during the 2007 ANZCA ASM, which was held in Melbourne, including: A Museum promotional display, located at the ASM venue, the Melbourne Exhibition and Convention Centre; A Museum viewing on Friday 25 May, as part of the ANZCA 'Open Afternoon' and the launch of the new Museum Display, All in a Days Work, following the History of Anaesthesia and Resuscitation SIG Workshop which was held at the College on Monday 28 May 2007.



From top left:  
Dr Noel Cass, Dr Herb Newman, Dr Christine Ball  
and Dr Rod Westhorpe  
ASM Museum display  
Dr Rod Westhorpe and Dr Christine Ball  
ASM Museum display  
Dr Rod Westhorpe launches the display  
Guests enjoying the display  
Launch of Museum display - guests  
Launch of Museum display - guests



# Rural Special Interest Group Annual Report 2006

The Rural Special Interest Group Executive  
for 2006-07 is as follows:

<b>Dr Diana Khursandi</b> Chair, JCCA Member Chair ANZCA Rural Education & Services Committee	<b>QLD</b>	<b>Dr Andrew Michael</b> <b>Dr John Male</b> Coopted member	<b>SA</b> <b>WA</b>
<b>Dr Frank Moloney</b> Chair JCCA	<b>NSW</b>	<b>Dr Daryl Catt</b> JCCA member Chair, Rural Anaesthesia Recruitment Service (RARS)	<b>SA</b>
<b>Dr Anna Hawke</b>	<b>NSW</b>		
<b>Dr Michael Miller</b>	<b>NZ</b>		
<b>Dr Craig Mitchell</b>	<b>VIC</b>		
<b>Dr Brian Spain</b> JCCA member	<b>NT</b>		

**There are 303 members of the Rural SIG, with two associate members. There are currently 22 rural centres accredited for ANZCA training in Australia, and six in New Zealand.**

A teleconference was held on 1 March 2006 in which, amongst other matters, future presentations were discussed. It was decided to extend a permanent invitation to the Chair of RARS and the Chair of the JCCA to attend Rural SIG meetings if these persons were not already on the Executive. There are ongoing discussions about extending both the RARS and an organisation similar to the JCCA to New Zealand.

The Annual General Meeting was held at the ANZCA ASM in May 2006 in Adelaide.

Brian Spain and Frank Moloney both presented at the Rural SIG Session:

Frank spoke on 'What works and what doesn't', and Brian presented 'Training GP Anaesthetists', a review of 10 years of experience in this field in the Northern Territory.

Workforce shortages remain an important factor in the delivery of anaesthesia services to some rural areas of Australia and New Zealand, although other areas have now reached a critical mass. The rural and regional workforce continues to be augmented in some centres with overseas trained specialists (OTS).

27 OTS were successful in gaining the diploma of FANZCA in 2006. They were based in the following regions/countries: 12 Queensland, 6 NSW, 1 WA, 3 South Australia, 3 New Zealand, and one each NT & ACT.

DR DIANA C S KHURSANDI  
Chair Rural SIG  
10 December 2006

# Western Australian Combined CME Committee

## Updates in Perioperative Analgesia



**On Friday 9 March 2007, more than 90 Fellows, Trainees and GP Anaesthetists—as well as their families and partners—travelled to beautiful Bunker Bay near Dunsborough for the annual WA country weekend meeting. The theme of the meeting was Updates in Perioperative Analgesia.**

The weekend began with welcome drinks by the pool on the Friday evening. Delegates and partners had a chance to unwind after the long drive from Perth and other parts of WA and admire the fantastic views that Bunker Bay offers.

On Saturday morning, the academic program commenced with the first session entitled 'Optimising Oral Analgesia'. Informative presentations were given by Drs Christian Brett, Bill Weightman and Professor Stephan Schug. After morning tea, Drs Steve Myles, Steve Watts, Garry Wilkes and Mr Riaz Khan all gave excellent talks on 'Regional Anaesthesia'. The final session for the day prior to lunch was a case-based discussion covering 'Anaesthesia and Adverse Outcomes'. The panel for this discussion included Drs Steve Watts, Dermot Murphy.

The Saturday afternoon was set aside for social activities, including golf, wine tasting, pottery, beaching or the resorts pool and spa facilities followed by an enjoyable gala dinner in the evening.

On Sunday morning in the first session Drs Jane Mair and Holger Holldack covered topics related to 'Pain in the PACU' followed by a case debate from Drs Rob Storer, Brien Hennessey and Peter Platt on whether 'Nitrous Oxide should be banned'. In the session after morning tea Drs Duncan McKay, Lac Truong and Mark Schutze spoke about 'Persistent and Chronic Pain and how it can be prevented'. The final session for the weekend covered 'The Difficult Patient' and this was presented by Drs Roger Goucke and Divya Sharma.

The weekend was a great success and the Combined CME Committee would like to thank all the presenters along with the three convenors Drs Angie Lee, Steve Watts and Paul Kwei for their contributions to a very informative and well run meeting.



# 2007 ASM



The 2007 College Ceremony was held during the ANZCA ASM in Melbourne in late May. 106 new Fellows of ANZCA and 12 Fellows of the FPMANZCA were presented during the ceremony. The Barbara Walker Prize was awarded to Dr Mark Schütze. The Renton Prize was awarded to Dr Damien Wallman and the Cecil Gray Prize was awarded to Dr Peter Chong, Dr Brett Chaseling and Dr Heidi Walker. The presentation of awards and Fellowship was followed by an oration delivered by Adam Elliot the Oscar winning director of Harvie Krumpet.









# ANZCA/ASA Combined CME Committee

## 10th Annual Registrars Meeting



On 17 February 2007, the 10th Annual Queensland Registrars Meeting was held. With 11 presentations, two of those from New Zealand, and 50 people in attendance, the day was a great success.



Top from left to right: Dr Barry Benham, Dr Sheila Malcolmson, Dr Gloria Liu, Dr Steven Cook, Dr Theresa Trinh, Dr Daniel Tsui, Dr Rebecca Black, Dr George Pang, Dr Rod van Twest, Dr Pal Sivalingam, Dr Nigel Akroyd, Dr Michael Fanshawe

Professor Tess Cramond and prize winner Dr Rod van Twest  
Dr Phelim Reilly and Prize winner Dr Gerald Wong  
Adjudicators, Dr Martin Wakefield, Dr Frank Phillips and Dr Michael Fanshawe

**Adjudicators this year were, Dr Frank Phillips, Dr Michael Fanshawe and Dr Martin Wakefield. These doctors were representative of both public and private hospitals in Brisbane. Dr Lisa Cowell generously donated her time as Time Keeper and did a great job of ensuring the day ran to time.**

All presentations were of high quality and the winner of the Annual 'Tess Cramond Award' was Dr Rod van Twest who presented 'A BIS Guide to Relaxant Free Intubation'.

Axxon Health generously sponsored the second place award and named it in honour of Dr Phelim Reilly. The adjudicators agreed the winner to be Dr Gerald Wong who presented 'Evaluating the time interval from theatre notification until delivery in emergency caesarean sections'.

We were delighted that Professor Tess Cramond and Dr Phelim Reilly were able to attend to present the awards for first and second place and thanked them for their continued support of Anaesthetic Education in Queensland.

On behalf of everyone, I would again like to thank Ms Sharon Miethke, Ms Kylie Joynson and Mrs Amy Pearson for their organisation and administrative assistance.

**DR PAL SIVALINGAM**  
Formal Projects Officer  
Queensland Regional Committee

## ANZCA REGIONAL/NATIONAL ANNUAL REPORTS May 2006-February 2007

### OFFICE BEARERS AND MEMBERS

#### Chair

Dr Cliff Peady

#### Deputy Chair

Dr Stephen Brazenor

#### Secretary

Dr Grant Devine

#### Treasurer

Dr Caroline Fahey

#### Regional Education Officer

Dr Carmel McInerney

#### Formal Projects Officer

Professor Thomas Bruessel

#### Continuing Education Officer

Dr Stephen Brazenor

#### New Fellow Representative

Dr Caroline Fahey

#### Trainee Representative

Dr Richard Galluzzo

#### ICU Representative

Dr Mark Oliver

#### Regional Administrative Officer:

Mrs Eve Edwards

#### Attendance at Regional Committee Meetings

Dr Brazenor	5/5
Professor Bruessel	3/5
Dr Devine	3/5
Dr Fahey	5/5
Dr Galluzzo	2/5
Dr McInerney	4/5
Dr Peady	5/5

It is a pleasure to be able to commence this report without the usual opening statement that '2006 was another difficult year for anaesthesia in the ACT...'

Additional consultant appointments have eased workforce pressures, and with continued maturation of the ACT Anaesthesia Training Scheme (8 ACT Trainees and one Overseas Trained Anaesthetist are expected to sit the Part 2 FANZCA exam in 2007) this trend is anticipated to continue.

Supervision of Trainees has improved, and The Canberra Hospital received a much more positive report when reinspected by ANZCA in August 2006.

21 trainees continue to be rotated in the ACT Anaesthesia Training Scheme— however, all are now ACT based, following the withdrawal of the rotating registrar from Sydney. The ACT rotation continues to satisfy all module completion requirements (and includes a rural rotation to Albury/Wodonga Hospitals).

ACT trainees continued to enjoy examination success: Dr Daniel Lane passed the Part 2 exam at first attempt, and Drs Long Le and Ross Peake passed the Part 1.

Dr Lane also submitted and had accepted his Formal project 'Anaesthetic Implications of Vascular Type Ehlers-Danlos Syndrome' (published in *Anaesthesia and Intensive Care* 2006;34:501-505).

The annual 'Floriade' Continuing Medical Education meeting was held on the weekend of September 23rd-24th 2006, with the theme of 'Monitoring and Outcome'. Professor Bruessel is again to be congratulated for organising an informative and entertaining program, with an exciting group of local, interstate and cross-Tasman speakers. 115 registrants attended, a small increase on the 2005 figure. The date and theme of this year's meeting will be set shortly.

Dr Brazenor and Professor Bruessel were again co-convenors of the local CME program—a series of lectures for the benefit of ACT Fellows and Trainees.

Speakers and topics included Dr Ian Jeffery ('Recent Advances in Cardiology and Anaesthesia'), A/ Prof J. Carmody ('Mechanisms of Anaesthesia'), Dr B. Silbert ('Postanaesthetic Cognitive Dysfunction'), A/Prof D. J. Cooper ('Decompressive Craniectomy'), Dr Paul Burt ('Ventilation in Anaesthesia'), and Drs N. Gemmel-Smith and H. Lawrence ('Tricky Orthopaedic Cases').

On a wider front, it has long been recognised that the ACT is the only Australian State or Territory lacking a means of reporting Anaesthetic Mortality data.

The Chair of the ACT Regional Committee has had several meetings, and frequent correspondence with the ACT Department of Health and the ACT Coronial Office on this subject.

Agreement in principle has been achieved regarding the formation of a Committee, structured and enjoying the same protection and privilege of other State Mortality Committees, but with Terms of Reference to include not only post anaesthetic, but also post sedation, mortality and significant morbidity.

Unfortunately, earlier offers of secretarial support to the proposed Committee by ACT Health have been withdrawn. With the small numbers of FANZCAs present in the ACT this lack of secretarial support may prove difficult to overcome.

The ACT Regional Committee would again like to thank Mrs Eve Edwards, our regional administrative officer, for her invaluable and cheerful assistance throughout the year.

# New Zealand

## ANZCA REGIONAL/NATIONAL ANNUAL REPORTS 2006/2007

### OFFICE BEARERS AND MEMBERS

#### Chairman

Dr Vaughan Laurenson

#### Deputy Chairman

Dr Vanessa Beavis

#### Honorary Secretary

Dr Gerard McHugh

#### Honorary Treasurer

Dr Gerard McHugh

#### Education Officer

Dr Paul Smeele

#### Formal Projects Officer

Dr Arthur Rudman

#### Committee Members

Dr Peter Cooke

Dr Brian Lewer

Dr Geoff Long

Dr Alastair McGeorge

Dr Joe Sherriff

Dr Malcolm Stuart

#### New Fellows' representative

Dr Rebecca De Souza

#### Councillors

Dr Leona Wilson

Prof Alan Merry

#### Joint Faculty of Intensive Care Medicine Representative

Dr Tony Williams, Chair, JFICM NZNC

#### Faculty of Pain Medicine Representative

Dr David Jones, FPM Board member

#### NZ Trainees' Committee

Dr Nick Hutton, Chair NZ Trainees' Committee

#### NZSA Representative

Dr Graham Sharpe, President, NZSA

#### Executive Officer

Heather Ann Moodie

#### Administrative Officer

Jan Brown

#### Asst. Administrative Officer, ANZCA and Administrative Officer, JFICM

Karen Hearfield

#### TOTAL NUMBER OF NATIONAL COMMITTEE MEETINGS FOR THE 2006 YEAR:

Three (one and a half days each)

#### ATTENDANCE OF ELECTED MEMBERS:

Friday/Saturday morning 24/25 March 2006  
Apologies from Dr Tom Watson and Dr Duncan Watts

Friday/Saturday morning 21/22 July 2006  
(New committee and retiring members):  
Apologies from Dr Don Mackie, Dr Alastair McGeorge, Dr Tom Watson, Dr Duncan Watts and A/Prof Jennifer Weller

Friday/Saturday morning 24/25 November 2006:

Apologies for Saturday morning from Dr Joe Sherriff, Dr Paul Smeele, Dr Malcolm Stuart and Dr Vanessa Beavis

### CHAIRMAN'S REPORT – DR VAUGHAN LAURENSEN

The ANZCA New Zealand National Committee (NZNC) and staff have had a busy year with a wide range of activities and issues to respond to. These activities are outlined in more detail in the body of this report and include: the anaesthetic technicians' application to become regulated as health professionals under the Health Practitioners Competence Assurance Act; the Medical Council's requirements for registration and assessment of doctors; rural hospital doctors; ANZCA CPD Program; Ministry of Health Workforce Taskforce; the Accident Compensation Corporation's system for reporting of harm; Australia and New Zealand Therapeutic Products Authority.

The New Zealand Committee of ANZCA is formed on a two yearly basis and elections were held in 2006. A postal ballot for the election was not required in 2006. The new members of the committee, Drs Brian Lewer, Geoff Long, Arthur Rudman and Joe Sherriff joined the seven returning members:

Drs Vaughan Laurenson (Chair), Vanessa Beavis (Deputy Chair), Peter Cooke, Alastair McGeorge, Gerard McHugh (Hon Secretary and Treasurer), Paul Smeele (Education Officer) and Malcolm Stuart. The first meeting of the 2006-2008 NZNC committee was held on 21/22 July. I wish to acknowledge and thank the retiring members of the committee, A/Prof Michael Harrison, Dr Don Mackie, Dr Tom Watson, Dr Duncan Watts and A/Prof Jennifer Weller. Their hard work and commitment to ensuring ANZCA's role in New Zealand is effectively maintained has been most appreciated.

Our committee is also well supported by our two New Zealand councillors, Professor Alan Merry and Dr Leona Wilson, the JFICM Chair, Dr Tony Williams, Dr David Jones who represents the FPM Board, Dr Rebecca De Souza, the New Fellows' representative and the New Zealand Trainee Committee Chair, Dr Nick Hutton. The committee members willingly give their time and expertise and I appreciate their support.

JFICM Board members, Drs Ross Freebairn and Jack Havill provide input on issues of common interest and have represented ANZCA on a number of Ministry working parties.

Dr Graham Sharpe, President of NZSA attends our NZNC meetings and we value the close relationship with the Society. Our two committees have a joint meeting in Wellington in the middle of the year. Prior to the July 2006 joint meeting, we invited the Minister of Health Hon Pete Hodgson to meet with representatives of our organisations. Topics discussed included: workforce issues, the ANZCA Disaster Response Plan, and the Medicines Act and unlicensed medicines. At the joint meeting, the Health and Disability Commissioner (HDC), Ron Paterson and Deputy HDC, Rae Lamb had interesting discussions about cases related to anaesthesia.

I attended the Council meeting in February and December 2006. This always provides NZNC with an opportunity to be involved in the discussions on issues affecting both sides of the Tasman arising from Council

and ANZCA headquarters including: the proposed new CPD Program, the ANZCA Strategic Plan, ANZCA taskforces, review of professional documents, review of the OTS assessment processes and rural anaesthesia services. As New Zealand is a separate country with its own legislation and health systems, being able to share issues is invaluable. I know NZNC feels that it is in the interests of both the New Zealand and Australian Fellows for us to maintain good communications.

The New Zealand committee appreciates the support it receives from Council and ANZCA staff, and in particular the President in dealing with the many issues that arise in New Zealand. We were pleased to welcome the President, Dr Wally Thompson and the Hon Treasurer, A/Prof Kate Leslie to the November NZNC meeting. In association with this, they were able to attend functions which honoured two Fellows.

The first function was a dinner attended by the family of the late Dr John Campbell (Cam) Barrett. The President presented Cam Barrett's posthumous award of a Council citation to Mrs Liz Barrett. Cam had a long and distinguished career in anaesthesia and intensive care in New Zealand. He was a past Chair of the NZ Committee of the Faculty of Anaesthetists and was instrumental in the formation of the Wellington ICU, one of the first in this country. He was responsible for setting up the Wellington Anaesthesia Trust and the Simulation Centre.

The second occasion was the symposium and dinner organised by the Wellington Department of Anaesthesia to celebrate the career of Stuart Henderson on his retirement from the department. There were moving speeches that acknowledged Stuart's contribution to anaesthesia in New Zealand and Australia. Stuart had been the Director of the department for fifteen years. During that time he served on the ANZCA New Zealand National Committee and College Council.

The Committee was pleased to hear about achievements gained by New Zealand Fellows and others in 2006:

- > Dr Leona Wilson on her election as ANZCA Vice President
- > Professor Alan Merry, appointment by the Minister of Health to the EpiQual Committee
- > Dr Ron Trubuhovich, JFICM medal
- > A/Professor Jennifer Weller, Doctor of Medicine
- > Mr Bruce Corkill, Chair of the Health Practitioners Disciplinary Tribunal

We were saddened this year to hear of the deaths of five Fellows who have served the anaesthesia community well during their careers:

- > Dr Douglas Chisholm (NZ) – FFARACS 1957, FANZCA 1992 – Doug made an enormous mark on New Zealand anaesthesia with major contributions in the early days to the Faculty, the Society and the establishment of the Anaesthetic Technicians' Board. At the Christchurch level, he guided, directed and tutored many at the start of their anaesthesia careers.
- > Dr Hugh Clarkson FFARACS 1965, FANZCA 1992 – Hugh was a very significant figure in New Zealand anaesthesia: Consultant anaesthetist in Hamilton from 1966 to 2005; Supervisor of Training, Waikato Hospital; President, New Zealand Society of Anaesthetists; Chairman, New Zealand Committee of FARACS (now ANZCA); Chairman, Braemar Hospital Trust.
- > Dr Peter Lloyd, FANZCA (1995) – Peter was highly respected by New Zealand anaesthetists and anaesthetic trainees. He made a major contribution to the science and art of anaesthesia, including his work on acid base analysis. He was an enthusiastic and diligent teacher and served as an ANZCA Supervisor of Training in Hawkes Bay for a number of years.
- > Dr Brendan V Lyne, FFARACS (1954), FANZCA (1992) – Brendan was an Irishman who came to New Zealand early in his career and served Auckland well for many years, both as a part-time specialist in the Auckland Hospitals and in private anaesthetic practice.
- > Dr Ward Douglas FANZCA – Ward was a valued member of the Wellington anaesthesia community and had been involved with the College as an examiner.

#### **NZNC COMMUNICATION**

GASBAG, the monthly email communication to all New Zealand anaesthetists from the NZNC has now been in circulation for six years. It has been emailed to all hospital departments, but in 2006, thanks to improvements to ANZCA IT systems, the newsletter was emailed directly to all New Zealand anaesthetists and trainees. This is a cost effective way of disseminating information from the New Zealand Committee to anaesthetists.

The ANZCA website and iMiS database are valuable sources of information for the New Zealand office staff, College Fellows and trainees. The New Zealand staff members have appreciated being included in the iMiS training sessions in Melbourne. The recent improvements to the iMiS database system has allowed direct access to data and reports that were not previously available. The e-community facility has allowed the NZNC agenda, discussion documents and submissions to be posted on the e-communities, thus allowing access electronically from the internet.

The New Zealand anaesthesia website, [www.anaesthesia.org.nz](http://www.anaesthesia.org.nz) is shared jointly by NZSA and ANZCA NZNC. It also includes information about the NZ Anaesthesia Education Committee (NZAEC) and CME events and courses. A public area provides information about anaesthesia services. Thanks are due to Dr Richard French for his coordination of this. If Fellows have news they would like included in Gasbag or the website, please contact the New Zealand office.

#### **ELLIOTT HOUSE - SALE AND RELOCATION OF THE ANZCA NZ OFFICE**

ANZCA intends to sell its share of Elliott House, where the New Zealand office is currently situated, and to find new office space in the Wellington CBD, closer to the other medical colleges, the Ministry of Health and Government.

The valuation of Elliott House and the cost of future seismic strengthening requirements have been obtained so negotiations with RACS can occur. RACS and ANZCA have respectively a two-thirds-one-third ownership of Elliott House. It is hoped that the New Zealand office relocation will occur in 2007.



# New Zealand

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### **NZAEAC AND SCIENTIFIC MEETINGS**

The New Zealand Anaesthesia Education Committee (NZAEAC) is a joint venture between NZSA and the NZNC of ANZCA. Dr Ross Kennedy has been the Chair of the committee this year and I am grateful to him, the administrative officer, Rose Chadwick and committee members for the work achieved. Key areas of activity were: updating the NZAEAC conference manual, the formation of a network of those interested in and responsible for providing CME at a departmental level, the BWT Ritchie Scholarship award and continuing support and ongoing planning of the NZSA/ANZCA combined ASM including strengthening liaison with the industry and sponsors.

In 2006, New Zealand hosted an ASM and a Single Theme Meeting:

#### **Single Theme Meeting (STM), Rotorua 17 - 18 March 2006**

The STM theme was 'Current Concepts in Emergency Anaesthesia and Trauma'. The sessions attracted a lot of interest and support from other specialities beside anaesthesia and ICU. The social events, especially the conference dinner, were well received. Unfortunately this is the last of the STMs that have long been a feature of the NZ scene. Thanks are due to Dr David Laidlow and the STM team for a great event.

#### **NZ Anaesthesia Annual Scientific Meeting, Dunedin, August 2006**

The theme of the ASM was Establishment and Innovation and the meeting aimed to re-examine established practices of the past in light of current knowledge, and to discuss issues of current and future interest for the practising anaesthetist. The organisers succeeded in combining a great mix of conventional practice with some very challenging sessions on innovations and possible future directions.

The keynote invited speakers were A/Prof David Clarke (Stanford), Dr Martin Tramer (Geneva) and Prof Paul Myles (Melbourne) and the NZSA Visitor was A/Prof Brian Anderson (Auckland) with the help of a strong supporting cast of speakers, the program was interesting, challenging and informative.

Topics included genetic disorders and anaesthesia, pharmacogenomics, pain relief, sacred cows in anaesthesia, modern spinal surgery, anaesthesia and the persistent pain patient, evidence-based practice and not-so-evidence based practice.

#### **NZAEAC Meetings during the ASM**

Four NZAEAC meetings were run during breaks in the ASM program. These meetings included sessions with Trade representatives, ASM Convenors and Departments' CME Co-ordinators. The discussions were useful and participants appreciated the opportunity to be able to raise issues.

My grateful thanks to the ASM convenor, Duncan Watts, and the others on the organising committee: Robyn Chirnside, Lisa Horrell, David Hunt, Geoff Laney, Paul Templer, Tim Wright, Mathew Zacharias and Pat Johnston and the Dunedin Conference Management Service team. The Annual Business Meeting of New Zealand Fellows was held during the Dunedin ASM.

#### **BWT Ritchie Scholarship**

The 2006 recipients are Dr Amanda Dawson (Cardiac Anaesthesia Fellowship at Papworth Hospital in Cambridge) and Dr Paul Gardiner (Fellowship/consultancy in Anaesthesia and Intensive Care at Addenbrookes, Cambridge, England). Congratulations to Dr Dawson and Dr Gardiner.

#### **FANZCA TRAINING**

I would like to thank A/Professor Michael Harrison (2004-2006) and Dr Paul Smeele (2006-2008) for their guidance as Education Officers and also gratitude to the Rotational Supervisors and the Supervisors of Training and Modules Supervisors together with the Heads of Departments for all the work they do to make sure the training in the New Zealand setting gives trainees a rewarding experience. Many Fellows also give significant time to the training in their roles as examiners, committee members, hospital inspectors and work on the vocational training scheme committees.

The Education and Training Committee continues to refine the FANZCA Program and ANZCA headquarters has been streamlining administrative processes to ensure training documentation is up to date.

#### **ANZCA training rotation schemes**

Council has accepted NZNC's recommendation that the Northern Rotation be split into two with the new rotation called Midland based on Waikato Hospital and including Tauranga, Rotorua and New Plymouth. The Northern rotation includes all the Auckland hospitals and Whangarei.

#### **Formal Projects**

In July, Dr Arthur Rudman took over the Formal Project Officer's role from Dr Alastair McGeorge. Over the last few years, the assessment workload has increased significantly, so a deputy Formal Project Officer position has been created. Dr Geoff Long has filled this position. Assessment of Formal Projects is an important and time-consuming role. I thank Alastair, Arthur, Geoff and the other colleagues who have helped review projects.

#### **National Registrars' Meeting**

This inaugural National Registrars Meeting grew out of the Auckland Hospital CME meeting where registrars could present scientific work. Dr Nelis Kruger, as an ANZCA Supervisor of Training, has helped organise these meetings in the past and decided that a registrar meeting could be developed where formal project work could be presented. ANZCA regional committees run similar registrars' meetings. NZNC supports this initiative and has worked with Nelis Kruger to ensure that Formal Project requirements are addressed.

#### **ANAESTHESIA WORKFORCE**

This has been one of the main topics that NZNC has discussed over the last year, especially rural anaesthesia services.

### **The Minister of Health's Workforce Taskforce**

The Minister of Health has established a Workforce Taskforce to provide him with advice that will lead to actions on specific issues. The Taskforce is chaired by Dr Robert Logan. The taskforce is to advise the Minister of Health and the Minister for Tertiary Education by the end of March 2007 on how to get the best out of medical education and clinical training in the shortest time.

Options that the Taskforce has been asked to consider include:

- > shortening the number of undergraduate years;
- > starting specialist training during undergraduate years;
- > moving to a method of 'payment for output' for medical education;
- > collapsing the first and second postgraduate years (PGY1 and PGY2) into one year;
- > giving more recognition to prior learning in the specialist training years; and
- > appraising the apprenticeship training model in view of modern service delivery models.

The New Zealand committee invited Dr Logan to the November NZNC meeting and had a useful dialogue with him. Robust discussion occurred during which members of the Committee advised Dr Logan of their concerns regarding the proposals. A key point made was that gaining judgment to make medical decisions takes time to learn and can not be compromised by shortening the time it takes to train a specialist. Dr Logan then asked what one thing could be changed in the medical training. The Committee agreed that the TI-PGY2 years could be managed better. NZNC advised that it was important that the breadth of training be preserved.

### **Rural Hospital Doctors – application to MCNZ for vocational scope recognition**

NZNC continues to have discussions with the Rural Hospital Doctors working group, the Joint Consultative Committee for Anaesthesia and the Royal New Zealand College of General Practitioners about the suggestion of a training and MOPS program for rural doctors in New Zealand who wish to provide anaesthesia services in a rural setting.

The Rural Hospital Medicine (RHM) doctors have applied to the Medical Council of New Zealand for recognition as a separate vocational specialty. Currently this group is associated with the Royal New Zealand College of General Practitioners. NZNC prepared a submission to MCNZ on the RHM application. If the RHM application is successful New Zealand will have a framework to develop a New Zealand variant of the JCCA.

### **New Zealand Anaesthetic Technicians Society (NZATS)**

Dr Malcolm Stuart is the NZNC representative to the NZATS Executive and NZNC provides the funds for Malcolm to travel to the Auckland NZATS Executive meetings.

The New Zealand Anaesthetic Technicians Society (NZATS) has applied to the Ministry of Health (MoH) for regulation of the profession of Anaesthetic Technicians (NZAT) under the Health Practitioners Competence Assurance Act 2003. NZNC prepared a submission on the MoH discussion document pertaining to this. The Minister of Health has now advised that anaesthetic technicians will become registered health professionals and the Ministry is currently consulting on the form of the authority to regulate this profession.

The Ministry is seeking feedback on whether the registration authority for anaesthetic technicians should be:

- > a stand alone authority or
  - > a 'blended' authority
- Under the 'blended' authority, three options of potential regulatory partners are suggested:
1. The Medical Council
  2. The Nursing Council
  3. Establishing a Technicians' Board.

Currently 40% of the anaesthetic technicians are from a nursing background. However, NZNC's preference is for a separate regulatory board which could include groups such as the ambulance, perfusion and renal dialysis services' professionals. NZATS and NZSA seem to favour the paramedical grouping option too.

Anaesthetists will need to seek representation on the technicians regulatory board as anaesthetists and technicians are mutually dependent in their work as part of the operating theatre team.

NZNC suggested at its last meeting that an independent report be commissioned that would look at the aspirations of the various groups with respect to the regulation of the paramedical professions. This idea was raised at the December Council of Medical Colleges (CMC) meeting.

### **MEDICAL COUNCIL OF NEW ZEALAND (MCNZ)**

NZNC and the office staff work closely with MCNZ in a number of areas, the most significant being the assessment of overseas trained specialists (OTS)/International Medical Graduates (IMG) on behalf of the Medical Council. I am grateful to our New Zealand Assessor, Dr Vanessa Beavis, for the time and expertise she gives and to the members of the assessment panel, Drs Alastair McGeorge, Paul Smeele and Leona Wilson and staff involved. Lorna Berwick is the lay member of the panel.

During 2006, MCNZ undertook a review of the International Medical Graduates (IMG) registration pathway within a vocational scope in New Zealand. NZNC prepared a submission on the MCNZ IMG review document.

NZNC has concerns as there is a major effort by the MCNZ to remove examination from the assessment, substituting peer review and practice visits. A one-day on-site assessment is being considered. Every college handles IMG assessments differently but ANZCA is the only College that insists on an exam as ANZCA believes a knowledge-based assessment is still the best indication of performance in anaesthesia. ANZCA can still require a period of assessment to be taken in a teaching hospital. ANZCA doubts that MCNZ on-site assessment tools will be adequate for our needs. We have major concerns about the validity of the proposed processes as we do not think enough work has been done yet to show they are reproducible and consistent.

NZNC members and staff have attended a number of MCNZ workshops and meetings on topics such as international medical graduates' pathway to registration within a vocational scope; cultural competence; performance evaluation program; as well as

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preparing submissions on a number of discussion documents. Submissions included topics such as: Performance Evaluation Program, Cosmetic Procedures, IMG registration pathway, Vocational Scopes of Breast Medicine and Rural Hospital Medicine. A number of College representatives attended the International Association of Medical Regulatory Authorities Conference in Wellington.

The Faculty of Pain Medicine intends seeking recognition as a separate scope of practice in New Zealand, as it already is in Australia. There are five medical colleges whose clinicians deal with different aspects of pain. The strong connections that FPM has to the ANZCA CME, CPD and Standards should strengthen the application process.

### **MOH PROTECTED QUALITY ASSURANCE ACTIVITIES UNDER THE HPCA ACT**

The ANZCA MOPS program has protected QAA status. Professor Garry Phillips, as the 'Responsible Person' under the Act, provides reports to the Minister.

### **COUNCIL OF MEDICAL COLLEGES (CMC)**

The NZNC is an active member of the Council of Medical Colleges. CMC meets four times a year and maintains correspondence regarding issues that arise between meetings. The CMC is able to provide support to ANZCA with respect to issues affecting anaesthetists.

The CMC meetings provide a forum to discuss issues of mutual interest with Medical Colleges and other organisations, such as the Ministry of Health, Medical Council and Medical Association.

### **PERINATAL AND MATERNAL MORTALITY COMMITTEE (PMMRC) AND ITS MATERNAL MORTALITY WORKING GROUP**

In 2005, the Minister of Health announced the composition of the Perinatal and Maternal Mortality Committee. As currently composed there is no anaesthesia representative on this committee, although Dr Ted Hughes, an anaesthetist, is on the committee to represent Pacific Islanders.

The Perinatal and Maternal Mortality Committee (PMMRC) invited NZNC to provide nominations for the PMMRC maternal mortality working group. Dr John S Walker was appointed by PMMRC to this working group. John Walker currently represents NZNC on maternity matters.

### **NEW ACC TREATMENT INJURY LAW CHANGES**

ACC's medical misadventure rules are being replaced with new Treatment Injury provisions under a new law. The primary purpose of the Injury Prevention, Rehabilitation, and Compensation Amendment Act (No 3) was to implement new rules for medical misadventure that would be known as treatment injury. ANZCA and JFICM representatives have attended ACC workshops during the year on the 'Reporting of Harm' process and ACC representatives attended the November NZNC meeting.

### **CHANGES TO THE MEDICINES ACT AND THE PROPOSED AUSTRALIA NEW ZEALAND THERAPEUTIC PRODUCTS AUTHORITY – THERAPEUTIC PRODUCTS AND MEDICINES BILL**

The Therapeutic Products and Medicines Bill has passed its first reading in the House and was referred to Select Committee. NZNC prepared a submission on the Bill for the Select Committee. The Bill covers the proposal to establish a trans-Tasman regulatory scheme that should provide health and safety protections for consumers who use medicines, medical devices and complementary health products.

As well as establishing the trans-Tasman regulatory agency, the Bill will also update the medicines legislation. Section 29 of the Medicines Act 1981, which covers the use of unlicensed medicines, is an area that NZNC has raised concerns about with the Minister as the committee feels that this part of the Act does not work well currently.

### **IN CONCLUSION**

It has been a busy year for the New Zealand National Committee. Forty-seven consultation documents and requests for nominations have

been considered for the year to March 2007. Formal submissions have been made on 33 of these consultation documents and nominations, up from 20 last year. This takes time and energy but is worth the effort in order to ensure that our perspectives on issues are understood. I would like to acknowledge all the committee members who give freely of their time as well as the many others who contribute to the fellowship, such as examiners, inspectors, lecturers at exam courses and clinicians who provide mentorship and assistance to trainees and peers. It is these activities and those of the office staff that keep our college alive and relevant.

### **TREASURER'S REPORT – DR GERARD MCHUGH**

(Year ending 31 December 2006)

#### **Expenditure**

The New Zealand Committee expenditure during the year ending 31 December 2006 was down 7.7% compared with the previous year. The total operating expenses equalled \$401,776 (previous year, \$435,360).

#### **Income**

The total 2006 income as shown in the statement of Financial Performance was \$282,824. Most of this income relates to ANZCA and JFICM Annual Training Fees (\$243,834). These fees are collected in New Zealand.

The previous year's (2005) income (\$606,034) cannot be used as a comparison with the 2006 income as in 2005 NZNC collected \$327,086 in funds from the ANZCA ASM. This ASM only occurs in New Zealand approximately every seven years, so is not part of the 2006 income.

#### **Income from New Zealand Fellows' Annual Subscriptions**

Currently New Zealand Fellows pay their annual subscriptions to the ANZCA head office. A portion (70%) of these New Zealand subscriptions is deemed to cover work that is carried out in New Zealand on behalf of the Fellows and this portion attracts New Zealand GST.



In recent NZNC annual financial statements an amount labelled 'Funds from Australia' has been recorded as a liability when it actually represents income from New Zealand Fellows' subscriptions that are transferred back from Australia. The funds from these transfers have accumulated as a liability over the last few years to an amount of \$503,793 and results in the 2006 NZNC financial report showing a deficit of \$118,952.

When the New Zealand annual income and expenses are incorporated each year into the overall ANZCA financial report at ANZCA headquarters this deficit is negated by the New Zealand subscription income collected in Australia.

The problem of the deficit and liability could be solved by collecting the New Zealand Fellows' subscriptions in the New Zealand office. This would also address the GST and ANZCA Foundation requirements. This solution is being discussed with head office.

### **Increases/Decreases in income and expenditure**

The main increases/decreases (those over \$5,000) in income and expenditure compared with the year ending 2005 were:

#### **Income**

- > ANZCA Annual Training Fees – 24% increase in 2006 from \$177,096 to \$219,587
- > Medical Council OTS interviews – increase from \$10,563 to \$19,152 (with a subsequent increase in expenses (\$4,101))
- > No income from FPM Refresher courses (2005, \$29,173)
- > CME Account income – decrease from \$36,895 to \$15,564 (Due to the 2004 NZAEC ASM profit being shown in the 2005 accounts).

#### **Expenditure**

- > NZ Committee – decrease in 2006 of 40% (\$55,292 to \$32,987) as in 2005 the New Fellows' Conference expenses were included (approximately \$24,000)
- > NZAEC – decrease from \$11,263 to 5,000
- > Melbourne expenses – increase from \$30,469 to \$38,961 due to an increase in travel costs and frequency between Melbourne and Wellington
- > Administration costs expenses were down 5% (\$286,159 to \$271,411).

The total assets of the committee are \$205,983 with fixed assets amounting to \$92,130. ANZCA's interest in the shared ownership of Elliott House is recorded in the Financial Position as \$398,194.

### **NATIONAL EDUCATION OFFICER'S REPORT – DR PAUL SMEELE**

The role of NEO was performed by A/Professor Michael Harrison until June 2006. His considerable contribution to the training of anaesthetists in New Zealand during his 3+ years as NEO is acknowledged.

#### **Revised FANZCA Program**

The modular system for training anaesthetists seems to be working well. Although individual trainees continue to report problems with modular completion these problems appear to be able to be resolved at a local level with no reports of modular completion delaying completion of FANZCA.

#### **Training Rotations**

With the advent of neurosurgical services at Waikato a new 'Midlands' Rotation has been formed. Tauranga, Rotorua and Taranaki are also part of this rotation. The Northern Rotation now includes Auckland and Whangarei. The Central and Southern Rotations are unchanged.

There are a number of registrar posts, predominantly outside the main centres which are not formally part of a rotation. Trainees do not appear to be disadvantaged by this arrangement.

#### **Trainee Committee, NZ 2006**

The Trainees' Committee for 2006 was: Dr Nick Hutton, Dr Daniel Faulke, Dr Jennifer Taylor, Dr Annick Depuydt, Dr Corinne Law, Dr Kathleen Mistry, Dr Chris Poynter and Dr David Whybrow. Dr Darren Cathcart stayed on the Committee until April 2006. Dr Vaughan Laursen, Chairman of the NZNC and Dr Paul Smeele, National Education Officer are ex-officio members of this Committee.

The committee has met on three occasions by teleconference in 2006.

### **Supervisors of Training**

Education sub-committee meeting  
A request was made for items for an agenda — two items were raised—both very local. It was decided to address these problems locally and by email consultation.

#### **Supervisor re-appointment in 2006**

Dr Justin Imrie from Tauranga

#### **Supervisors – Certificates of Recognition after 5 years service**

- Dr D J Price, North Shore Hospital
  - Dr C K Thorn, Wellington Hospital
  - New SoTs
  - Dr Colin King, Auckland City Hospital, L8.
  - Dr David Williams, Waikato
  - Dr Rob Carpenter, assisting at Waikato
  - Dr Stephan Neff, now Dr Mandy Perrin, Rotorua
  - Dr Gary Hopgood, Tauranga
  - Dr J Woods, Christchurch
- Rotational Supervisors:
- Dr Malcolm Futter - Northern rotation
  - Dr Andrew Munro – Midland Rotation
  - Dr Deborah Goodall - Southern rotation
  - Dr Chris Thorn - Central rotation

#### **Clinical Teachers Course**

A Clinical Teachers Course, 'Teaching in Small Groups', was conducted at the beginning of December at Elliott House with 12 SOTs and Module Supervisors attending. The next course will be held in Wellington on 14 September 2007 with the title being 'Teaching in the Operating Theatre'.

#### **Hospital inspections**

The Northern and Midland rotations underwent their scheduled hospital inspections in November.

Common issues noted were:

- > Shortage of recovery beds;
- > Inadequacy of departmental space;
- > Anticipated endoscopy load;
- > Suspected inaccuracy of census data and the resultant underestimation of the number of people that the DHBs will serve; and
- > The need to integrate trainees in peripheral and central hospitals.

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### **New Zealand Courses:**

#### **Part I FANZCA Course - Christchurch**

Course dates: 22-29 January 2006

FANZCA Final Course, Oral Examination – Wellington

Course dates: 27-30 April 2006 & 10-13 August 2006

#### **Part I FANZCA Course – Hamilton**

Course dates: 22 May to 2 June 2006

#### **Part II Revision Course – Auckland**

Course dates: 19-30 June 2006

The College is grateful to all those who work hard to make the FANZCA training program a success—the supervisors, those involved in the exam courses, hospital inspectors, ANZCA committee members and staff.

### **FORMAL PROJECT OFFICER'S REPORT – DR ARTHUR RUDMAN**

Firstly, I would like to thank Dr Alastair McGeorge who stepped down as NZNC FPO in August 2006. Dr McGeorge established a superb database for the assessment of Formal Projects and also streamlined the whole FP process for both trainees and assessors. I would also like to acknowledge Dr Geoff Long who is the assistant FPO for the NZNC and whose support and wisdom I greatly appreciate. Thanks also to all NZ Fellows who give their time freely to help assess FPs.

2006 continued to be a busy time with a steady stream of Formal Projects being submitted throughout the year.

New Projects Registered:	43
Projects Confirmed by Assessor:	37
Projects currently Registered and in Progress:	35
Projects currently with Assessor:	8

The standard and quality of Formal Projects submitted continues to vary widely and I question the usefulness of this module for most trainees. There seems a definite trend towards an increasing number of submitted case reports and reviews and less scientific research. I wonder whether an alternative to the FP module should be offered e.g. overseas electives, rural attachments, courses/papers, teaching, critical review of published literature etc.

During 2006, Auckland hosted an 'ANZCA-approved' Registrar Scientific Meeting which saw 12 registrars from across NZ present their FPs. This was a national meeting organised by Dr Nelis Kruger and by all accounts the meeting was very successful and it is hoped that this will become an annual event. Congratulations to Dr Kruger and his committee for establishing this national forum for registrar presentations.

New Zealand trainees in general seem to have a good understanding of the process required from registration to completion of their FP. The NZNC has specific forms for registration and completion of the FP as well as a Supervisor Evaluation form which is required before any FP is assessed.

The shortlist of FPs for the New Zealand Formal Project Prize for 2006 is currently being assessed by the judging panel and a decision will be made in the next few weeks. This prize will hopefully be presented later this year.

### **Projects Completed and Confirmed**

#### **Glenn Arnold**

BiSpectral index and entropy in elderly patients

#### **David Charles Brown**

Ability of angiotensin II to modulate striatal dopamine release via the AT1 receptor in vitro and in vivo

#### **Katharine Brunette**

Bilateral brachial plexopathy following laparoscopic bariatric Surgery

#### **Anne Craig**

Bridging the gap -  
A case of paradoxical embolism

#### **Allan Crowther**

Exposure of anaesthetists to ionizing radiation in the operating theatre

#### **Keith Davenport**

An audit of the introduction of intrathecal morphine for caesarian section

#### **Tamsin Dovell**

Fibreoptic training survey among Great British and Irish trainees

### **Claire Frost**

A comparison of the 26S proteasomes in Alzheimer's and normal brain

### **Pavel Gajdusek**

The Australasian Obstetric General Anaesthesia for Caesarian Section survey

### **Paul Gardiner**

Postoperative respiratory failure and non-invasive ventilation after non-thoracic surgery

### **Janette Gross**

Where is it? How do you use it? An audit of the familiarity of anaesthetic department staff with the location and use of emergency equipment at a teaching hospital

### **Jeremy Hickling**

A randomised cross-over dose-effect trial of paracetamol 60 and 90mg/kg in third molar surgery.

### **Grant Hounsell**

An audit of airway management equipment in a Metropolitan region

### **Christopher Jephcott**

Case reports of two unusual presentations of meningococcaemia in elderly patients with an up to date literature review of the role of genetic polymorphisms in susceptibility to meningococcal sepsis

### **Angela Jerath**

Abnormal protein expression in neurodegenerative diseases

### **Manoja Kalupahana**

Pre-operative oral carbohydrate and major abdominal surgery

### **Mark Krumrey**

The effect of a sedation algorithm used in the intensive care unit on duration of ventilation and sedative drug use

### **Paul Lockington**

Subcutaneous naloxone for the prevention of intrathecal morphine induced pruritus in elective caesarean delivery

### **Rachelle Lumsden**

Anaesthetic management on ECMO of two patients with pheochromocytoma and underlying cardiac morbidity.

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**Nicholas Marks**

PICC line insertion in children  
at Christchurch Hospital 1996-2004

**Morag Marr**

Oxygenation using CPAP through a  
transtracheal catheter for an obstructing  
laryngeal tumour - case report

**Nolan McDonnell**

Malignant Hyperthermia and Day Stay  
Anaesthesia

**Martin Minehan**

Osler-Weber-Rendu syndrome: Case report,  
review of anaesthetic management and  
discussion

**Martin Misur**

Liver transplantation complicated by  
pulmonary thromboembolism - a possible  
complication of antifibrinolytic therapy  
successfully treated with recombinant tissue  
plasminogen activator

**Rhyanon Murray**

Paediatric Day Surgery and obesity. Body Mass  
Indexes in 2-13 Year olds presenting for day  
surgery

**Michael Ranger**

Changing body position alters the location of  
the spinal cord within the spinal canal. A study  
using Magnetic Resonance Imaging in healthy  
volunteers

**Reinette Robbertze**

Sedation and anaesthesia outside the  
operating room

**Johanna Rose**

Ruptured abdominal aortic aneurysms :  
clinical presentation in Auckland 1993-1997

**Joann Rotherham**

The proconvulsant effects of combined low  
dose pethidine and tramadol

**Tanya Selak**

A prospective audit of thromboprophylaxis  
in a neurosurgical Intensive Care Unit

**Vincent Sperando**

Tramadol - Pharmacology and clinical  
implications in anaesthesia

**Richard Sullivan**

Is ventilation affected by removal of dentures?

**Jamai Tashkandi**

Brugada syndrome and anaesthesia -  
a case report and review

**Mathew Taylor**

Bradycardia with sevoflurane in siblings  
with Branchio-Oto-Renal syndrome

**Narko Tuto**

Intravenous coconut water therapy

**Zarina Wong**

The role of intraoperative frozen section  
in the management of thyroid nodules

**Neil Wylie**

The assessment of a system for monitoring  
invasive blood pressure in the MRI

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DR VAUGHAN LAURENSEN  
Chair, New Zealand National Committee  
ANZCA March 2007

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# Status Anaestheticus

## Gwen Wilson Memorial Lecture, 2007

Some years ago, Gwen Wilson alerted me to a quotation that has resonated with me ever since.

The quotation came from Dr Kasner Moss, a pioneer anaesthetist from Perth, who, in 1921, made a statement that reflected the status of the anaesthetist in Australia at the time:

‘After a successful anaesthetic of 3 – 4 hours (perhaps even a difficult case), the surgeon doesn’t congratulate the anaesthetist, he simply remarks – “He took it well, didn’t he?”’

How much has the status of the anaesthetist changed in the 86 years since then? Is our status improving, or are we in ‘status anaestheticus’?

How often, when we ask the question, ‘Who was your anaesthetist?’ of a patient or acquaintance, do they stare at you blankly? They can remember the name of the surgeon, and often the name of at least one nurse, but sadly we are often the silent partner.

Of course that is so long as we do our job well during the procedure. Then we have little to show for our efforts. There is no lasting scar, just a pain-free and comfortable patient—no reminder.

The medical profession as a whole enjoys a relatively high status in the general community, and before examining the status of anaesthetists in particular, it is important to understand the evolution of that position.

Some 10,000 years ago, humans changed from being nomadic hunter-gatherers to settle in communities engaged in cultivation and pastoral activity. Medicine men began to develop an important role in the social and political structures that emerged.

The treatment of injuries and diseases gained importance. No longer was it appropriate to abandon the injured as the tribe moved on. The treatment of the sick changed to the provision of care, food and protection. The medicine man became a healer, and although most healing techniques involved magic and ritual, the pharmaceutical industry began with the appearance of potions and herbal remedies.

Medical treatment flourished in ancient Egypt around 1500BC, with further

developments in ancient Greece and Rome. Under Hippocrates, doctors began to reject traditional healers and develop anatomical concepts, believing that disease arose from internal imbalance rather than from external causes. Doctors began to play a significant role in society through their wider interests, and some, like Plato and Aristotle, became very influential. Galen, in the second century AD, refined and expanded Hippocratic principles, and became the major influence on medicine.

From Rome to the Middle Ages, medicine became subordinate to religion, and doctors were subordinate to priests.

During the Renaissance, the study of anatomy and new knowledge in the fields of chemistry led to little that helped cure disease, but did begin to elevate the status of physicians. In 1518, Henry VIII established a charter for the College of Physicians. This period saw the beginning of examinations and licensing of medical practice.

Surgeons were still at the bottom of the hierarchy, with apothecaries. Surgery was a manual skill, and was learned by apprenticeship, often established in guilds that were linked to barbers. Their repertoire was usually minor procedures, blood letting, lancing boils, dressing wounds, pulling teeth etc. The name ‘surgery’ is derived ultimately from the Greek *cheiros* (hand) and *ergon* (work), thus work of the hand, not of the head.

The 17th and 18th centuries were a time of major socio-economic change, and the formal regulation of the medical profession that existed in the 16th century was weakened. The warfare that accompanied colonial expansion created a demand for surgery, and Europe saw the appearance of early surgical entrepreneurs, who devised and then promoted more adventurous surgical techniques.

Surgeons began to enjoy new found status. Schools of surgery and medicine sprang up around Europe. Surgeons and physicians were now equally anxious to enhance their professional status and respect, though their practice was more like a trade. Patronage and social class played a significant role in established medical practise, and many practised without formal qualifications.

Voltaire typified the general distrust of doctors, referring to them as ‘pouring drugs of which they knew little, to cure diseases of which they knew less into human beings of which they knew nothing’.

Success depended on a capacity to impress the patient and public—by whatever means.

The late 18th century saw the emergence of medical ethics, and the modernisation medical practice with restructuring of medical education and formal regulation really began in the early 19th century.

Industrialisation, the rise of the market economy and the appearance of the middle classes led to the need for more doctors. Aristocratic nepotism and patronage were challenged, and the profession aspired to collective status on the basis of merit and achievement. Private practitioners became self-employed mini capitalists in a lucrative but competitive market.

Still in the mid 19th century, medicine was less well respected than the law as a profession, and often ridiculed for snobbery and self-advancement.

A number of specialties were established, and physicians had begun to develop sub specialties. There were pathologists, specialists in the eye and the ear, paediatricians, obstetricians, dentists and, of course, surgeons. Already, in London and Paris, there were theatres for virtuoso surgeons. Colleagues, students and the public at large clamoured for a seat at the regular weekly operating day, applauding the surgeon as he approached the operating table. This was the scene into which anaesthesia appeared in 1846.

Specialisation, as a marker of academic and scientific advancement, was one of the key ingredients in status, and anaesthesia was not about to become an instant specialty. Every general practitioner, physician, and even surgeon began to administer anaesthetics, and some of the first ones were given by dentists. There was resistance from the medical profession to recognition of anaesthesia as a specialty.

The Australian Medical Journal, July 1868 published the account of a death under

chloroform in a previously healthy woman of 33 having surgery for her anal fistula and haemorrhoids at the Melbourne Hospital. The report was made to the Medical Society of Victoria by the attending surgeon, who, with the patient ready and no sign of the resident House Surgeon or House Physician, proceeded to administer the chloroform himself. As two resident staff entered the room, the patient began to struggle and died shortly thereafter. Although the cause of death was unclear from post mortem examination, kidney disease or impure chloroform was implicated. It was recommended that the hospital should appoint a chloroformist to exclusively administer anaesthetics. Needless to say, the proposal was not supported.

A death under chloroform at the Melbourne Hospital was reported in the Australian Medical Journal in February 1891, with the recommendation by the City Coroner '...that there ought to be some specially qualified gentleman in the hospital for the administration and teaching of the use of chloroform'. The suggestion was put to a meeting of the Medical Staff Committee who decided that no action was necessary.

In the same journal, in June of that year (1891) there was another report of a chloroform death at the hospital, which noted the recommendation from the inquest, that chloroform should be administered under the supervision of an expert. The coroner said it appeared to him, 'that cases of death under chloroform occurred far too frequently at the Melbourne Hospital. Students were allowed to give chloroform without any supervision. The wonder was not that deaths should occasionally occur, but that they did not happen more frequently'.

The 1891 editorial entitled 'Anaesthetics at the Melbourne Hospital' extolled the virtues of the appointment of a specialist anaesthetist to administer not only chloroform, but other anaesthetics, and to supervise and instruct residents in the practice of anaesthesia.

The approach of the Melbourne Hospital was to ignore the suggestions. They continued to deal with deaths under chloroform by meetings of the Medical Staff passing motions of confidence in whoever administered the chloroform.

This illustrates the hierarchy in medical practice at the time. Physicians were at the top and controlled everything in the hospital. Surgeons were not far behind and were beginning to exert substantial influence. Anaesthesia rated very poorly—the task being entrusted to junior staff or students—and when things went wrong, it was invariably a problem with the patient or the chloroform, and not the administration or the administrator.

It is quite apparent that many anaesthetics, particularly in rural Australia, were given by non-medical anaesthetists. The medical profession was quick to condemn such practices, but it did nothing to advance the establishment of anaesthesia as a specialty.

The Australasian Medical Gazette reported with concern in March 1884, that a patient had died under chloroform at Tamworth Hospital the previous month. The journal sought an explanation as to why, when Dr Eustace Pratt was operating, he did not use the services of another medical man, but had Mr Goodwin, a local chemist, administer the chloroform.

The next issue brought an angry retort from Dr Pratt, attacking the editor for his audacity, and chastising him for forwarding copies of his editorial to the local Tamworth papers as well as to several prominent citizens. He described how 'hundreds of men, not legally qualified, have to give chloroform in the bush', and went on to accuse the Gazette of being 'a moribund and poverty stricken organ of a small clique of mutual admirers'!

In the colony of New South Wales, a more enlightened approach is evident. Nine deaths under anaesthesia in the three years up to 1888 attracted considerable public attention and prompted a parliamentary enquiry. A code of ethics was proposed for the administration of anaesthetics to include: a careful selection of the anaesthetic to be used; an exhaustive examination of the patient before; and supervision during its use; as well as necessary protection to the administrator and surgical operator in case of a fatal result.

Despite the proposal, it is clear that non-medical anaesthetists continued to be engaged and the colonial government was reluctant to introduce any sanctions.

The NSW branch President expressed his concern at the Annual General Meeting in March 1889, that 'with respect to the practice of the unqualified and unscrupulous pretender, nothing has been done by our "Noble Army" of Legislators by way of drawing a line of demarcation between the legally qualified practitioner and the unprincipled and designing pretender'.

The Australasian Medical Gazette also commented in 1889: 'With few exceptions, the absence of a diploma is proof that a man so deficient either had not gone through the prescribed course of study, or having gone through it, that he failed to pass his examinations either from lazy inattention to his studies, or from brainlessness.'

Little further correspondence appears on either the issue of specialisation, or of the non-medical anaesthetist, for the next twenty years.

In the first decade of the 20th century, four honorary anaesthetists were appointed to the Melbourne Hospital, to instruct and supervise residents, however a furore erupted after a death under anaesthesia at the Hospital in September 1912. An extremely ill 66 year old man presented for surgery at 6am. The resident who was unfortunate enough to be on duty for anaesthetics administered ethyl chloride and ether by an open mask, whereupon the patient immediately succumbed. It was not usual for honoraries to attend out of hours, and anaesthetics at those times were undertaken by residents who had to view 20 cases before attempting one. Although it was clear that it was not the anaesthetic per se that caused the death, the consternation arose because one of the honorary anaesthetists, Dr Rupert Hornabrook, made a personal representation to the Coroner, leading to a public enquiry. The results of the enquiry were then published in *The Age*. He was of the opinion that the residents should not be compelled to deal with such cases, and that a senior anaesthetic resident should always be present, adding 'anaesthetic work should be more respected than it is'.

# Status Anaestheticus

## Gwen Wilson Memorial Lecture, 2007 continued

The Coroner added fuel to the fire by stating 'there appears to be a feeling among medical men that the anaesthetists work is not as necessary as some might think'.

The hospital was outraged, and claimed that Dr Hornabrook's action was disloyal to the hospital and to the residents, and correspondence spread over several editions of the Australasian Medical Gazette.

In the Australian Medical Journal April 1913, Rupert Hornabrook bemoaned the fact that, 'although the Alfred and St Vincent's Hospitals in Melbourne recognise honorary anaesthetists on their staff with full honorary staff privileges, the same is not true of the Melbourne Hospital'.

'The anaesthetist should be placed on the staffs of hospitals ... on equal footing with other members of the staff. It is useless to expect good men to come forward unless they are given some status.'

Thus a vicious circle had been established—tacit recognition of the desirability of specialisation, but low status and difficulty attracting doctors into anaesthesia.

Public hospitals were controlled by physicians and surgeons and, in private practice, surgeons depended on referrals from general practitioners, who were often engaged as assistants or anaesthetists. They wanted anaesthetists to provide services, but they were not about to give them more than passing acknowledgment.

What anaesthesia needed for recognition and status was three things. Anaesthesia needed to be formally taught and examined; anaesthetists needed to be appointed to hospitals with all the rights and privileges of other medical staff; and there needed to be an organisation of practitioners devoted to anaesthesia.

In Britain, led by prominent anaesthetists of the time, a Society of Anaesthetists was established in 1893. In 1901, the Society succeeded in convincing the Royal Colleges and Universities to include formal instruction in anaesthesia as part of their curricula.

Hewitt and Robinson, in their text, 'Anaesthetics and their administration' (1912), wrote:

'The governing bodies of most hospitals to which medical schools are attached are now fully alive to the importance of having anaesthetics administered by men who have received proper instruction and possess practical experience. Anaesthetists are at last being treated as equal in position to the other members of staff'.

Such was not the case in Australia.

Closely allied to the issue of status was the matter of remuneration. The traditional relationship between the surgeon and the referring practitioner as the chloroformist was hard to break, and in the early 20th century, the idea of the surgeon collecting the fee on behalf of the anaesthetist, was firmly entrenched. Even when anaesthetists began to levy fees independently, they were constrained by the relativity that had been traditionally established. In 1897, a meeting of the NSW branch of the BMA noted that 'it was hardly fair that the anaesthetist who had so much more responsibility, was paid less than the assistant at the operation'. Of course, the assistant was often also the referring practitioner.

Then, as now, status is inexorably related to money. The more an individual is paid for performing ostensibly the same work or providing a similar service, the more status that individual attracts.

Surgeons were keen to keep anaesthetists in their place, and with their paltry remuneration, anaesthetists had to rely on other activities such as general practice to supplement their income. If they undertook public hospital work, they were engaged as unpaid honoraries, just as with the other specialties who were more able to sustain such activity. There was no time for research or development, and they were not a unified group.

Surgeons were able to take several months to travel to 'the old country' for 'CME', but woe betide an anaesthetist, if he could possibly afford it, doing likewise. He would have no private practice to return to!

Two anaesthetists of the time stand out. Edward Embley, from his position at Melbourne University, was very influential, and did much to champion the cause of

anaesthetists in addition to gaining world-wide fame for determining the cause of death from chloroform. Remarkably, he supported his unpaid research by his general practice in Camberwell.

Rupert Hornabrook was also very influential, if unconventional and apt to rile the establishment. It was he who saw the need for anaesthetists to unite, and suggested in April 1913 that a Society of Anaesthetists be established.

If they had acted then, things may have been different, but the situation was not to improve for at least another 40 years.

As a clear illustration of what it was like, in 1927, Geoffrey Kaye—when contemplating a career in anaesthesia—was told by the senior surgeon at the Alfred hospital, 'Why waste your opportunities'.

Kaye recalled that anaesthetics was rated very low as a specialty, and was regarded as the province of the physically handicapped or those who had failed in other branches of medicine. The surgeons of the day insisted that the best anaesthetists they had ever met were the medical orderlies of the 1914 War, 'because those blokes did as they were told'.

'Anaesthesia was regarded as an entirely practical subject, and any attempt to drag basic sciences into it was resented, even by the average anaesthetist, most of whom were GPs. Even spinal and local anaesthesia was the province of the surgeon.'

At the time, there were only three full time anaesthetists in the country, Rupert Hornabrook and Fred Green in Melbourne, and Gilbert Brown in Adelaide. They, with several others and the young and enthusiastic Kaye, were instrumental in getting the Australasian Medical Congress to establish a section of anaesthetics in 1929. After the Congress, an editorial appeared in the 1930 Australian Medical Journal that stated: 'The anaesthetist is a specialist in the truest sense. The time has come when he should be recognised as such.'

The suggestion fell on deaf ears.

In the period up to the 1940s, anaesthesia changed from a practical specialty to become a scientific one. The advent of new agents, like the intravenous barbiturates and more efficient



apparatus, were appreciated by surgeons and patients alike, but the perception of the anaesthetist did not change, and the idea of specialist education had not dawned on most universities. Teaching of anaesthetics at the postgraduate level was non-existent, and most anaesthesia was still learnt by copying the tricks of their senior colleagues.

Around the world, in the 1930s and 40s, some visionary anaesthetists were considering the status and future of anaesthesia. The principal visionaries were Ralph Waters at Madison, Wisconsin, appointed to a chair in 1927; Robert Macintosh appointed to the first fully endowed chair at Oxford in 1936; and Geoffrey Kaye who established teaching at Melbourne University in 1946.

The story of Macintosh's appointment in Oxford is an interesting one. Macintosh had become a close acquaintance of Sir William Morris, later Lord Nuffield, the wealthy automobile manufacturer. In 1936, Oxford University asked Nuffield for a million pounds to establish Chairs of Medicine, Surgery, and Midwifery. Nuffield observed: 'They've forgotten anaesthetics again!' and implored them to include a Chair of Anaesthetics. Oxford was reluctant to agree, until Nuffield threatened to offer the funds to London University. In the end, Oxford relented, Nuffield donated 2 million pounds and chose the professor himself!

What became important to evolving status was the connection between education, remuneration and organisation.

John Elam wrote in the *British Journal of Anaesthesia*, in 1946: 'The Dangers of Modern Anaesthesia demand the improved status and remuneration of the Anaesthetist.' And further, 'Anaesthesia is not a popular branch of medicine because the responsibility of the anaesthetist is great, the work hard and, even in London, the reward ridiculous. People will not pay for a good anaesthetic, given by the professional ...so young people on completing their medical education have no encouragement whatsoever to take up the art and science of anaesthesia as a specialty.'

In late 1948, the British National Health Service was established following the Beveridge Report of 1942. Anaesthetists were to be placed on a lesser salary scale to their

physician and surgeon colleagues. It was the Council of the AAGBI, led by Geoffrey Organe, later Sir Geoffrey, who fought a long battle with the legislators to ensure equality for anaesthetists, but only after they had demonstrated that training in anaesthesia was as demanding as for the other specialties. This led directly to the DA becoming a two part examination, and soon after to the English Faculty Fellowship examination.

Robert Orton, in his retiring address as president of the ASA in 1949, reflected on the means by which the status of anaesthesia in Australia could be improved. They were to ensure that anaesthetists were properly trained, with higher qualifications being considered essential for senior appointments; and that surgeons be made aware of the advantages of modern anaesthesia.

He went further to suggest that the anaesthetist should take responsibility for preoperative assessment and preparation, intravenous fluid therapy, and postoperative care. For this to happen, there were only two options: larger anaesthetic fees; and payment for public hospital work.

Robert Orton was, together with others, instrumental in the establishment of Faculty of Anaesthetists in the RACS, and went on to be the second Dean. His name is perpetuated by the medal named in his honour. Geoffrey Kaye also did his utmost to promote education and scientific research in Australian anaesthesia. He had established undergraduate and postgraduate teaching at Melbourne University.

After the establishment of the Society in 1934, Diplomas in both Sydney and Melbourne, in 1944 and 1946, and then the Faculty in 1952, we had in both Australia and New Zealand, the solid foundations for a specialty with status. But did we gain status?

There were many enlightened surgeons, especially those involved in the RACS, but this was a time when surgeons and anaesthetists were uneasy partners. Each needed the other, neither really took the opportunity to maximise the outward benefits of the relationship to enhance the status of anaesthesia.

There was a lot of tradition to overcome.

Dr Rupert Hornabrook wrote an article in the *Australian Medical Journal*, April 1913, entitled 'A plea for the more considerate treatment of patient and anaesthetist by the surgeon'.

'...more consideration should be shown by some surgeons towards their patients and the anaesthetist. Some gentlemen seem to have no idea of punctuality—half or three quarters of an hour late in the time of starting an operation seems to be nothing to them, they never appear to think of what that extra half hour or so must mean to the patient, in many cases it must be perfect hell.' He goes on to say how the lateness impacts on staff and other hospital arrangements.

'On one occasion, after waiting an hour for a well-known surgeon, I walked out of the operating theatre as he walked into it. He remarked that he was ready to start, and I told him that if he was, I was not, and that if he wanted the patient put under an anaesthetic he had better get someone else to do it...'

This was when he called for the formation of a Society of Anaesthetists.

Again in the *Australian Medical Journal*, May 1914, he wrote a further article entitled 'Some of the difficulties the anaesthetist has to contend against'.

'One of the greatest difficulties the teacher has to contend with is the inborn idea that any fool can administer an anaesthetic.' He described how a senior Melbourne surgeon had been heard to remark that 'a drayman could administer chloroform' and how '...no matter how foolish and inaccurate such a statement was, the reputation of the surgeon is likely to mislead some of the younger men into thinking that anaesthetic work is child's play'.

'A few years ago, I was stopped one morning and asked by a surgeon if I was not busy on the following day could I come to a certain private hospital and be present while he did a big abdominal operation. The patient was a lady who had been sent to him by Dr X. Dr X had sent him a case before, and on that occasion he had asked him to assist at the operation; that he had found Dr X to be such a fool at assisting that he had this time asked him to give the anaesthetic.'

# Status Anaestheticus

## Gwen Wilson Memorial Lecture, 2007 continued

'For the next few minutes the air was electric.'

Dr Stuart Marshall was President of the ASA in 1951 and 52, and member of the interim Board of Faculty 1951, wrote a paper in the Australian Medical Journal in 1954, entitled 'Problems which surgeons create for anaesthetists'. The paper came soon after the first Commonwealth Medical benefits Schedule, where, as Orton might have predicted, the rebates for anaesthesia services were far less than those for surgery.

Some passages from Marshall's 50 year old paper may strike a chord with some anaesthetists of today:

'The outmoded idea that the anaesthetic is any fool's business still persists, not only in responsible medical circles, but also among hospital authorities, government officials and the public as well. Surgeons in general are apparently not averse to other perpetuation of these anomalies, and thus play a major part in creating serious economic problems for anaesthetists.'

'None can deny the enormous benefits of good anaesthesia, yet there are surgeons who seek to preserve a degraded status for anaesthetists; who decry their achievements; who ridicule their knowledge and skill... Others effect a sublime indifference to the anaesthetist's convenience and obligations, giving inadequate information about patients, making awkward short-notice changes of plan, monopolising operating theatre facilities and the limited nursing staff available, and often dallying unconscionably over the work in hand. Loud in their denunciation of unpunctuality, they are frequently and euphemistically delayed themselves, and so become the main cause of the anaesthetist's subsequent lateness elsewhere.'

In concluding the paper, Marshall writes: 'Contrary to widespread surgical and lay belief, the acquisition of reasonably comprehensive knowledge and skill in specialised anaesthetics is not a matter of a few weeks training, but of at least two to three years' intensive postgraduate study and practical work. Fortunately many surgeons, both senior and junior, have a lively appreciation of the situation... The recent establishment of the faculty of Anaesthetists of the RACS marks a

great step forward in this respect'.  
...and it indeed it was!

However, the next 40 years saw very little change. It is my view that our relationship with the College of Surgeons had its advantages and disadvantages. It was a necessary step at the time, and although Geoffrey Kaye dearly wanted an independent College to be established then, the College provided the specialty with infrastructure and political clout. Nevertheless, the faculty was always a subordinate organisation, continually reinforcing the prejudices that had been established over 100 years.

Nevertheless, in the latter period, important milestones were achieved:

- > The publication of the Journal, *Anaesthesia and Intensive Care*, first proposed in 1954, and finally published in 1972, and the contribution by Ben Barry, Brian Horan, John Roberts and Jeanette Thirlwell;
- > The long and persistent campaign from the mid 1980s by Greg Deacon and others to break the nexus between surgeon's and anaesthetist's fees in Government rebate schemes;
- > The establishment of the Australian Patient Safety Foundation, by Bill Runciman and colleagues in 1987, establishing Australian and New Zealand anaesthetists at the forefront in patient safety;
- > The promulgation of Faculty policy documents, giving anaesthetists the means to argue for better conditions and facilities for the safe care of patients; and ...
- > The final step of becoming a College in our own right in 1992.

These initiatives helped to improve the professional status of anaesthesia, relative to other doctors—but did they improve our status in the community?

There have been numerous studies around the world in recent years, examining patients' knowledge of the role and attributes of the anaesthetist. Although there is considerable variation in different countries, the conclusions drawn are that many patients don't know we are doctors, or that we stay with them during the procedure, or that we have other roles in the hospital.

If we want the public to know more about what we do and, more importantly, how well

we do it—how should we go about it?

We need to ask, 'Are they interested? Do they really want to know?' If we take the generally accepted number of three million anaesthetics per year in Australia for a population of 20 million, and a comparable number in New Zealand, we can expect that each citizen is likely to have an anaesthetic no more often than once every 10 years. Even then, most anaesthetics will occur in the later years of life.

For the great majority of the public, information about anaesthesia has no immediate relevance. It doesn't matter how well it is presented, how big the advertisement is, or how glossy the brochure, it just doesn't rate.

In 1981, the American Society of Anesthesiologists instituted a public education program. They commissioned an external study of the program after four years, which concluded that in spite of the many efforts put into it, 'the man in the street in this country is not the least bit concerned about anaesthesiology, let alone anaesthesiologists'. It was promptly stopped, and a smaller program to target legislators was initiated.

We tried to market anaesthesia through the vehicle of National Anaesthesia Day, first in 1996, and for several years afterwards. Was it successful? It had a marginal effect on the public, but the benefit that I believe we really gained from National Anaesthesia Day, was that it made us all more aware of our own achievements and professional role.

Even television medical shows can't glamorise anaesthesia, because mostly it is boring. You and I might really love what we are doing every day, but it is only when things go wrong that anaesthesia gets exciting to the onlooker, and that is not necessarily the image we want to portray.

We only have to read a newspaper or watch the television news to realise that the press is not the least bit interested in the mundane. In order to get column space or air time, the story has to have an 'angle'—something to make people sit up and take notice.

Sensation or disaster sells!

A good and safe anaesthetic is far from

sensational, and the citizens of Australia and New Zealand enjoy the best and safest anaesthesia care in the world.

Are government officials or politicians swayed by glowing reports of how safe anaesthesia is? Or how well we are trained, or how much good we do for the community? They will pay lip service to us and we might feel encouraged by their interest, but they invariably have their own agenda.

Government opinion ultimately reflects public opinion, and it is the public that we must address... but we cannot do it via mass media.

We have available to us, the marketing industry's most desirable marketing opportunity. The one on one personal sales opportunity—3 to 4 million times a year!

We fail to maximise the benefit of that opportunity, and there is a long history to this state of affairs.

Geoffrey Kaye described the practice of anaesthesia in 1927. 'The care of patients was rudimentary in the extreme. Nobody ever dreamt of paying them a preoperative visit. Anaesthetists and patients met as strangers in the operating theatre. Nobody ever charted blood pressure, pulse or respiration during operations.'

40 years ago, Dr Paul Rainsford wrote an editorial in the 1966 Newsletter of the ASA. 'Consider what does a member of the public know about anaesthetics before and after he has experienced one? He cannot say "Anaesthetist", is uncertain whether it is a doctor, probably never sees one respectably dressed, rarely or never gets to talk to one, is unlikely to know his anaesthetist's name, has no idea of his background, training or competence.'

Is it any wonder that we were overshadowed by the surgeons?

We are not taught in our training, either in University or as postgraduates, how to run a single operator small business, how to maximise commercial return by customer interaction—in short—how to sell ourselves.

Further, we are encouraged to do a rush job of the preanaesthetic consultation, in a crowded room with inadequate facilities. We have, with the preanaesthetic consultation, the perfect opportunity to market ourselves

and our specialty, and we have been supported strongly by the College and the Societies, in emphasising the importance of the interaction and ensuring that it is adequately remunerated. We must take the preanaesthesia assessment seriously. If we can, we should do it ahead of time. We must not accept time constraints or poor facilities. We must look the part. If you see your patients dressed in theatre greens, you accept the profile of a nurse or orderly. You don't need to wear a tie or designer outfit, but equally dress respectably in the context of the patients you are seeing.

See your patients afterwards. If you have to be in theatre greens for the preanaesthetic consultation, at least let them see you dressed properly afterwards. If you can't see them, telephone them. Give them your 24 hour contact details. We must continually strive to 'value add' our service.

Gwen Wilson summed up the situation when she said, 'The value or status placed by the public is not based on definite and tangible value received; it is determined by the public's opinion of value received'.

I believe there have been two further factors in recent years that we have allowed to interfere with our ability to enhance our status. The first is the ease with which we have allowed third party payment arrangements to remove the relationship between the value of the service and its cost. Perception of value is very much related to status in our socio-economic society. Secondly, the influence of the legal profession on the practice of anaesthesia has been counterproductive to improvement in status of the specialty.

The lawyers tell us that we must explain everything that can go wrong—how bad the anaesthetic can be!

Do I tell my patients, and their parents all about complications? No, I tell them how great the anaesthetic is going to be; how pleasant it will be going off to sleep; how I will look after them all the time while they are asleep; and all the things I will do to ensure that they wake up comfortable, not vomiting, and feeling good. If the parent or patient wants more information—information about complications—they'll get it, but they have to

indicate a desire to want that information.

When I undertake an anaesthetic, I engage the patient or family in trusting me to perform that task to the best and safest of my ability. I tell them as much as they indicate they want to know—no more, no less. I rely on creating a sense of trust and two-way communication.

As for financial protection against adverse outcomes... that's what I pay insurance for!

We have an enviable record. Adverse outcomes are rare and I treat medico-legal insurance like car insurance. I will drive as carefully as I can, but I will not allow an insurer to tell me how to drive.

Enhancing our status in the eyes of the general public cannot be done by the College or the Societies on our behalf. They do not treat patients, we do. The College or Societies can go to an advertising agency and the agency will gladly design a promotional campaign costing many hundreds of thousands of dollars. My experience of several years tells me that it costs a lot of money for very little effect.

They can usefully lobby legislators on specific issues, but don't be lulled into the belief that they will improve our public profile for us. The College and Societies can only support what we do as individual practitioners. Remember that you are the shop window of a highly expert consulting business.

The status of anaesthetists in the eyes of the general public is in your own hands. No one else can raise that status for you.

Be proud of the service that you provide. Value add your service, and let them know what a great job you do. Your patients will be happy, you will add to the status of your chosen profession, and you will have great job satisfaction.

ROD WESTHORPE



## Dean's message

Dr Richard Lee

## CHANGE



DR RICHARD LEE

Those who have worked in Intensive Care Medicine long enough to remember the first wave of steroids for septic shock or Bird adult ventilators will have observed the ever-changing landscape of intensive care practice and training, and will recognise that few aspects of our lives are immune from change. Now appears to be a particular point in time when multiple changes that impact on JFICM are coming to fruition or are appearing on the horizon.

**Some change is forced upon us, some we produce ourselves inadvertently and some we drive, lead and control.**

**The challenge is to ensure that change is beneficial, sensible and accepted by our constituency.**

### External change

In terms of change impinging on us externally, we can list the changes to policies and procedures of our parent colleges and on a national level, National Registration in Australia and shifts in the assessment of overseas trained specialists in New Zealand.

JFICM is incorporated within ANZCA but governed by RACP and ANZCA, so changes within both colleges may affect us. The Board and its representatives are involved at many levels with the Councils and their committees, with the aim of remaining abreast of changes and ensuring that there is synergy across often diverging policies.

Recently ANZCA and RACP have undergone Governance Reviews and RACP is undergoing an Education Strategy Review. These Reviews were in part driven by the desire to streamline processes, organise structure, manage corporate risk and increase efficiency, but in the case of RACP there was a strong desire to empower the Faculties and Divisions and improve communication. Fellows of RACP have recently approved a new constitution and many facets of the RACP will be altered greatly. In particular, Education will be a major focus because of a realisation that the apprenticeship, time-based model is

outdated, curricula are not transparent and that aspects of the RACP exam are unreliable or have low validity. For instance, the MCQ section is thought by some to be overly esoteric and may be unanswerable by its own specialists. Modes of assessment will therefore be updated and courses added and our curriculum will be expected to mesh in.

### Inadvertent change

In terms of changes inadvertently brought about by our own actions, it is believed that we are currently seeing some undesirable effects of attempting to create a flexible supra-specialty.

We accept diverse Basic Training programs, often not focused on acute medicine and we provide exemption from our Basic Sciences exam. After rapid transit into Advanced Training, trainees have two core ICM years in which they try to fit the exam, project and ADAPT course. As a result many trainees present to the Fellowship Examination without the necessary experience and too much pressure is then placed on the Exam to drive learning and 'weed out' the under-prepared trainees.

For trainees to be able to gain maximum benefit from the two core years they must be ready to move into Advanced Training and have achieved relevant early skills. It is not surprising that the most successful group of recent times at the Exam has been trainees with the ACEM Primary.

**'Change is inevitable. In a progressive country change is constant.'**

**Benjamin Disraeli 1804-1881**

Flexibility and lack of tight structure in our program have also often meant that we attract trainees in large numbers, but lose them later to the 'lifestyle' specialties, as the pressure of life increases. Between 2000 and 2002 we registered 262 trainees but graduated only 73 Fellows between 2004 and 2006.

### Leading change

There is no question that Intensive Care Medicine has a lot to offer in terms of job satisfaction, intellectual challenge, working in a team and longitudinal care of very sick patients, but trainees will only be aware of these if they are engaged by the specialty and provided with a structured career early on. To that end JFICM is considering a restructuring of the program, not in its duration or major components, but in how it is taught. Draft Objectives of Training and Competences (OTC) for Basic Training and Advanced Training are before the Board. Once they are accepted, ways of assessing achievement of the OTCs will be finalised. It is proposed that an enhanced program from PGY2 will be available and other Basic Training will be accepted but trainees will be expected to meet the OTCs before moving into Advanced Training. For instance, it might be required

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that all or part of an ALS certificate, ADAPT course, basic course and JFICM Primary be completed satisfactorily before moving from Basic to Advanced Training. ICM learning will then be distributed over a longer period without extending the training time.

It is also suggested that the hybrid 'hot cases', which are becoming difficult to run in the exam with > 50 candidates per sitting, be moved to in-training, their natural place.

The aim of these changes is not to provide further hurdles or make training more difficult, but to engage, teach and challenge the trainees during their entire program.

### **The future**

In 1998, the then Dean of the Faculty of Intensive Care (FICANZCA), Dr Duncan, reported in the Bulletin the results of the survey of Fellows. He noted that 90% of respondents favoured the ultimate formation of a separate College of Intensive Care Medicine, most in a 2-5 year time frame. This issue is brought to prominence by the difficulties of functioning as a joint Faculty and the maturing of our specialty.

Nonetheless, it is unwise to underestimate the value of the contributions we receive from our parent colleges. We would need to know that our situation as a separate college would be improved and that we have the resources (financial, physical, intellectual, labour) to survive, before separating. I highlight this topic because, after getting the curriculum in order, it will be next on our agenda for discussion.



# Victoria

## JFICM REGIONAL/NATIONAL ANNUAL REPORTS APRIL 2006 – MAY 2007

### **Deputy Chair**

Dr David Green

### **Co-opted**

Dr Himanagsu Gangopadhyay

### **Co-opted**

Dr Neil Orford

### **Co-opted**

Dr Jonathan Barratt

### **Ex-officio**

Dr Megan Robertson

### **Ex-officio**

Dr Peter Morley

### **Ex-officio**

Dr David Ernest

### **The JFICM –VRC continues to focus its efforts on keeping Victorian Fellows informed of current College and Regional affairs and to assist Trainees in their academic preparation for Fellowship.**

In May 2006, Dr Craig French relinquished his role as Chair of the JFICM-VRC after having served both as Honorary Secretary/Treasurer and Chair over the past four years. We extend our sincere thanks to Dr French for his commitment and valuable contribution to the VRC which was given so generously despite his busy work schedule.

To the retiring members we also thank you for your support and interest in serving on this Committee and wish you well in your future endeavours.

During 2006, Elections were held to appoint a new Committee for the term June 2006 to May 2008. Accordingly the new Committee now operates under the Chairmanship of Dr Julian Hunt-Smith.

The Chair is pleased to report the resumption of the JFICM Lecture Series for Intensive Care Trainees which commenced in February 2007 and will run through until October of this year. We thank the participating hospitals in advance for their co-operation in facilitating these Lectures and believe the Trainees will find them of great benefit.

Over the past twelve months, the Committee has continued to review College and Joint Faculty Professional Documents, Coroner's Reports and a range of documents from Department of Health Services. The Committee was also involved in hospital inspections and sourcing new members for the VRC.

I look forward to the remainder of our term of office and to working with the new Committee. On behalf of the members I would like to thank the VRC administrative staff for their assistance and the JFICM Executive Officer Mrs Carol Cunningham Browne for her ongoing support.

JULIAN HUNT-SMITH  
Chairman

# Western Australia

## JFICM REGIONAL/NATIONAL ANNUAL REPORTS MAY 2006 to MAY 2007

### OFFICE BEARERS AND MEMBERS

#### Chairman

Dr David Morgan

#### Deputy

Dr Cyrus Edibam

#### Hon. Treasurer

Dr David Simes

#### Hon. Secretary

Dr Mary Pinder

#### Ex-officio members

#### Board member

Dr Vernon van Heerden

### Co-opted members

#### New Fellow representative

Dr Stuart Baker

#### Trainee representative

Dr John Lewis

#### ANZICS Rep

Dr Brad Power

#### Trainee Liaison Officer

Dr Steve Edlin

#### Administrative Officer

Ms Sandra Box

### Meetings 2006/2007

16 August 2006

30 January 2007

### Attendance of Elected Members

Dr D Morgan	2
Dr C Edibam	2
Dr D Simes	0
Dr M Pinder	1

### Chairman's Report

This year has seen a period of consolidating the previous year's initiatives in Western Australia. Most actions this year pertain to training and education of the ever expanding number of trainees in the field of intensive care medicine.

#### 1 Central Trainee Liaison Officer

**position**—This has been undertaken by Dr Steven Edlin. His role has been as an interhospital liaison for all trainees in Western Australia. Through his initiative there has been the establishment of weekly clinical teaching sessions at the tertiary campuses for all JFICM trainees. As in the past, we have encouraged intensivists to release trainees from clinical duties if at all possible. Such schemes have always been difficult to coordinate in the past due to the limited number of local trainees.

#### 2 Anaesthesia Training Requirements—

We have attempted to streamline the allocation of anaesthesia positions for intensive care trainees. Because such positions are limited and anaesthesia training is often the last component of training, obtaining suitable positions has proved difficult at times. Because a number of trainees register with intensive care 'to keep their options open' this does give a spuriously high number of candidates needing to meet training requirements. The WA JFICM is aiming to have a closer relationship with our WA ANZCA counterparts with regard to anaesthetic placements in the future.

#### 3 Combined local ANZICS/JFICM

**meetings**—The local chapters of the Faculty and ANZICS continue to have a strong relationship. In order to help foster interhospital collegance within Perth we continue to aim for 4 educational meetings per year (AGM/ASM included). In May we had the good fortune to host the Dean as he attended a successful combined ANZICS/JFICM meeting.

#### 4 Future Provision of Services—

Following the Reid Report into the Western Australian Health Service, there are dramatic changes intended for health in this state. The future direction of intensive care in Western Australia remains topical, particularly regarding future bed capacity, with the states population continuing to grow and age. The planned development of the new Tertiary campus at Murdoch offers an ideal opportunity to productively plan for critical care for successive generations.

DR DAVID MORGAN CHAIRMAN  
WA Regional Committee  
April 26th 2007



# New South Wales

## JFICM REGIONAL/NATIONAL ANNUAL REPORTS May 2006 – April 2007

### OFFICE BEARERS & MEMBERS 2006 / 2007

#### Chair

Raymond Raper

#### Vice Chair/Secretary

Elizabeth Fugaccia

#### Elected members

Deepak Bhonagiri

Priya Nair

#### ACT Representative

Mark Oliver

#### New Fellows' Representative

Mark Lucy

### Ex-officio Board Members

Richard Lee

John Myburgh

### Co-opted member

Ian Seppelt

### Retirement of Regional Committee members 2006

E Stachowski

Y Shehabi

### Total number of Regional Committee meetings held: 3

### Meetings 2006/2007

18 July 2006

8 November 2006

7 March 2007

### Attendance of elected members

Elizabeth Fugaccia 3

Priya Nair 2

Deepak Bhonagiri 3

Raymond Raper 3

### Hospital accreditation

The current status of hospitals accredited at C24 and C12 remained unchanged.

Inspections were undertaken at The John Hunter Hospital, Gosford District Hospital, Hornsby and Kuringai Hospital, Bankstown Hospital, St George Hospital and Prince of Wales Hospital.

### NSW Intensive care long & short Courses

These courses continue to attract trainees from NSW and interstate and have been running in 2006/07 along the same format as previously.

### Bimonthly meetings

This initiative has been discontinued in 2007. The Regional Committee wishes to express its appreciation to the convenor of these meetings, Yahya Shehabi. It is planned to co-ordinate with the regional committee of ANZICS to continue to support the professional education of Fellows in NSW.

### AMA Career Exhibition day 28 April, 2007

The Regional Committee of the JFICM, in conjunction with the NSW ANZICS executive, attended the AMA careers day at NSW University. The JFICM booth was well decorated with posters and photos and an excellent continuous slide show enhanced

the appeal of the booth. Much of this was the work of Dr Richard Piper who, together with the executive members, manned the booth throughout the day and responded to the questions of the many junior doctors and medical students who attended. The Regional Chairman delivered an oral presentation on training and working in Intensive Care that was well received.

This event will be held annually following the success this year. Attendance would be enhanced with the provision of brochures and 'give-aways' with an Intensive Care flavour. Other Colleges, Faculties and employer groups provided sample bags, pens, fruit, etc.

### State Committee representation

The Regional Committee Chair continued to represent the JFICM on the NSW Standing Committee for College Chairmen, through which comments and response from the Regional Committee on issues of concern were presented. Unfortunately, this committee meets very rarely. Institute of Medical Training and Education (IMET) initiatives related to training in intensive care in NSW are continuing, but to date have had no real impact on Intensive Care. The national executive response to the IMET plans for overseeing ANZCA training in NSW was well received but has not yet been actioned.

Access for ICU trainees to Anaesthesia experience remains problematic.

Dr Elizabeth Fugaccia represented the RC on the Transfusion Advisory Committee. Dr Peter Clark is the RC representative on the Trauma Verification program but this has not been especially active. Dr Stuart Lane was the NSW nominee for the 'New Fellows' conference and Dr Nhi Quynh Nguyen is the NSW nominee for the Trainee Committee. The NSW RC was represented on or provided input into a number of selection panels for ICU Specialist appointments.

### New Elected Regional Committee members:

The following were elected unopposed:

Dr Deepak Bhonagiri

Dr Elizabeth Fugaccia

Dr Priya Nair

Dr Raymond Raper

This year will see the third combined ANZICS/JFICM ASM held in Sydney. Dr Ian Seppelt is convening the meeting with the assistance of the Committee and the local ICU community. The program looks very impressive and early registrations suggest the meeting will be very successful.

RAYMOND RAPER  
Chairman NSW Regional Committee  
May 1, 2007

# New Zealand

## JFICM REGIONAL/NATIONAL ANNUAL REPORTS 1 April 2006 to 31 March 2007

### OFFICE BEARERS AND MEMBERS

#### Chair

Dr Tony Williams

#### Vice Chair

Dr Grant Howard

#### Honorary Secretary

Dr Claudia Schneider

#### Honorary Treasurer

Dr Claudia Schneider

#### Elected member

Dr Mike Gillham

#### Elected member

Dr Seton Henderson

### Ex-officio members

Dr Ross Freebairn: Board of Faculty Melbourne

Dr Jack Havill: Immediate Past Dean of JFICM

Dr Peter Roberts: Royal Australasian College of Physicians

Dr Gerard McHugh: Australian and New Zealand College of Anaesthetists

Dr Peter Hicks: Australian and New Zealand Intensive Care Society

Dr Claudia Schneider: New Fellows Representative

### Administrative Assistance:

Karen Hearfield

**Total Number of National Committee Meetings for year: 3**

### Attendances of Elected Members up to and including November meeting

Dr Freebairn	3-3
Dr Gilham	2-3
Dr Henderson	2-3
Dr Howard	1-3
Dr Williams	3-3

### EDUCATION AND TRAINING

Currently New Zealand has 78 Trainees and 50 Fellows.

After the resignation of Dr Stanley Koshy, the trainee representative, the JFICM NZNC has made several attempts to obtain nominations for a replacement trainee representative. A nomination was received from Dr Sesha Boppudi and his appointment as trainee representative has now been ratified by the board.

### CHAIRMAN'S REPORT

#### New Fellows Conference

Dr Michael Gillham presented a report on the New Fellows Conference that he attended as the New Zealand representative. Dr Shawn Sturland has been nominated by the New Zealand National Committee for consideration for the 2007 Conference.

### ASM

The JFICM ASM in conjunction with ANZICS will be held at Sofitel Wentworth, Sydney – 1-3 June 2007.

### Annual General Meeting

The Annual General Meeting was held on 5 April 2006, at the Grand Chancellor Hotel, Christchurch. The next AGM will be held in October at the federal ANZICS meeting.

### Ministry of Health

The JFICM Quality Assurance Activity registration with the Ministry of Health was due for renewal on 4 December 2006. Originally the registration was done under the Medical Practitioners Act 1995 and in 2003 this was replaced by the Health Practitioners Competence Assurance Act 2003. The first documentation that we submitted for this renewal did not quite meet the requirements set by the Ministry of Health. JFICM resubmitted their application on 19 February 2007. At this point in time we are still waiting to hear from the Ministry of Health the outcome of our application.

The JFICM NZNC would like to extend their thanks for Dr Felicity Hawker and Katie Griffin for their time and efforts in putting this information together

The ministry has convened a two day meeting entitled, Functionally Mapping New Zealand's On-Shore and Off-Shore Health Capability for Disasters with a Health Component, on 5 and 6 March. Drs Vaughan Laurenson (ANZCA) and Ross Freebairn (JFICM) each attended one day of the meeting representing both NZNC's.

### Medical Council of New Zealand

Reaccreditation – the JFICM NZNC extend their thanks for Dr Jack Havill, Dr Ross Freebairn and Carol Cunningham-Browne for their contribution in putting together the information required for JFICM's reaccreditation with the Medical Council of New Zealand. Confirmation of this reaccreditation for six years, with a further four years being granted on receipt of a satisfactory report at the end of the fifth year, was received on 25 August 2006.

### Air Ambulance Service Sector Standard Committee

Dr Ross Freebairn was a member of this committee and participated in reviewing and updating the Air Ambulance Service Sector Standard.

### ACC

Updated information received with regard to Notification of Harm. A further meeting was held by ACC on 24 October 2006. Dr Peter Roberts attended this meeting on behalf of the JFICM NZNC.

### CMC

JFICM NZNC attended the four meetings during the year on behalf of the committee.

# New Zealand

## JFICM REGIONAL/NATIONAL ANNUAL REPORTS 1 April 2006 to 31 March 2007 continued

### **IAMRA Conference**

This conference was held in Wellington from 11 – 14 November 2006. It was attended by Dr Felicity Hawker, from Melbourne and Dr Ross Freebairn as the JFICM NZNC representative.

### **NZ ICU Registrars' Annual Meeting**

This meeting is taking place in Auckland on 8-9 June 2007 and is open to all Intensive Care trainees. It is the third meeting to be held and we look forward to receiving a good response. Dr Nick Barnes has run two successful meetings in the Waikato. This year's meeting is being run by Dr Michael Gillham.

### **Hospital Accreditation and Inspections.**

Hawkes Bay Hospital has been accredited for Basic Training.

Dunedin Hospital has been accredited for Basic Training.

Middlemore Hospital had an inspection on 17 October 2006.

### **Submissions made by NZNC, JFICM.**

1. Ministry of Health – Direct to Consumer Advertising of Prescription Medicines.
2. ANZTPA Consultation – Proposed ANZTPA Joint Regulatory Scheme.
3. Ministry of Health – National Ethics Advisory Committee (NEAC) Ethical Values for planning for and responding to a Pandemic in New Zealand (joint submission with ANZCA).
4. ANZTPA Consultation – Draft Labelling Requirements for Medicines under a Joint Australia New Zealand Therapeutic Products Agency.
5. Medical Council of New Zealand – Draft Policy for Registration within a vocational scope of Practice for International Medical Graduates.
6. Medical Council of New Zealand – Consultation Document for the Scope of Breast Medicine.
7. National Fatigue Management & Wellness Program – Proposed National Doctors Fatigue Management and Wellness Program.
8. Ministry of Health – Review of Policy Relating to the Operation of Medicines (Standing Orders) Regulations 2002.
9. Standards New Zealand – Recommended changes to the Draft Standard Ambulance Service Sector Standards (including pre-hospital emergency care, paramedics, transport, emergency, ambulance communication centres and event services).
10. ANZTPA – Product Vigilance in the Australia New Zealand Therapeutic Products Authority and The Regulation of Blood under the ANZTPA Consultation Papers.

11. Medical Council of New Zealand – Performance Evaluation Program (PEP).
12. Medical Council of New Zealand – Vocational Registration for rural hospital medicine.

### **Other Documentation received for comment**

1. HWAC Care and Support in the Community
2. Medical Council of New Zealand Cultural Competence Resources
3. NEAC – Ethical Guidelines for Observational Studies: Observational research, audits and related activities
4. New Zealand Medical Association – Code of Ethics
5. Functionally Mapping New Zealand's On-shore and Off-Shore Health Capability for Disasters with a Health Component – Dr Ross Freebairn to represent JFICM at the meeting being held on 5 March 2007.
6. Medical Council of New Zealand – Draft statement on cosmetic procedures
7. Ministry of Health – New Zealand Influenza Pandemic Action Plan V15
8. Ministry of Health – Health and Disability Sector Standards Review

TONY WILLIAMS Chairman  
New Zealand National Committee, JFICM  
March 2007

# Queensland

## JFICM REGIONAL/NATIONAL ANNUAL REPORTS 30 May 2006 – 30 May 2007

### OFFICE BEARERS AND MEMBERS

#### Chair

Assoc/Prof Rob Boots

#### Vice Chair

Dr Chris Anstey

#### Honorary Secretary/Treasurer

Dr Hayden White

#### Elected Member

Dr John Fraser

#### Elected Member

Dr Ranald Pascoe

#### Ex-officio Members

#### Board Member

Assoc Prof Bala Venkatesh

#### Board Member

Dr Bruce Lister

#### ANZICs Qld Chairman

Dr Ahmod Karnik

#### ANZCA QRC Chairman

Dr Michael Fanshawe

### CO-OPTED MEMBERS

#### Rural Representative

Dr Michael Corkeron

#### North Qld SOT Representative

Dr John Evans

#### SEQ SOT Representative

Dr Marc Ziegenfuss

#### New Fellows Representative

Dr Nikki Blackwell

#### Trauma Committee Liaison

Dr Neil Widdicombe

#### Advanced Skills Workshop Convenor

Dr Jeremy Cohen

#### Regional Trainee Representative

Dr Andrew Udy

#### Metropolitan Trainee Representative

Dr Owen Callender

### WORKSHOP CONVENORS

#### Foundation Skills Workshop

Dr Hayden White

#### Advanced Skills Workshop

Dr Jeremy Cohen and Dr John Fraser

#### Education Evening Program

Assoc Prof Rob Boots

### SECRETARIAT

#### Queensland Regional Co-ordinator

Ms Sharon Miethke

#### Queensland Administrative Assistant

Ms Kylie Joynson

#### Total Number of Qld Regional Committee Meetings for year: 5

#### Attendances of Elected Committee Members:

Assoc Professor R Boots	5:5
Dr C Anstey	3:5
Dr R Pascoe	3:5
Dr H White	2:5
Dr J Fraser	1:5

### CHAIRMAN'S REPORT

2006-2007 has been a consolidation year of the present Queensland Regional Committee. The charter of programs planned at the commencement of this committee in 2004 has almost reached fruition. With the enormous changes occurring within QHealth and the Queensland Government in general, there has been an expansion of the Regional Committee with interested co-opted fellows to allow representation of the JFICM at an increasing numbers of forums. The Queensland Regional Committee continues to be extremely active with major contributions to Intensive Care training and management done by both the Queensland Regional Committee directly and enthusiastic individuals within Queensland. The Queensland Regional Committee has made submissions or representations for:

1. The reorganisation of the Medical Board of Queensland;
2. Changes to the Coroners Act of Queensland;
3. AMA Chairs of Colleges Meetings; and
4. Queensland Trauma Plan.

Inputs have additionally been made to various credentialing committees around Queensland. Fellows have made important contributions to area of need assessments and unit inspections for training accreditation. The latter is becoming an increasing task as units, both public and private, continue to grow allowing for upgrading of existing accreditations or new accreditations to be granted.

New Units to receive accreditation are as follows:

- > Mackay Base Hospital – Basic Training
- > Allamanda Private Hospital – Basic Training

The Queensland Regional Committee is pleased to welcome its new regional and metropolitan trainee representatives Dr Owen Callender and Dr Andrew Udy. We look forward to their input to ensure the regional committee represents the needs of our Queensland trainees. The committee was impressed with the enthusiasm of our trainees to be actively involved in College activities.

The Queensland Regional Committee looks enthusiastically forward to hosting the JFICM Annual Scientific Meeting in 2009.



# Queensland

## JFICM REGIONAL/NATIONAL ANNUAL REPORTS 30 May 2006 – 30 May 2007 continued

### Specific Queensland JFICM Regional Committee Activities

#### 1. Supervisors of Training Support Forum

The Supervisors of Training Forum has evolved to be a bi-annual evening meeting, generally planned to be associated with a Teaching on the Run program or an Education Master Class. This meeting is facilitated by the Queensland Regional Chairman. Meetings held in the last year have forwarded information for consideration of the Board in relation to overseas trainees, continuity of supervision and other issues in relation to the trainee program.

#### 2. Updated Trainee Database for Queensland

It is clear that the information held on trainees and their location, current supervisor and plans for examinations is in need of updating. Regular searches for current trainee lists show some very now elderly and lapsed trainees. It is our hope to have a business case presented for this so that the Queensland Regional committee can make at least annual proactive contact with our Queensland trainees to assist with the management of their training.

### EDUCATIONAL ACTIVITIES

#### 1. Education Evenings

This program has continued 2nd monthly hosted by the Wesley Hospital with a range of sponsors. The sessions are open to JFICM, RACP, ANZCA and ACEM fellows and trainees. Local talent is emphasised but opportunity is made of visiting experts. It is video-conferenced across the State and to Northern NSW. The take up of the program by linked in sites has been variable but the numbers participating has made the program worthwhile to continue. Soon the program will be available from the Qld Regional JFICM office on DVD.

The lectures for 2006-2007 were:

#### 14 June 2006

Subject: Obstetrics and the ICU  
Presenter: Drs Karen Lust and Peter Lavercombe

#### 9 August 2006

Subject: All that Bleeds or Not!  
Presenter: Dr Greg Comadira

#### 4 October 2006

Subject: Care for the Clinically Dead  
Presenter: Dr Neil Widdicombe

#### 6 December 2006

Subject: Unusual Intoxications  
Presenters: Drs Jason Roberts and Darren Roberts

#### 7 February 2007

Subject: Common but Difficult Scenarios in Paediatric ICU  
Presenter: Dr Phil Sargent Mater ICU

#### 4 April 2007

Subject: Disasters and International Approaches  
Presenter: Dr Nikki Blackwell

#### 2. Regular Newsletter

The activities of the Regional Committee are now biannually distributed in a newsletter to the trainees and fellows in Queensland from the Regional Chairman.

#### 3. Teaching on the Run Workshop

The first 6 modules of this program continue to be delivered by Dr Helen McKeering and A/Prof Rob Boots to an intercollegiate group of participants. The foundation program comprising clinical teaching skills and dealing with difficult trainees is delivered over 2 days. This is the program designed by Professor Fiona Lake of the University of Western Australia in collaboration with the Federal Department of Employment and Training.

Two Master Classes developed by Rob Boots and Helen McKeering have now been run have revisited the difficult trainee and a practical program of how to incorporate our trainees needs into busy daily routines.

#### 4. Advanced Procedural Skills Workshop

This program is now in its third year. It is organised for our trainees in a workshop format to assist in some of the practical skills for intensive care. The sessions covered include Percutaneous Tracheostomy, Bronchoscopy, Balloon Pumps, Pulmonary Artery Catheters and Haemodynamic Monitoring and Pacing Problems. There was no registration fee and the meeting was supported by a grant from the Joint Faculty in addition to the following sponsors: sponsors Mayo Health Care, Edwards Life Sciences, Medtel, Olympus and Boots Health Care. The feedback has been excellent with requests for further such sessions and other topics to be included, including dialysis therapies and basic suturing techniques. Our thanks to the official organisers, Drs Jeremy Cohen and John Fraser, the additional tutors Drs Peter Scott, Dan Mullany, Carole Foot, Marc Ziegenfuss and Andrew McCann, and the organisers of the Brisbane Metropolitan training program for allowing us to schedule the meeting into one of the regular Wednesday afternoon sessions, and of course our Queensland Secretariat Sharon for bringing this successful meeting together.

## **6. Foundation Skills in Intensive Care Program**

This is a new program for the Qld Regional Committee and was run on 17 February 2007. It focuses on elementary practical skills needed in intensive care by basic trainees such as central line insertion, chest drain insertion, defibrillation/pacing/CPR and airway management and intubation. The program was coordinated by Dr Hayden White with additional tutors Dr Khoa Tran and Dr Chris Flynn. The workshop was held in the Queensland Health Skills Development Centre. Twelve trainees attended with positive feedback. No registration fee was required.

## **OTHER PROGRAMS OCCURRING IN QLD DUE TO ENTHUSIASM OF FELLOWS**

### **1. Crisis Resource Management in Intensive Care**

This program has been developed by Dr Carol Foot and colleagues focussing on crisis resource management in the intensive care unit. At this stage, it is the only program of its type in the world. The one-day program is aimed at trainees and ICU nursing staff using the high fidelity simulation facilities at the Queensland Skills Development Centre. It is aimed to run three times per year.

### **2. Basic Assessment and Skills in Intensive Care**

This international program developed by Professor Charles Gomersall and the BASIC steering committee has now been run 6 times in Queensland coordinated by A/Prof Rob Boots at the Queensland Skills Development Centre. Planning is well underway to make this program available in more states of Australia. The program combines lectures, skills stations and now has introduced advanced simulation crisis scenario training to reinforce the skills developed in the module in a three day course. Feedback has been positive with the focus of the training being for basic trainees in intensive care, critical care nurses and trainees and specialists who need to wither infrequently or regularly manage ICU patients without the direct supervision of an intensivist.

### **3. Academy of Critical Care Medicine – Second Part Pre-exam Course**

This well developed program continues under the co-ordination of Professor Bala Venkatesh involving now a large number of registrants and the involvement of all of the large metropolitan ICUs either providing venues or tutors. The cooperation of fellows across the city to make this program is a truly an excellent achievement for the organisers and the goodwill for QLD fellows.

### **4. Basic Science Meeting – Qld ANZICS (August 24-26 2006)**

This meeting continues to steadily grow with a focus of basic science in critical care for Australia and the Asia Pacific area. Chaired by

Associate Professor Bala Venkatesh this meeting has now developed as a calendar must for all those interested in both basic science research and its clinical applications. Key note speakers included Luciano Gattinoni, John Marshall and Didier Payen.

### **5. Vocational Expo 26 May 2006 at Royal Brisbane and Womens' Hospital**

Assoc Prof Rob Boots and Dr Nikki Blackwell represented the JFICM at the annual Queensland Vocational Expo. This meeting showcases most of the medical specialties and targets final year medical students and junior medical staff in Queensland. Experience at this meeting has been positive with approximately 30 young doctors including many female potential trainees expressing serious interest in intensive care. Information is made available about the training program and the life and work of intensivists.

## **IN CONCLUSION**

The Queensland Regional Committee continues to be an enthusiastic group of individuals working for the promotion of intensive care and training within the state. The present planning charter is now almost complete with all plans almost completed within the three year appointment. Local operating policy changes are hoped to ensure that the new initiatives will be able to be continued by future committees.

.....  
**ASSOCIATE PROFESSOR ROB BOOTS**  
Chairman, Queensland Regional Committee

# Tasmania

## JFICM REGIONAL/ANNUAL REPORTS May 2007

### OFFICE BEARERS & MEMBERS

#### Chair

Dr Allan Beswick

#### Hon. Secretary

Dr David Cooper

#### Hon. Treasurer

Dr Alan Rouse

### Committee Members

Dr Andrew Turner

Dr Anthony Bell

Dr Ram Sistla

### Board members

Dr Allan Beswick

(Co-opted representative of Tasmania)

### Regional Administrative Officer

Di Cornish (ANZCA Hobart)

### EDUCATION

Dr David Cooper remains the supervisor of training for the Royal Hobart Hospital while Dr Scott Parkes has taken on the role of supervisor of training for the Launceston General Hospital.

The Royal Hobart Hospital (RHH) remains accredited for 24 months of core training and the Launceston General Hospital for 12 months of core training. The RHH Department of Critical Care Medicine has undergone considerable expansion with approximately 1,100 admissions per year including cardiothoracic and neurosurgical patients. Junior medical staff consist of 2 senior registrars, 5 junior registrars and 5 JMOs (years 2-3). Rather than shift work, the Senior registrars participate in on call responsibilities with consultant support and supervision. The Launceston General Hospital also enjoys improved junior medical staffing numbers with 5 registrars and one JMO.

### Continuing Education

In 2006, Tasmania hosted the ANZICS/ ACCCN ASM—a great success and credit to the heavy commitment given by the state's small JFICM/ANZICS community and ACCCN members.

Combined JFICM ANZICS state wide meetings continue to facilitate interesting case discussion and business pertinent to both ANZICS and JFICM activities. Always well attended by long distance travellers, these meetings not only provide a forum for continuing education but also cultivate a collegial and harmonious relationship between those providing intensive care services around the state.

### Acknowledgements

The Tasmanian regional committee would like to acknowledge the administrative support provided by Dianne Cornish of ANZCA Tasmania.

# South Australia

## JFICM REGIONAL/ANNUAL REPORTS 2006

### OFFICE BEARERS & MEMBERS 2006

#### Chair

Robert Young

#### Vice Chair

Sandra Peake

#### Honorary Secretary

Gerrard O'Callaghan

#### Honorary Treasurer

Evan Everest

#### Northern Territory Rep

Dianne Stephens

#### Ex-officio Board Members

Michael O'Fathartaigh

### EDUCATION

#### Trainees

Four local trainees, Owen Roodenburg, Milind Sanap, Nandkumar Raut Pradeep Rangappa and Rajaram Ramadoss, were successful in the Joint Faculty Fellowship Examination in 2006. Owen Roodenburg won the Don Harrison Medal as the most outstanding candidate in the Joint Faculty Fellowship Examination in 2006.

'Tub's course' (the Australian Short Course on Intensive Care Medicine) remains heavily oversubscribed. To increase the number of candidates who could attend, the 2007 course was divided into concurrent 2- and 4-day courses. This format was successful with good feedback from candidates. The course remains dependent on the support of Fellows who make it possible through their efforts on the faculty. This year, the course required 28 faculty, including 3 from interstate: Peter Morley, John Gowardman and Matthew Maiden.

The Joint Faculty's withdrawal of accreditation for training in 2008 of the Royal Adelaide Hospital has resulted in significant changes to the Intensive Care Unit at that hospital. A further review by the Faculty is planned in 2007 for reconsideration of the Royal Adelaide Hospital's training status.

#### Supervisors of Training:

All South Australian Supervisors of Training remain as co-opted members of the Regional Committee to facilitate communication between the different training Units.

### CONTINUING EDUCATION

#### Local Meetings

A combined JFICM and ANZICS meeting on infectious diseases was addressed by A/Prof John Iredell from Westmead Hospital.

#### OTHER MATTERS

The close liaison between the Chair of ANZICS (SA) and the Chair of the JFICM (SA) continues with meetings of the respective regional committees held concurrently throughout the year.

Dr Robert Young, Chair  
28 March 2007



# Dean's report to the Annual General Meeting 2007



DR ROGER GOUCKE

### Strategic planning day

This was held last July with a view to providing some direction for the Board over the next two years. Discussions centred on four areas:

**Academic** – Focusing on promoting a Pain Module in medical schools and encouraging the Council of Post Graduate Medical Education foundations to include pain in PGY1 and 2; To consider a 'prize' for Pain Medicine at medical school level; To continue with 'standards setting' for Pain Medicine.

**Fellowship** – Acknowledge the need to provide services for Fellows (in addition to our current and continuing focus on trainees), promote and expand CPD, regional committees in larger states and possibly regional business meetings.

**Relationships** – Form a Board sub-committee to progress these issues; Develop draft Memoranda of Understanding with parent colleges; Establish links with both the Australian and New Zealand Colleges of General Practitioners; Commence dialogue with the Australian Pain Society and the New Zealand Pain Society to develop an arrangement to discuss future Annual Scientific Meetings, speakers, timing and perhaps national activities such as the 'Global Day Against Pain'.

**Policy/Government** – Make contact with the Medical Council of New Zealand to raise the profile of Pain Medicine in New Zealand, continue communication with national (AMC) and state/territory Registration Boards.

Many of these objectives have already been achieved.

### Fellowship

There are 219 Active Fellows. The Board is aware that more needs to be done to meet the requirements of Fellows. To this end, an emphasis on Continuing Professional development will be made, the Education and Training Committee is developing patient information material, and a second regular Educational meeting has been planned to be known as 'The Spring Meeting'. This year it will be on the Gold Coast in association with the Medico Legal Society of Queensland. The 2008 meeting is in development and will probably be in association with the Acute Pain Special Interest Group. There has been considerable work done on a number of Professional Documents. These include: Intrathecal analgesia and drug administration systems (PM4, PM6), Off Label use of Drugs, Diagnostic Medial Branch Blocks and Guidelines on Acute Pain Management. The Board of Faculty would welcome suggestions from Fellows with regard to their needs.

### Continuing Professional Development

The Faculty has been actively involved in the design of the new CPD program run by ANZCA and believes that it will be suitable for all Fellows. Compliance with a CPD program is a mandatory requirement for ongoing Fellowship, and an audit of compliance is being undertaken. Requests and suggestions for CPD activities are welcome from Fellows.

### Examination

Due to the growth in the number of candidates, the Faculty has investigated the possibility of separating the written examination to two weeks before the clinical examination. No decision has yet been made. A Deputy Chair of Examinations has been appointed and a New Fellow representative is included on the Examination Committee and observers from one of the founding Colleges have attended all recent examinations.

A major feature of the Faculty's examination process is the cross-disciplinary standardisation of questions/scenarios and answers/responses during the examiners workshop. All sections of the exam are marked by two examiners, usually from different disciplines, and the long case is an observer long case examination.

The 2006 Examination was held at Sir Charles Gairdner Hospital in Perth on 29 November – 1 December. Fourteen of the twenty candidates were successful.

### Training Unit and Program Accreditation

There are currently 22 accredited units in Australia and New Zealand with 41 trainees. There is increasing flexibility for trainees to 'design' their own program with assistance from their SoT and in certain cases advice from the censor. The Faculty is aware of the increasing importance of SoTs in the relatively short training program for Fellowship and is planning regular SoT workshops and has appointed a Supervisor of SoTs (Dr Tim Semple).



# Faculty of Pain Medicine Board

BACK ROW: Professors G D Phillips, E A Shipton, Drs C A Arnold, F J New, B J Moore, Ms H M Morris (Executive Officer)

FRONT ROW: A/Professor M L Cohen, Drs D Jones, C R Goucke (Dean), P A Briscoe (Vice-Dean), G C Booth, A/Professor R L Atkinson

## Research

The Faculty has embraced research as one of our core roles and is pleased that Pain Medicine is always strongly represented in applications for research funding from the College. At this ASM the Faculty will award the inaugural Dean's Prize for the best research paper in Pain Medicine judged to be of sufficient standard.

## Finance

Despite our significant fees, the Faculty remains financially dependent and therefore responsible to ANZCA. A delegation of responsibility document is in place between ANZCA Council and the Faculty and is working very satisfactorily. Forward budgeting is being developed and, once agreed by Council, relative autonomy is given to the Faculty Board. The implications of this are that we must think to the future and plan for at least one year ahead. Reactive or whimsical spending is not appropriate, however contingency funding is held by the CEO.

## Regional Committees

As discussed in the Strategic Plan, it was anticipated that these would develop during this year. It is pleasing that Queensland Fellows have taken the opportunity to set up an interim Regional Committee for Pain Medicine and we are currently refining regulations to govern the committees. Congratulations to Paul Gray who has taken on the role of Interim Chair of the Inaugural Queensland Regional Committee.

## Personnel

This AGM sees the stepping down of Geoff Booth from the Board. Geoff has chaired the Research Committee and contributed significantly during his time on the Board and seen through a number of developments. We wish Geoff well for the future.

During the year we welcomed Jenni Allison to the Faculty office and unfortunately we must farewell Monique Baker who moves to the Finance Department within ANZCA.

## Thankyou

In my first year as your Dean, I must thank all the Board members for sound advice and their dedication to a sometimes onerous workload. Also to those Fellows who are active in the various committees of the Board. Helen Morris our Executive Officer works tirelessly for trainees, Fellows, Committees, the Board and me, an almost impossible task, yet she does it with skill, dedication, patience and elegance.

ROGER GOUCKE  
27 May 2007

## GUIDELINES FOR LONGTERM INTRATHECAL INFUSIONS (ANALGESICS / ADJUVANTS / ANTISPASMODICS)

**To be read in conjunction with Professional Document PM4 (2005) *Guidelines for Patient Assessment and Implantation of Intrathecal Infusion Devices***

### 1. INTRODUCTION:

- 1.1 Persistent pain with associated disability is a common problem.<sup>1</sup>
- 1.2 In all patients with persistent pain, appropriate evaluation requires assessment of physical, psychological and socio-environmental factors.
- 1.3 Treatment of only one dimension of the patient's pain may result in less than optimal outcome.
- 1.4 The long-term intrathecal delivery of drugs is an established method of pain management in a small carefully selected subgroup of patients.
- 1.5 A range of delivery systems allows for the safe long-term delivery of intrathecal medication.<sup>1</sup>
- 1.6 Drugs may be administered directly into the intrathecal space, as single or repeated injections or by continuous infusion.
- 1.7 Non-analgesic drugs may be used for specific indications (e.g. baclofen for spasticity associated with neurological disease of central origin).<sup>17</sup>

### 2. PRINCIPLES OF USE:

- 2.1 Intrathecal administration provides direct access into the cerebrospinal fluid for drugs acting at a spinal and/or supra spinal level.
- 2.2 This invasive form of therapy is generally reserved for patients in whom pain or spasticity is not adequately controlled by less invasive measures and who meet certain criteria.
- 2.3 Intrathecal drug administration allows the use of relatively small doses of drugs compared with systemic administration.<sup>2</sup>
- 2.4 Intrathecal drug administration can result in significant undesirable side effects, and has the possibility of morbidity and mortality.<sup>3,4</sup>
- 2.5 Drugs administered into the intrathecal space need to be carefully assessed in respect of additives and preservatives, which may make them unsuitable for intrathecal use. A small number of medications have been deemed safe for intrathecal use.<sup>2,7</sup>
- 2.6 Care should be taken when considering off label use of drugs ensuring that additional patient education and consent is obtained.<sup>1</sup>
- 2.6.1 In Australia only baclofen is licensed for long-term intrathecal use.

### 3. METHODS OF ASSESSMENT:

- 3.1 Effective management of intrathecal therapy requires appropriate patient selection. Education of the patient increases their understanding of the potential benefits, risks and their responsibilities.
- 3.2 A multidisciplinary assessment must be undertaken. Continuing support by a pain medicine facility is required to provide refills and support with technical problems, but also to allow the patient to gain maximum benefit from the therapy.
- 3.3 Prior to the consideration of a trial of intrathecal drug therapy, the response to appropriate trials of oral and parenteral therapies should be assessed.
- 3.4 Prior to the insertion of long term delivery systems, the following should be assessed:
  - 3.4.1 Intrathecal trials should be undertaken to assess appropriate drugs, doses and efficacy of the drug or drug combinations.
  - 3.4.2 Testing with temporary catheter systems allows investigation of the potential side effects of the proposed procedure and medication.
  - 3.4.3 Base line levels of pain, function and Quality of Life should be recorded.
  - 3.5 Treatment requires regular assessment and documentation of efficacy, tailoring therapy to the individual.
  - 3.6 Treatment requires regular assessment, documentation and management of complications of the intervention and side effects of the medication.
    - 3.6.1 Long-term complications of the intervention include infection, catheter tip masses or failure of the device.
    - 3.6.2 Long-term side effects of medication include hormonal changes and hyperalgesia.
    - 3.6.3 If drug combinations are used, interactions with other drugs should be considered, including stability of the mixture.<sup>15</sup>
  - 3.7 Treatment requires ongoing assessment of the patient's pain, function and Quality of Life.

### 4. PHARMACOLOGICAL THERAPIES:

- 4.1 Opioids are the most frequently utilised agents for long-term intrathecal therapy. The most common opioid used is Morphine sulphate.<sup>5</sup>
  - 4.1.1 If good analgesia can be achieved with minimal side effects and risks using alternate routes, there is little evidence for improved outcomes with the intrathecal route.
  - 4.1.2 Failure to respond to an intrathecal trial or need for a rapidly increasing dose may indicate pain that is poorly responsive to opioids.

- 4.1.3 Inadequate analgesia may result in dose escalation of opioid over time. It is important to consider the many factors which may result in inadequate analgesia including:
- development of tolerance,
  - progression of the underlying disease,
  - emergence of a new source of pain,
  - development of opioid induced hyperalgesia,
  - distress
  - social reinforcers
  - pain which is not opioid responsive
- 4.1.4 Increasing analgesic requirements may also result from failure of the infusion device, dislodgement of the intrathecal catheter or other catheter related complications including the development of a catheter tip mass.
- 4.2 A range of non-opioid spinal analgesic agents are utilised for long-term therapy, some of which are supported by low levels of evidence and for which safety has not been fully established.<sup>2, 6, 7, 8</sup>
- 4.2.1 There is level I evidence that intrathecal administration of baclofen is efficacious for the management of muscle spasm of central origin.<sup>9, 10, 17</sup>
- 4.2.2 There is level II evidence for efficacy in treating
- neuropathic pain with intrathecal clonidine<sup>11</sup>
  - neuropathic pain following spinal cord injury with morphine and clonidine combined<sup>12</sup>
  - neuropathic pain with ziconotide<sup>2</sup>
- 4.2.3 Intrathecal administration of opioids and local anaesthetics and / or clonidine could be considered as an alternative agent in patients with poorly controlled neuropathic pain in cancer or following spinal cord injury.<sup>8</sup>
- 4.2.4 Many of these combinations are “beyond licence” or “off label” and appropriate patient consent must be obtained.<sup>13, 14</sup>
- 4.3 Combinations of intrathecal analgesic agents have potential advantages.<sup>6, 8, 12</sup>
- 4.3.1 Improvement in analgesic efficacy.
- 4.3.2 Reduction in side effects if reduced doses of both agents are possible when compared with single agent therapy.
- 4.4 Combinations of agents may be unstable for long-term use in implantable reservoirs.<sup>15</sup>
- 4.5 Due to the large number of potential combination therapies, the evidence for the most appropriate agents in different clinical situations is limited.
- 4.6 Both physician and patient should be aware of current data relating to safety and potential neurotoxicity of proposed intrathecal medications.<sup>7</sup> Toxicological studies to date suggest no long-term adverse effects of baclofen, morphine, bupivacaine or clonidine.<sup>2, 15, 16</sup>

## 5. FUTURE DEVELOPMENT:

- 5.1 Currently, there is limited evidence based data relating to intrathecal therapy for the management of chronic cancer and persistent non-cancer pain.
- 5.2 Further studies are needed in relation to:
- 5.2.1 Inclusion criteria.
- 5.2.2 Standardised reporting of the intensity, quality and aetiology of pain.
- 5.2.3 Comparison with other routes of administration.
- 5.2.4 Long term follow-up of efficacy, side-effects, and technical complications.
- 5.2.5 Efficacy of intrathecal agents, both alone and in combination.
- 5.2.6 Stability of combination therapies.
- 5.2.7 Evaluation of neurotoxicity.
- 5.2.8 Development of new agents.
- 5.2.9 Assessment of outcome measures from the perspective of analgesia response, function, mood, cognition and quality of life issues (including patient satisfaction).(18)

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## GUIDELINES FOR LONGTERM INTRATHECAL INFUSIONS (ANALGESICS / ADJUVANTS / ANTISPASMODICS)

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### FACULTY OF PAIN

#### MEDICINE PROFESSIONAL DOCUMENTS

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

**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 policy 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 and Faculty endeavours to ensure that documents are as current as possible at the time of their preparation, they take no responsibility for matters arising from changed circumstances or information or material which may have become available subsequently.*

Promulgated: 2007

Date of current document: Feb 2007

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Faculty Website: <http://www.fpm.anzca.edu.au>



## FACULTY OF PAIN MEDICINE PROFESSIONAL DOCUMENTS

<b>PM1</b>	(2006)	Policy for Trainees Seeking Faculty Approval of Programs for Training in Multidisciplinary Pain Medicine			
<b>PM2</b>	(2005)	Guidelines for Units Offering Training in Multidisciplinary Pain Medicine	<b>PS4</b>	(2006)	Recommendations for the Post-Anaesthesia Recovery Room (Adopted February 2001)
<b>PM3</b>	(2002)	Lumbar Epidural Administration of Corticosteroids	<b>PS7</b>	(2003)	Recommendations on the Pre-Anaesthesia Consultation (Adopted November 2003)
<b>PM4</b>	(2005)	Guidelines for Patient Assessment and Implantation of Intrathecal Catheters, Ports and Pumps for Intrathecal Therapy	<b>PS8</b>	(2003)	Guidelines on the Assistant for the Anaesthetist (Adopted November 2003)
<b>PM5</b>	(2006)	Policy for Supervisors of Training in Pain Medicine	<b>PS9</b>	(2005)	Guidelines on Conscious Sedation for Diagnostic, Interventional Medical and Surgical Procedures (May 2002)
<b>PM6</b>	(2007)	Guidelines for Longterm Intrathecal Infusions (Analgesics/Adjuvants/Antispasmodics)	<b>PS10</b>	(2004)	The Handover of Responsibility During an Anaesthetic (Adopted February 2001)
<b>PS3</b>	(2003)	Guidelines for the Management of Major Regional Analgesia	<b>PS15</b>	(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)
<b>PS38</b>	(2004)	Statement Relating to the Relief of Pain and Suffering and End of Life Decisions	<b>PS18</b>	(2006)	Recommendations on Monitoring During Anaesthesia (Adopted February 2001)
<b>PS40</b>	(2005)	Guidelines for the Relationship Between Fellows and the Healthcare Industry	<b>PS20</b>	(2006)	Recommendations for Responsibilities of the Anaesthetist in the Post-Operative Period (Adopted February 2001)
<b>PS41</b>	(2007)	Guidelines on Acute Pain Management	<b>PS31</b>	(2003)	Recommendations on Checking Anaesthesia Delivery Systems (Adopted July 2003)
<b>PS45</b>	(2001)	Statement on Patients' Rights to Pain Management	<b>T1</b>	(2006)	Recommendations on Minimum Facilities for Safe Anaesthesia Practice in Operating Suites (Adopted May 2006)
<b>PS48</b>	(2003)	Statement on Clinical Principles for Procedural Sedation			
<b>PS49</b>	(2003)	Guidelines on the Health of Specialists and Trainees			

### ANZCA Professional Documents adopted by the Faculty:

<b>PS4</b>	(2006)	Recommendations for the Post-Anaesthesia Recovery Room (Adopted February 2001)
<b>PS7</b>	(2003)	Recommendations on the Pre-Anaesthesia Consultation (Adopted November 2003)
<b>PS8</b>	(2003)	Guidelines on the Assistant for the Anaesthetist (Adopted November 2003)
<b>PS9</b>	(2005)	Guidelines on Conscious Sedation for Diagnostic, Interventional Medical and Surgical Procedures (May 2002)
<b>PS10</b>	(2004)	The Handover of Responsibility During an Anaesthetic (Adopted February 2001)
<b>PS15</b>	(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)
<b>PS18</b>	(2006)	Recommendations on Monitoring During Anaesthesia (Adopted February 2001)
<b>PS20</b>	(2006)	Recommendations for Responsibilities of the Anaesthetist in the Post-Operative Period (Adopted February 2001)
<b>PS31</b>	(2003)	Recommendations on Checking Anaesthesia Delivery Systems (Adopted July 2003)
<b>T1</b>	(2006)	Recommendations on Minimum Facilities for Safe Anaesthesia Practice in Operating Suites (Adopted May 2006)

# 2007 ASM



The Faculty's 2007 Refresher Course Day, Annual Dinner and ASM Program in Melbourne were a great success. Thanks go to the Convenors, local organising committee, speakers and all who participated.









# Statement No.: WPI 14

Date of this document: March 2007

RANZCOG/ANZCA/RACGP/ACRRM

## POSITION STATEMENT ON THE PROVISION OF OBSTETRIC ANAESTHESIA AND ANALGESIA SERVICES

### PREAMBLE

- The RANZCOG, the ANZCA, the RACGP and the ACRRM regard the safety and wellbeing of mother and baby as paramount during pregnancy, labour and the puerperium.
- Every woman in Australia and New Zealand should have access to a safe and appropriate level of maternity services, which should include access to anaesthesia and analgesia and essential support services.

### STATEMENT

#### 1. Training and Credentialling

- 1.1 Obstetric anaesthesia and analgesia should only be administered by, or under the supervision of, medical practitioners with appropriate training, ongoing experience, and involvement in continuing professional development.

Refer to ANZCA Professional Document TE3 - Policy on Supervision of Clinical

Experience for Vocational Trainees in Anaesthesia:  
<http://www.anzca.edu.au/publications/profdocs/traineduc/index.htm>

Note: Joint ANZCA/ACRRM/RACGP Consultative Committee on Anaesthesia Advanced Rural Skills Curriculum Statement in Anaesthesia (Third Edition 2003)

Refer to ANZCA Professional Document PS2 - Statement on Credentialling in Anaesthesia:  
<http://www.anzca.edu.au/publications/profdocs/profstandards/index.htm>

#### 2. Minimum Facilities for the Provision of Obstetric Anaesthesia and Analgesia Services

2.1 Patients should be informed prospectively of the obstetric anaesthesia and analgesia services offered by an institution. Where such facilities are limited, patients should be informed and offered transfer antenatally to a centre with more comprehensive services.

Refer to Joint Consultative Committee on Obstetrics of the RANZCOG and RACGP

(JCCO) Policy Statement on shared antenatal care for low risk obstetric patients in Australia (2003)  
(RANZCOG Statement WPI:9)  
<http://www.ranzcog.edu.au/>

- 2.2 All healthcare facilities in which anaesthesia and analgesia services are provided for women in labour should have a system that offers such services on a 24 hour basis in a safe and timely manner. This includes the provision for continuity of care by appropriately trained medical practitioners for patients having epidural analgesia.

Refer to RANZCOG Statement C-Obs 14 Decision to delivery interval for Caesarean Section (2005) <http://www.ranzcog.edu.au>

- 2.3 Medical practitioners providing obstetric and anaesthesia care are responsible for developing and maintaining a professional relationship with each other in order that appropriate and timely anaesthesia and analgesia services can be provided. These services include antenatal assessment, analgesia, anaesthesia and assistance with management of high-risk patients with medical problems or requiring resuscitation. The relationship between those practitioners providing obstetric and anaesthesia care should include early referral of high-risk patients and a high level of communication.

- 2.4 Operating theatres and recovery rooms should comply with the minimum essential standards as set out by ANZCA.

Refer to ANZCA Professional Documents  
T1 - Recommendations on Minimum Facilities for Safe Anaesthesia Practice in Operating Suites and Other Anaesthetising Locations  
<http://www.anzca.edu.au/publications/profdocs/technical/index.htm> and  
PS4 - Recommendations for the Post Anaesthesia Recovery Room  
<http://www.anzca.edu.au/publications/profdocs/profstandards/index.htm>

- 2.5 Delivery Suites should comply with the specific recommendations as set out by ANZCA.

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Date of this document: March 2007 continued

Refer to ANZCA Professional Document  
T1 – Recommendations on Minimum Facilities for Safe  
Anaesthesia Practice in Operating Suites and Other  
Anaesthetising Locations

<http://www.anzca.edu.au/publications/profdocs/technical/index.htm>

- 2.6 Maternity units must have timely access<sup>1</sup> to:
- Neonatal paediatric specialist consultation
  - Operating theatres
  - Resuscitation services
  - Intensive care specialist consultation
  - Haematology and Blood Bank services including specialist haematological consultation
  - Policy Documents detailing methods of accessing emergency assistance
- Where external services or transfer from the healthcare facility would be required for any service, a policy must be in place. These policies must be published and distributed, ready for emergency use.
- 2.7 All hospitals should have a quality improvement program, including audit of the time to provide emergency operative delivery.
- 2.8 A trained assistant for the anaesthetist should be present for all anaesthesia procedures.

Refer to ANZCA Professional Document  
PS8 - Guidelines on the Assistant for the Anaesthetist  
<http://www.anzca.edu.au/publications/profdocs/profstandards/index.htm>

<sup>1</sup> Access here is taken to include methods of electronic and telephonic consultation available in rural contexts, and the level of Blood Bank services provided in rural centres.

### 3. Professional Standards

- 3.1 Hospital antenatal classes should involve input from the anaesthesia service on anaesthesia and analgesia provided at that hospital, to facilitate the provision of informed medical consent.

Refer to ANZCA Professional Document  
PS26 - Guidelines on Consent for Anaesthesia or Sedation  
<http://www.anzca.edu.au/publications/profdocs/profstandards/index.htm>

- 3.2 Maternity units, whose services include regional analgesia and anaesthesia services, should provide appropriate equipment and in-service training of midwifery and nursing staff in the management of regional analgesia and anaesthesia, and of patients in the recovery room.

Refer to RANZCOG Statement  
C-Obs 9 Standards for epidural/spinal anaesthesia in Obstetric Practice (2006)  
<http://www.ranzcog.edu.au/> and  
ANZCA Professional Document  
PS3 - Guidelines for the Management of Major Regional Analgesia  
<http://www.anzca.edu.au/publications/profdocs/profstandards/index.htm>

- 3.3 A medical practitioner must be designated to be responsible for the maintenance of clinical standards in the obstetric anaesthesia and analgesia service.
- 3.4 Hospitals should be adequately staffed and resourced to allow antenatal anaesthesia assessment of women likely to require or seek anaesthesia and analgesia services.
- 3.5 The primary role of the anaesthetist is with the care of the mother. Neonatal resuscitation services should be available from other sources.

### 4 After-hours Provision of Obstetric Anaesthesia/Analgesia Services

- 4.1 Hospitals undertaking obstetric care with anaesthesia and analgesia are responsible for the provision of 24 hour obstetric anaesthesia and analgesia services.
- 4.2 Hospitals must have clearly documented lines of communication to ensure the availability of obstetric anaesthesia and analgesia services if needed in an emergency situation, including alternative options if a particular medical practitioner is unavailable.
- 4.3 Medical, midwifery and nursing staff of maternity units must have regard for the level of emergency of delivery as set out in RANZCOG Statement C-Obs 14

Decision to delivery interval for Caesarean Section, ie:

Category 1 - Immediate threat to the life of a woman or fetus.

Category 2 - Maternal or fetal compromise but not immediately life threatening.

Category 3 - Needing early delivery but no maternal or fetal compromise.

Category 4 - At a time to suit the woman and the caesarean section team.

Refer to RANZCOG Statement  
C-Obs 14 Decision to delivery interval for  
Caesarean Section (2005)  
<http://www.ranzcog.edu.au/>

- 4.4 Maternity hospitals should be aware of the risk of fatigue and provide appropriate facilities to medical practitioners providing after hours obstetric anaesthesia and analgesia services.

Refer to AMA Position Statement: Workplace Facilities and  
Accommodation for Hospital Doctors  
<http://www.ama.com.au/web.nsf/doc/SHED-5G3E6L>

- 4.5 Medical practitioners should be aware of the effect of fatigue on individual performance and be prepared to modify their work practice accordingly.

Refer to AMA Position Statement: Workplace Facilities and  
Accommodation for Hospital Doctors  
<http://www.ama.com.au/web.nsf/doc/SHED-5G3E6L>

Refer also to ANZCA Professional Document  
PS43 - Statement on Fatigue and the Anaesthetist  
<http://www.anzca.edu.au/publications/profdocs/profstandards/PS43.htm>

#### References

- 1 Spencer MK, MacLennan AL How long does it take to deliver a baby by emergency caesarean section?  
*AustNZ J Obstet Gynaecol*; 41:7-11
- 2 Lessons from the Inquiry into Obstetrics and Gynaecological Services  
King Edward Memorial Hospital 1990-2000,  
Australian Council for Safety and Quality in Health Care, July 2002
- 3 AMA National Code of Practice:  
Hours of Work, Shiftwork and Rostering for Hospital Doctors
- 4 Joint ANZCA/ACRRM/RACGP Consultative Committee on  
Anaesthesia Advanced Rural Skills Curriculum Statement in  
Anaesthesia (Third Edition 2003)

## Appendix

### Definition of Anaesthesia

ANAESTHESIA means 'absence of all sensation'.

General Anaesthesia is a state of drug-induced nonresponsiveness characterised by absence of response to any stimulus, loss of protective airway reflexes, depression of respiration and disturbance of circulatory reflexes.

Regional Anaesthesia is a state of drug-induced nonresponsiveness to any stimulus in a region of the body which has minimal, or no effect on consciousness, respiration or circulation (minor nerve blocks), or may affect consciousness, respiration or circulation (major nerve blocks such as spinal or epidural or caudal).

### Definition of Analgesia

ANALGESIA means 'absence of pain perception'.

Absence of pain sensation, or reduction in pain perception, is commonly induced by drugs which may act locally (by interfering with nerve conduction) or generally (by depressing pain perception).

Obstetric Analgesia may be achieved by regional techniques such as epidural, or by central techniques such as Entonox or an Opioid. Both techniques allow analgesia to be titrated to the effect desired. Anaesthesia, when necessary, may be provided by spinal or epidural, or by general anaesthesia.

### Disclaimer

This College Statement is intended to provide general advice to Practitioners. The statement should never be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of each patient. The Statement has been prepared having regard to general circumstances. It is the responsibility of each Practitioner to have regard to the particular circumstances of each case, and the application of this Statement in each case. In particular, clinical management must always be responsive to the needs of the individual patient and the particular circumstances of each case. This College Statement has been prepared having regard to the information available at the time of its preparation, and each Practitioner must have regard to relevant information, research or material which may have been published or become available subsequently.

Whilst the Colleges endeavour to ensure that College Statements are accurate and current at the time of their preparation, it takes no responsibility for matters arising from changed circumstances or information or material that may have become available after the date of the Statements.

# 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

<b>TE1</b>	(2005)	Recommendations for Hospitals Seeking College Approval for Vocational Training in Anaesthesia	<b>PS16</b>	(2001)	Statement on the Standards of Practice of a Specialist Anaesthetist
<b>TE2</b>	(2006)	Policy on Vocational Training Modules and Module Supervision (interim review)	<b>PS18</b>	(2006)	Recommendations on Monitoring During Anaesthesia
<b>TE3</b>	(2006)	Policy on Supervision of Clinical Experience for Vocational Trainees in Anaesthesia	<b>PS19</b>	(2006)	Recommendations on Monitored Care by an Anaesthetist
<b>TE4</b>	(2003)	Policy on Duties of Regional Education Officers in Anaesthesia	<b>PS20</b>	(2006)	Recommendations for Responsibilities of the Anaesthetist in the Post-Operative Period
<b>TE5</b>	(2003)	Policy for Supervisors of Training in Anaesthesia	<b>PS21</b>	(2003)	Guidelines on Conscious Sedation for Dental Procedures
<b>TE6</b>	(2006)	Guidelines on the Duties of an Anaesthetist	<b>PS24</b>	(2004)	Guidelines on Sedation for Gastrointestinal Endoscopic Procedures
<b>TE7</b>	(2005)	Guidelines for Secretarial and Support Services to Departments of Anaesthesia	<b>PS26</b>	(2005)	Guidelines on Consent for Anaesthesia or Sedation
<b>TE8</b>	(2003)	Guidelines for the Learning Portfolio for Trainees in Anaesthesia	<b>PS27</b>	(2004)	Guidelines for Fellows who Practice Major Extracorporeal Perfusion
<b>TE9</b>	(2005)	Guidelines on Quality Assurance in Anaesthesia	<b>PS28</b>	(2005)	Guidelines on Infection Control in Anaesthesia
<b>TE10</b>	(2003)	Recommendations for Vocational Training Programs	<b>PS29</b>	(2002)	Statement on Anaesthesia Care of Children in Healthcare Facilities without Dedicated Paediatric Facilities
<b>TE11</b>	(2003)	Formal Project Guidelines	<b>PS31</b>	(2003)	Recommendations on Checking Anaesthesia Delivery Systems
<b>TE13</b>	(2003)	Guidelines for the Provisional Fellowship Program	<b>PS37</b>	(2004)	Regional Anaesthesia and Allied Health Practitioners
<b>TE14</b>	(2007)	Policy for the In-Training Assessment of Trainees in Anaesthesia	<b>PS38</b>	(2004)	Statement Relating to the Relief of Pain and Suffering and End of Life Decisions
<b>TE17</b>	(2003)	Policy on Advisors of Candidates for Anaesthesia Training	<b>PS39</b>	(2003)	Minimum Standards for Intrahospital Transport of Critically Ill Patients
<b>TE18</b>	(2005)	Guidelines for Assisting Trainees with Difficulties	<b>PS40</b>	(2005)	Guidelines for the Relationship Between Fellows and the Healthcare Industry
<b>EX1</b>	(2006)	Policy on Examination Candidates Suffering from Illness, Accident or Disability	<b>PS41</b>	(2000)	Guidelines on Acute Pain Management
<b>T1</b>	(2006)	Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations	<b>PS42</b>	(2006)	Recommendations for Staffing of Departments of Anaesthesia
<b>T3</b>	(2006)	Minimum Safety Requirements for Anaesthetic Machines for Clinical Practice	<b>PS43</b>	(2007)	Statement on Fatigue and the Anaesthetist
<b>PS1</b>	(2002)	Recommendations on Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia	<b>PS44</b>	(2006)	Guidelines to Fellows Acting on Appointments Committees for Senior Staff in Anaesthesia
<b>PS2</b>	(2006)	Statement on Credentialling in Anaesthesia	<b>PS45</b>	(2001)	Statement on Patients' Rights to Pain Management
<b>PS3</b>	(2003)	Guidelines for the Management of Major Regional Analgesia	<b>PS46</b>	(2004)	Recommendations for Training and Practice of Diagnostic Perioperative Transoesophageal Echocardiography in Adults
<b>PS4</b>	(2006)	Recommendations for the Post-Anaesthesia Recovery Room	<b>PS47</b>	(2002)	Guidelines for Hospitals Seeking College Approval of Posts for Vocational Training in Diving and Hyperbaric Medicine
<b>PS6</b>	(2006)	The Anaesthesia Record. Recommendations on the Recording of an Episode of Anaesthesia Care	<b>PS48</b>	(2003)	Statement on Clinical Principles for Procedural Sedation
<b>PS7</b>	(2003)	Recommendations on the Pre-Anaesthesia Consultation	<b>PS49</b>	(2003)	Guidelines on the Health of Specialists and Trainees
<b>PS8</b>	(2003)	Guidelines on the Assistant for the Anaesthetist	<b>PS50</b>	(2004)	Recommendations on Practice Re-entry for a Specialist Anaesthetist
<b>PS9</b>	(2005)	Guidelines on Conscious Sedation for Diagnostic, Interventional Medical and Surgical Procedures			
<b>PS10</b>	(2004)	Handover of Responsibility During an Anaesthetic			
<b>PS12</b>	(2001)	Statement on Smoking as Related to the Perioperative Period			
<b>PS15</b>	(2006)	Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery			



# Review TE14

(2007)

## POLICY FOR THE IN-TRAINING ASSESSMENT OF TRAINEES IN ANAESTHESIA

### 1. INTRODUCTION

In-training assessment (ITA) of Trainees in Anaesthesia is an essential part of the Trainees' education. It complements other methods of evaluation, such as the College's examinations. ITA is a joint process of evaluation and goal setting by the Trainee and the Supervisor of Training (SOT), and requires active participation by the Trainee. It is essential that the assessment is conducted in accordance with sound educational principles, and that the principles of natural justice are observed.

The College's ITA follows a formative process only. Formative assessment is personal and aims to be supportive of the Trainee.

### 2. OBJECTIVES

The objectives of ITA are to:

- 2.1 Assess and assist with the Trainee's progress towards appropriate goals.
- 2.2 Provide regular feedback to Trainees.
- 2.3 Develop any remedial activities for the Trainee that may be required.

However, the failure to fully achieve the objectives will not invalidate the process.

### 3. PROCESS

- 3.1 It is the responsibility of each Trainee to maintain his or her Learning Portfolio throughout training. It should include originals or copies of formal documents related to training as well as voluntary documentation such as a log-book. It MUST contain the original signed copy of the ITA – 2 form from each final assessment with a SOT, and SHOULD contain all self evaluation of performance forms.
- 3.2 Formal assessment meetings must occur between the SOT and each Trainee at the beginning (the initial interview) and end (the final interview) of each six month period (or sooner if the term is less than six months). Trainees can initiate these meetings. Additional meetings between the Trainee and SOT should occur as appropriate. There should also be regular group meetings between the SOT and the Trainees together with the Head of Department if appropriate.
- 3.2.1 Any Trainee experiencing difficulty should bring this to the attention of the SOT as early as possible.
- 3.2.2 The initial interview between the SOT and the Trainee will review the Trainee's previous performance, and set appropriate goals for the next training term. This will involve review of the Trainee's Learning Portfolio, and self evaluation, which is to be completed using an ITA – 1 form. The SOT will contact other SOTs if necessary to assist with this process.
- 3.2.3 At the final assessment interview, the SOT and Trainee will review and discuss the trainee's performance during the completed attachment.
- 3.3 The formal assessment of the Trainee's performance over the previous attachment should be based upon:
  - 3.3.1 An assessment by the three senior staff who are best placed to provide that assessment. Each must complete an ITA – 1 form, and/or:
  - 3.3.2 An assessment by a consensus meeting of the senior staff of the Department in writing using an ITA – 1 form.
  - 3.3.3 The SOT should use this information to complete the ITA – 2 form. Prior to the final interview, the Trainee should be asked to complete an ITA – 1 form as self evaluation. This information will be used to discuss the past term and to establish goals for the next one. The ITA-2 form must be signed by the Trainee and the SOT, after the Trainee has had an opportunity to add comments.

(The signature is to confirm receipt of the ITA, it does not necessarily indicate acceptance of all its contents).

If the Trainee is continuing at the same institution for the following six months, then the final interview should be joined with the initial interview for the next term.
- 3.4 The signed original copy of the ITA – 2 form will be retained by the Trainee, along with any self evaluation forms the Trainee completed, and inserted into the Trainee's Learning Portfolio. A copy of the signed ITA – 2 form should be submitted to the Regional Education Officer (REO) by the SOT within two weeks of the assessment.

The REO will review these forms to ensure completeness of the documentation before forwarding them to the College where they will form part of the Trainee's central record.
- 3.5 The following points may assist senior staff and SOTs in situations where the Trainee's performance is not at the level indicative of a satisfactory assessment.

# TE14 (continued)

(2007)

- 3.5.1 If there is a performance less than that "consistent with level of experience" in any of the skills/attitudes/abilities listed on the ITA-2 (indicative of a consensus view of the senior staff involved), then this matter must be discussed with the Trainee with a view to establishing remedial strategies. An isolated "unsatisfactory" attribute does not necessarily constitute an unsatisfactory assessment.
- 3.5.2 A consistent unsatisfactory attribute over more than one assessment or multiple unsatisfactory attributes on the one occasion must be discussed with the Trainee and remedial strategies drawn up. The Trainee should be told in writing that his/her future performance will be specially monitored, and planning for the next term should take that requirement into account. It may be advisable to consult with the hospital's human resources department at this time.
- 3.5.3 Continued performance during serial assessments which is less than "consistent with level of experience" may be indicative of a situation which should be discussed with the Head of Department, with the REO, and reported to the Chief Executive Officer of the College.
- 3.5.4 Advice as to remedial strategies can be obtained through the REOs and from the Education Unit at the College.

## 4. UNSATISFACTORY ITA PERFORMANCE

- 4.1 When a Trainee consistently performs at a level which is considered to be below that to be acceptable for a developing specialist anaesthetist, notwithstanding repeated documented attempts at remediation, then the provisions outlined in College Professional Document TE18 Guidelines for Assisting Trainees with Difficulties section 7 should be considered. This will require that processes outside In-Training Assessment are invoked. Any serious errors or incidents affecting patient safety may also trigger a review of the Trainee and his/her performance.
- 4.2 If a satisfactory resolution cannot be achieved using the provisions of College Professional Document TE18 Guidelines for Assisting Trainees with Difficulties, further assistance can be obtained using the Trainee Performance Review.
- 4.3 Advice on both these processes can be obtained through the REOs and the College's Chief Executive Officer.

## 5. PRIVACY

Information collected in relation to Trainees will be held, used and distributed as provided in the College's Privacy Statement and as permitted by law. Ordinarily each ITA will only be considered by the College,

and used for the purposes of the Training Program. It will not ordinarily be provided to the hospital/employer – unless the College believes it is appropriate to do so in the interests of patient safety, An ITA is not intended to be used for employment purposes, and is intended solely for use in the training program in accordance with the above objectives. ITAs may be shared with SOTs in subsequent rotations, especially to assist in the supervision, remediation and assessment of progress of Trainees.

## COLLEGE PROFESSIONAL DOCUMENTS

College Professional Documents are progressively being coded as follows:

<b>TE</b>	Training and Educational
<b>EX</b>	Examinations
<b>PS</b>	Professional Standards
<b>T</b>	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 is intended to apply wherever anaesthesia is administered.*

*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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