- CPD – A thumbnail dipped in tar
- Hazards of Anaesthesia for Laproscopic Castric Banding
- Midazolam Anaphylaxis
- Nitrous oxide

# THE ANZCA BULLETIN

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

OCTOBER: 2007

JOINT FACULTY OF INTENSIVE CARE MEDICINE
FACULTY OF PAIN MEDICINE

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

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# President's message

## 2007: What does the year hold in store?

DR WALTER THOMPSON

**The College and the Council have continued to make progress on a number of fronts and there have been some new initiatives.**

### Australian Medical Council (AMC)

Following the submission of the College's Annual Report to the AMC in 2007 and consideration of all the College's responses to requests from the AMC since the 2002 AMC Accreditation Report; the Council of the AMC made note of 'the many initiatives in relation to training and assessment, accreditation of training posts and continuing professional development, in anaesthesia, intensive care medicine and pain medicine'. The AMC therefore decided to extend the College's accreditation by the maximum possible period of four years, which is until 31 December 2012, subject to satisfactory annual reports from the College.

### Continuing Professional Development (CPD) Program

The Council accepted the revised version of the new CPD Program in June and the program will commence in January 2008. Details of the program are contained in the printed insert in this issue of the Bulletin. It has been widely expected that active participation in CPD would become a pre-condition for registration following the introduction of National Registration in Mid 2008.

The issue of National Registration has not made much progress in recent months and there are suggestions that the introduction may be delayed to 2009.

Recently Council has decided that participation in a formal CPD Program will be mandated for all active ANZCA Fellows in 2009. The new ANZCA CPD Program allows Fellows to design their own CPD requirements from a range of sources in order to fulfill their professional obligations.

### Code of Professional Conduct

The proposed Code arose out of the Taskforce on Professionalism and has undergone a number of revisions under the direction of Professor Alan Merry, Professor Garry Phillips and members of the Council. The Code was accepted at the August Council meeting and is now available on the College website. The Code is a 'living document' and it is intended that it will be reviewed periodically. In fact, the first revision will occur after the publication of both the Code of Conduct that the AMC is proposing to developed and the forthcoming revision by the New Zealand Medical Council of its Code of Conduct.

### Policy on Intellectual Property

The College has developed a policy on Intellectual Property with the assistance of Mr Michael Gorton. The policy was accepted at the August Council Meeting and can be found on the College website.

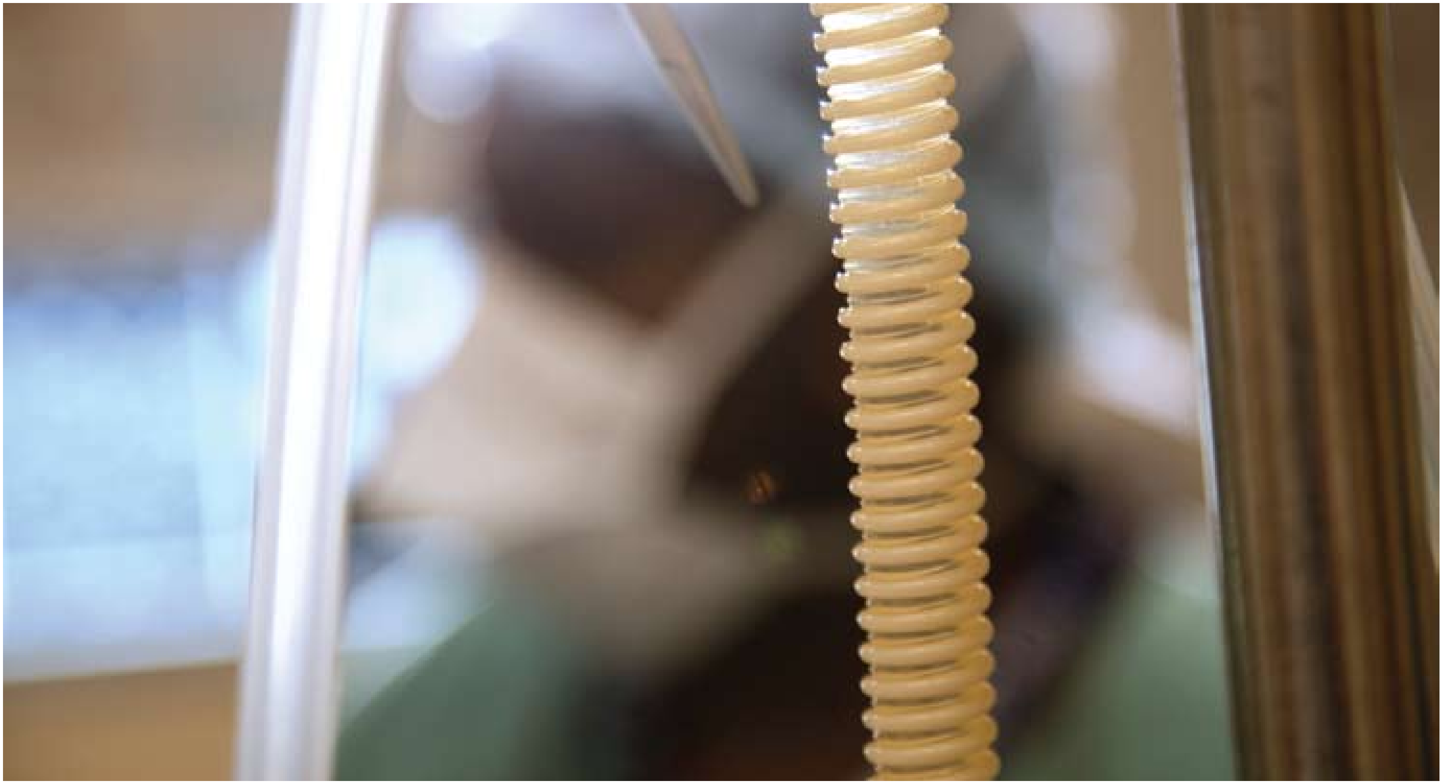
**'The review of the constitution is progressing and it is anticipated that there will be a postal ballot for the adoption of the new constitution before the end of the year.'**

### Review of the FANZCA Program

The current FANZCA Program was introduced at the start of the 2004 Training Year and it was planned that it would be reviewed after 5 years. The FANZCA Review will commence in September 2007 with the primary focus being curriculum review and the blueprinting of assessments plus teaching and learning methods against the curriculum. It is anticipated that recommendations will be made by July 2008 and then considered by Council with a view to implementation of changes at the start of January 2009. The Review will be led by Dr Lindy Roberts, who is the Chair of the Education and Training Committee.

### Review of the Constitution

The review of the constitution is progressing and it is anticipated that there will be a postal ballot for the adoption of the new constitution before the end of the year.



**Australian Anaesthesia Workforce Study**

The determination of status of the anaesthesia workforce and the prediction of workforce requirements has remained a vexed issue for a number of years despite the activities of a number government bodies (AMWAC, AHWAC and MTRP plus the recently established HWPC!) over a long period of time. The Commonwealth and State governments do not have accurate data and their predictions in the past have been wrong. The Australian Society of Anaesthetists (ASA) and the College have done regular surveys, which have generated some interesting data, but the response rates have been extremely poor. The College and the ASA now consider that it is important that the profession has credible workforce data in order to plan for the future and to effectively engage with the jurisdictions. To that end they have decided to jointly commission Access Economics to undertake a Workforce Study. Survey forms will be distributed in October and November. It is vitally important that we get accurate data and I would urge all Fellows to fill in the survey forms as soon as they receive them so that they are not lost in the lead up to the December festivities.

**ANZCA Final Examination**

In order to accommodate the increased number of candidates and to overcome the current logistic problems that are associated with staging the medical-clinical components in Melbourne and Sydney, the format of the final examination will change as of the first examination in May 2008. The decision has been made to separate the medical-clinical examinations from the anaesthesia vivas and to hold them at the time of the written examinations. The two medical-clinical examinations will be conducted the day after the written component of the examination. The written section will be held on a Friday and the medical clinical section on a Saturday. The written and medical-clinical sections will initially be held in the Brisbane, Sydney, Melbourne, Adelaide, Perth, Auckland and Hong Kong. Once the arrangements are stabilised and working satisfactorily, consideration will be given to expansion to other sites. Trainees, Supervisors of Training and Regional Education Officers have been notified of these changes.

Other matters that I wish to comment on are:

**Expanded Settings for Specialist Training Program (ESSTP)**

Following agreement from COAG on the principles endorsed by Medical Training Review Panel, the Commonwealth—through the Department of Health and Aging (DoHA)—has commenced ESSTP. There is limited funding for a period of four years in order to undertake 'pilot programs' in an attempt to adapt the system of medical specialist training to meet the anticipated influx of trainees in the next 4-5 years as the number of medical graduates rise. The aim is to provide specialist training in expanded settings, which in the context of anaesthesia largely means 'private hospitals'. The training in extended settings is to be initially based on proposals that meet 'educational imperatives' and do not detract from training in teaching hospitals nor the funding of teaching hospitals. It is also stipulated that training departments that wish to be part of ESSTP have to meet the accreditation requirements of the relevant College. In addition, the rights and expectations of trainees and patients are to be maintained and protected. The program is due to be refined based on the outcomes of the 'pilots' that came forth in 2007 and the funding mechanisms reworked as the total costs of ESSTP are calculated in an attempt to produce a viable program in the future. The progress of ESSTP to date has been rather confusing and frustrating due to the fact that DoHA has not had a 'preferred plan' and was waiting to see what arose out of the initial proposals. In addition, DoHA does not have a defined process and yet is attempting at different stages to involve 4 agencies viz; the hospital in question, the State jurisdiction, the Commonwealth jurisdiction and the College. Hence, to date

# President's message continued

'ANZCA is supportive of training in Expanded Environments and we have in the past accredited anaesthesia departments in private hospitals for training.'

many of the initial 'proposals' have been inadequately developed and have not met the requirements of DoHA or the College for introduction in 2008. However, with further clarification, they may meet the requirements for 2009. Added to that is the fact that the state and commonwealth jurisdictions are often at variance in relation to what they will support and/or finance. The issues have been further compounded by the suggestion that there should be 4-way contracts between the participating agencies mentioned above!

ANZCA is supportive of training in Expanded Environments and we have in the past accredited anaesthesia departments in private hospitals for training. As regards ESSTP, we have said that we are supportive but would require that:

> There was a defined educational imperative;
> The department was fully committed to training;
> The department met the ANZCA accreditation requirements (which are the same for all training hospitals);
> The 'extra positions' do not lead to 'bottlenecks' in the training program;
> The department is part of a rotational training program;
> The rights and expectations of the trainees and patients were protected; and
> There was support from relevant jurisdictions, the department in question and the relevant regional committee.

We have also pointed out that ANZCA accredits departments and not positions and we would not want to become involved with the ACCC through participation in ESSTP. In addition, ANZCA currently sees no need to be involved with the proposed 4-way contracts involving the four participating agencies (mentioned earlier), nor does the College have a desire to be the fund-holder for the positions.

Departments wishing to provide specialist training as part of ESSTP should ensure that:

> They are aware of the conditions imposed by DoHA;
> They are aware of the requirements of the College;
> They have the support of the private hospital, the departmental staff and the relevant State jurisdictional body; and
> They have the support of the ANZCA Regional Committee before submitting their proposal to DoHA and subsequently applying to the College for accreditation.

**National Registration and Accreditation**

This has been an ongoing saga for most of 2007. Fellows will recall prior to the COAG Meeting in April the medical profession and 7 out of the 8 other health professional groups had supported the Commonwealth's preferred model. That model included 9 separate Profession Specific Boards (PSBs), the continuation of the role of AMC and related bodies and no agencies or advisory councils interspersed between the PSBs and the health ministers. The model was accepted in principal by COAG and was to be further developed by the Department of Prime Minister and Cabinet and encapsulated in an Intergovernmental Agreement (IGA) before going back to DoHA for implementation.

There is ongoing uncertainty as to the status of the IGA and to date it has not been released to the professions. This uncertainty after so many months has led to speculation that the Commonwealth's preferred model is now being opposed by the States, who are once again said to favour a single national registration body, as originally proposed by the Productivity Commission.

There are suggestions that the 'current' version of the IGA contains a model in which:

> There would be profession-specific (registration) boards but they would not be independent of government or the bureaucracy and would not report directly to health ministers.
> There would be a single Ministerial Council that would sit above the PSBs. This Council would be appointed by and report to first ministers and would be able to get independent advice, including advice independent of PSBs.
> There would be a single Advisory Council which would not have Health Professionals on it. It would provide 'independent advice' to Health Ministers on Workforce, Accreditation & Training. It would resolve

NEW SOUTH WALES REGIONAL COMMITTEE
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

# PART II REFRESHER COURSE IN ANAESTHESIA

The course is a full-time revision course, run on a lecture/tutorial basis and is open to candidates presenting for their Fellowship (Part II) Examination in 2008

**Date:** Monday 11 February – Friday 22 February 2008
**Venue:** Large Conference Room, Kerry Packer Education Centre
Royal Prince Alfred Hospital
Missenden Road
Camperdown NSW 2050

**Fee:** A$660 (incl gst)

**For information contact: Suyin Conabere**
ANZCA New South Wales Regional Committee
117 Alexander Street, Crows Nest NSW 2065
Telephone: 02 9966 9085
Fax: 02 9966 9087
Email: nswcourses@anzca.edu.au

issues that the Ministerial Council could not resolve. It would advise the Ministerial Council and could independently investigate issues and advise the Ministerial Council.

- There would be a National Agency and its Committees, which would be the 'business arm' of national registration and would control the staff and assets and would be chaired by someone who was not in the professional groups. The Agency would also set the requirements for Registration, Accreditation and National Practice Standards.
- The AMC would continue in its current form for three years, but funding was only being provided on an annual basis. There was no commitment to AMC after the three years and no statement guaranteeing its independence.

If the suggestions are correct, then the model is vastly different from that previously supported by the medical profession. Discussions are ongoing in an attempt to re-align the models. The profession remains of the view that:

- There should be 9 independent and separate PSBs and that there should not be any bodies/councils between the PSB's and the health ministers;
- There is no requirement for the Ministerial Council or the Advisory Council and in fact the bureaucracy needs to be minimised rather than increased;
- The Colleges should set the standards for Training, Quality and Safety; and
- The AMC's current accreditation function in relation to the accreditation of medical education and training should be retained (in a reconstituted form if necessary) and the AMC should have certainty of tenure.

That viewpoint has been forcefully put, but at this stage we are yet to see the 'final' model. As this saga continues to unfold, the profession will have to present a united and cohesive position if we are to maintain standards and serve our patients.

In concluding, I wish to note a few staff changes:

- Professor Russell Jones has resigned from his position as Director of Education in order to take up a similar position with the Royal Australian College of General Practitioners. In his six and a half years at the College Russell has made a wide range of important contributions in the areas of education, training, examinations and support for both trainees and Fellows. We thank Russell for his contributions and wish him every success in his new position.
- Elizabeth Triarico has resigned as Museum Manager. Elizabeth had completed the inventory of the collection and had overseen the establishment of policies and procedures for the museum. We thank Elizabeth for her contributions to the museum and wish her success in her new position.
- John Biviano has joined the College as the Director of Policy and comes to the College with extensive experience in policy development and planning. His role will be to improve the policy capability of the College and to develop and enhance relationships with the Commonwealth and jurisdictions. We welcome John and look forward to his contributions.

DR WALLY THOMPSON
President

# CPD

## A thumbnail dipped in tar

PROF GARRY PHILLIPS

**I was the first MOPS Officer of ANZCA, and got my points in the early years, but when I retired from clinical work in 2001, I was no longer eligible to participate. However, the new CPD Program caters for non-clinicians, including people in administration, research, teaching, overseas aid, as well as clinicians. It can also be used by Fellows who are just plain retired—rocking chair, clay pipe, dozing in the sun—I wish!**

So I read the proposed Program on the web (yes, I access the web), and got to see the final version published in this Bulletin. I hesitated, but decided that these guys and girls had put a lot of work into this, so it was worth a try, even though it was still voluntary. Everyone I have spoken to can see the writing on the wall, or on the paper in the case of the Productivity Commission, the COAG resolutions, Bundaberg, the Queensland Inquiry etc. But apart from all that, it is actually an excellent way of formalising and documenting 'CME' and 'QA', to keep up-to-date, and to be seen to be providing safe quality care to patients. It will be mandated by regulatory authorities shortly.

After reading and re-reading the CPD Program, I realised that while there were similarities with MOPS, more thought (reflection) and planning were required (as with any worthwhile venture). Clearly, of the four categories and two subdivisions of each—with minimum points to be achieved in three of the four—whatever else I did, I had to have a fallback position. I was used to this both in Medicine (my wife is a GP who always exceeds her CPD requirements, and enjoys doing it, even if I do keep the master diary in our house); and in life (yes, I am one of those people who keeps their tax paperwork in a shoebox). I have always been meticulous in my work (within fatigue limits), as in servicing my car and the cars of my children (when I can resist it no longer). So the bottom line for me was a mixture of Category 1, Level 2, Category 2, Level 2, and Category 3, Level 2. Traditional Level 1 activities in Categories 1, 2 and 3 and all Category 4 would be bonus. This I knew would satisfy the South Australian Medical Board.

So I sat down to make a plan (for which I see I get credits), which turned out like this—basing the plan on my last year of clinical anaesthesia practice, to see how that worked.

**Category 1 (Group Learning Activities)**
**Level 2 (Interactive Activities)**
**Minimum 10 Credits or 5 hours per year**

The most attractive to me were small group discussions on any of the topics listed on page 3 of the document (the CanMEDS Attributes of a Specialist). I chose two 1 hour case discussions per year—one with the surgeon and theatre boss about a difficult situation in theatre, and one with the obstetrician and labour ward boss about a perceived obstetric problem thought to be associated with an epidural. To this I added a 1 hour meeting with the CEO about the implications for patient care of the latest budget cuts. Next was a 1 hour hands-on familiarisation session with a new Registrar and OTS who had just arrived; and finally, a 1 hour session to discuss with all and sundry (it seemed) as to how the Acute Pain Service could be improved, following an episode of apparent failure of an epidural postoperatively, and removal of the catheter by 'the team' while I was having a much needed sleep.

**OK – Done. Total 5 hours, 10 Credits.**

> 'So I thought some more, and a line came to me out of my school rote learning some 50 years ago: "And I think the same was written with a thumb nail dipped in tar"[1].'

Next year, I plan a one day workshop put on by my MDO on a less stressful topic than the above, even though I enjoyed most of the discussions.

**Category 2 (Self Learning Activities)**
**Level 2 (Interactive Activities)**
**Minimum 10 Credits or 5 hours per year**

I was flagging at this stage, having had several interruptions, getting older and more tired, remembering that I had just paid my medical defence, that my mother was not happy in 'the home', and that my wife's cat had just died. But my wife said in her meaningful way: 'You can do it', and the dog wagged his tail.

# Continuing Professional Development Program

The proposed Continuing Professional Development (CPD) Program has recently been approved by ANZCA Council and will be implemented in January 2008, replacing the current MOPS Program.

All practising Fellows will automatically be enrolled in the program.

A copy of the approved program is enclosed as an insert in this edition of the Bulletin. We ask you to keep this document as a reference.

Please refer any questions regarding the CPD Program to the Continuing Professional Development Department of ANZCA at cme@anzca.edu.au

So I thought some more, and a line came to me out of my school rote learning some 50 years ago: 'And I think the same was written with a thumbnail dipped in tar'[1].

I was already getting a good hour from preparing my CPD plan, so I needed four more for the year. And then I remembered seeing somewhere that the Canadians used a method which, in summary, meant that when, in the course of daily work, you came across something you wished you knew more about (related to any of the CanMEDS attributes), you made a note that same day.

I decided to start with clinical things. The first one was intractable postoperative vomiting, the second was spinal tap, and the third was failed intubation. The note could be made with anything, on anything. I had my arm, my gown, or a blank chart—even though I had no tar and had to borrow the nurse's pen (I was always on the lookout for spare pens). Before leaving work, I made a brief entry in my diary.

That night, I ran through my trusty textbook, remembered an article which I found, and scanned PubMed on the internet (my family accepted this absence, which was better than having me grumpy). I only found a couple of things I didn't know, so next day got an opinion from a colleague as we changed for the next lists. Not satisfied, I put it on the agenda for our next meeting, and got more views and more pointers to 'people who would know', relevant papers or meetings. After a series of notes in my diary, I came back to my colleague many weeks later and told him of my plan for 'next time', on which he commented—another diary note.

There, each topic would take a total of at least an hour, and have passed through the cycle of noting a relevant issue, thinking about it (reflection), researching and discussing it, and formulating a plan for next time. Total time barely noticeable because I enjoyed doing it in 5 minute bits. Once I got into the cycle (the template), it became like driving the car.

**OK – Done. Total 5 hours, 10 Credits**

**Category 3 (Practice Assessment Activities)**

**Level 2 (Self directed Activities)**

**Minimum 10 Credits or about 3-4 hours per year**

This had similarities to Category 1 and Category 2, so some ingenuity was required. Reflection notes of own experiences and Peer Review, an hour of each, could be linked to my Category 2 activities—an extra case would do it in my view (and it was up to me to make and justify that decision anyway). Clinical audit of my practice could be set up from my Category 2 activities, say two audits of aspects from my practice running concurrently, each taking at least three hours per year.

**? Done – but needs more thinking (reflecting) about**

Throw in **Category 4** and **Level 1** activities in **Categories 1 to 3** and I'm home and hosed.

With the template in place, next year will be easier—especially as I have planned to do an EMAC course, to find out what that's about.

**What about the Toolkits?**

With the template drafted, the Toolkits could be searched for the bits relevant to my plan.

- Practice Assessment Activities (Category 3) – An excellent overview of a daunting topic.
- Reflection – Resurrection of an old concept (Hippocrates did it all the time). Anaesthetists and Intensivists and Pain Specialists do it every day. The definition says it all 'Consciously thinking about and analysing what one has done'.
- Develop Your Individual CPD Plan – I did it my way.
- Conduct an Evaluation of Your CPD – with a template, a portfolio and a shoebox – easy.
- Preparing for CPD Audit – following the steps, again no problem. It won't happen often. I even thought I might write in and ask to be audited, just to show off.
- CPD Portfolio – Diary and Shoebox. As in Disaster Response Planning, elaborate on what works for you. Don't invent a new model which just won't work.

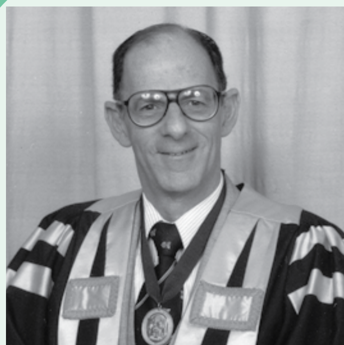
Back to Clancy, who saw 'the vision splendid of the sunlit plains extended, and at night the wondrous glory of the everlasting stars'[1]; a voice came from the kitchen: 'Don't forget to take your pills'.

GARRY PHILLIPS
FANZCA FJFICM

**1** Paterson AB. Clancy of the Overflow in *The Collected Verse of AB Paterson*. Angus and Robertson Sydney 1921.

# Series on past Deans and Presidents

## Douglas Joseph
AO, MB, BS (Sydney), DA(London), FFARACS, FFARCS



**This monograph is a synthesis of the obituary written by Gwen Wilson[1] for Doug Joseph and readers interested in a fuller review are directed to her excellent and extensive account. Douglas Joseph was the fourteenth Dean of the Faculty of Anaesthetists Royal Australasian College of Surgeons. He followed Dr Maurice Sando as Dean and was to be followed by Dr William Crosby.**

**Doug Joseph held the post of Dean of the Faculty of Anaesthetists, Royal Australasian College of Surgeons for two years during 1980-82. Other positions held within the Faculty by Doug were as a member of the New South Wales Regional Committee of the Faculty from 1958 until 1984, holding the position of Committee Chair in 1971 and 1972. He was subsequently elected to the Board of the Faculty and served his full tenure of twelve years from 1972-1984.**

Doug Joseph was born on 21 January 1925 and died at the age of 65 on 6 March 1990. He was born the youngest of four boys, all of whom pursued careers in medicine. His schooling was undertaken at Sydney Grammar. He completed his undergraduate medical degree at the University of Sydney graduating in 1947.

His internship was performed at the Royal North Shore Hospital in Sydney. It was as an intern on his anaesthetic rotation that he introduced himself to Gwen Wilson, who was herself a newly appointed anaesthetist, and commenced a firm friendship that lasted until his death. She remembers that Doug's inspiration to enter anaesthesia was Jim McCulloch, himself a former Dean of the Faculty.

In 1950, Doug Joseph was appointed to the Royal North Shore Hospital, Sydney, as an anaesthetic registrar; in fact this was the first appointment of an anaesthetic registrar to that hospital. After two years there as an anaesthetic registrar, and at the strong suggestion of Jim McCulloch, he travelled overseas to the UK. He spent 1952 in Newcastle-upon-Tyne as an anaesthetic registrar at the Royal Victoria Infirmary. It was whilst there that he obtained the Diploma of Anaesthesia, Royal College of Physicians and Surgeons.

Thereafter he moved to Scotland, where he spent 1953 and 1954 as senior anaesthetic registrar at the Edinburgh Royal Infirmary. Whilst there, he was recruited to return to Australia as the first Director of Anaesthesia at Sydney Hospital. He commenced there as Director in 1956, and it was in his first year that he inaugurated a modern recovery and resuscitation ward that served as the precursor to modern intensive care units. He is also credited with two other significant initiatives. The first was to offer regular training opportunities of several weeks to rural GP anaesthetists. The second was to arrange for the Australian Society of Anaesthetists' overseas visitor to administer anaesthetics and demonstrate techniques in the operating theatres of Sydney Hospital. The first such visitor was Professor Lucien Morris from Seattle USA. A subsequent visitor was Professor Cecil Gray from Liverpool UK. This latter visit culminated in Doug being lured to return to Liverpool with Cecil Gray where he took on the role of the Christiana Hartley Research Fellowship, University of Liverpool.

> '...it was in his first year that he inaugurated a modern recovery and resuscitation ward that served as the precursor to modern intensive care units.'

In 1962, whilst working in Liverpool, Doug successfully applied for the advertised position of the inaugural Chair of Anaesthetics at the University of Sydney, and commenced in the post in 1963. The Department was, at that time, housed in the unused tuberculosis wards of Royal Prince Alfred Hospital. He held this post as Professor and as honorary anaesthetist until 1971, when he became Professor and Head of Department.

From 1968 for 16 years he was a member of the Executive Committee of the World Federation of Societies of Anaesthetists, and Chaired the organising Committee of the 3rd Asian Australasian Congress held in Canberra in 1970. It is relevant and instructive to note that he was only given this role in 1968, so had a very brief time to arrange such an international meeting.

The Faculty of Anaesthetists RACS honoured him with the Robert Orton Medal, the highest award granted by the Faculty. The Australian Society of Anaesthetists honored him with the Gilbert Brown Award, the highest award of that Society. And our nation has honoured him with the Order of Australia for his services to medicine, particularly in the specialty of anaesthesia.

DR GWEN WILSON

**Reference:**
**1** Wilson,G. Obituary: A man of history. Douglas Joseph. *Anaesth Intensive Care* (1990), 18, 413-419.

# Changes to the Final Fellowship Examination From 2008

**In 1993, the Final Fellowship Examination changed to its current format in which the vivas are held over three days with the Anaesthesia vivas held on Friday and Sunday and the medical clinicals on Saturday. This format has become increasingly difficult to sustain because of:**

1 The increased number of candidates which has doubled since the format was introduced;
2 The reduction in size of hospital outpatient departments where progressively clinical spaces have been taken over for offices;
3 The need to synchronise the examination with hospital low activity days so that we have access to outpatient departments on Fridays for the anaesthesia vivas.

There has also been considerable discussion within the Final Examination Committee over the format of the medical clinical. The viva section of the examination consists of nine anaesthesia vivas, two medical clinical vivas and one investigation viva, all being of 15 minutes duration.

The Final Examination Committee considered a number of options and decided that it would be best to separate the medical clinicals from the anaesthesia vivas and hold them at a separate time. This would allow them to be conducted in major centres rather than dealing with the large number of candidates in either Melbourne or Sydney. The two medical clinical examinations will be conducted on the day after the written component of the examination. The written section will be held on a Friday and the medical clinical section on a Saturday when hospital outpatients departments are easily available. It will not be possible to hold the medical clinicals at all of the sites where the written examination has been held in the past. Candidates from smaller centres will therefore need to travel to another city to complete the written and medical clinical sections.

The new format will therefore consist of the written section (150 MCQs plus 15 SAQs), two medical clinical vivas each of 18 minutes and eight anaesthesia vivas each of 15 minutes duration. The total time of the viva examination remains effectively the same. There will be no specific investigation viva, but investigations will be included where relevant in both the medical clincials and the anaesthesia vivas.

The pass/fail criteria require candidates to pass the anaesthesia viva section and one other section of the examination. There may be some candidates who, after the written and medical clinical sections, have no chance of passing the examination, no matter how well they perform in the anaesthesia vivas. It would be unreasonable to have these candidates incur the stress and costs of attending the vivas with no prospect of passing the examination.

It will therefore be necessary to process the written papers in sufficient time and notify these candidates that they have been unsuccessful and are not required to attend the anaesthesia vivas. We will need to allow approximately eight weeks between the writtens and the anaesthesia vivas to allow time for marking the SAQs and providing notification to candidates not required to attend the anaesthesia vivas.

This separation of the medical clinical from the anaesthesia vivas has a number of advantages in that it will:

1 Free the medical clinical from the 15 minute time limit;
2 Improve the quality of patients, as each examination site/hospital will only have to provide for a small number of candidates;
3 Allow the vivas to be conducted on two days only on the weekend chosen by the College, instead of having to fit in with hospital low activity days.

A potential problem of distributing the examination to a number of centres is that sites may diverge in the way that the examination is conducted and a number of measures need to be put in place to ensure consistency in the examination. It will only be possible to hold the medical clinicals where:

1 There are sufficient candidates;
2 There are sufficient suitable patients;
3 A current or recent past examiner or other suitable person approved by the Chairman of Examinations is willing to supervise the selection of patients and preparation of the examination venue.

In 2008 the written and medical clinical sections will be held only in Adelaide, Brisbane, Melbourne, Perth, Sydney, Auckland and Hong Kong.

Unfortunately, this will impose an additional cost to the candidates as well as the College and may be of concern to Fellows and Trainees, particularly in Malaysia and Singapore. Within Australia and New Zealand, the impact will be on trainees spread throughout Queensland, in Tasmania and the trainees in New Zealand from outside the Auckland area.

There will be additional costs to the College as it will be necessary to send examiners from outside the region so that trainees are not always examined by examiners from their own city. There will also be administrative costs in the regions and substantial extra work for College staff to ensure adequate supervision and consistency in the way the examination is managed at all sites.

The overriding reasons to make the change are the unsustainability of the current examination with the increasing numbers of candidates and to open opportunities to further improve the quality of the medical clinical section of the Final Fellowship Examination. The implementation date for the new format examination is May 2008.

A M WEEKS
Chair of Examinations

# Hazards of Anaesthesia for Laparoscopic Gastric Banding

**Laparoscopic Adjustable Gastric Banding (LAGB) for the treatment of obesity is the most commonly performed bariatric surgical procedure in Australia. Advantages of this type of surgery include the laparoscopic approach, reversibility of the surgery and the ability to adjust the band. The health benefits of the procedure have been well documented.[1]**

**However, the Victorian Consultative Council on Anaesthetic Mortality and Morbidity (VCCAMM) has received a number of reports of morbidity and mortality of patients undergoing bariatric surgery—in some instances in suboptimal conditions. Poor pre-operative assessment and lack of planning have been identified as key issues.**

As the risks of elective surgery are markedly increased due to co-morbidities, involvement of the whole perioperative team is essential. Multidisciplinary input can optimise patients with diabetes, asthma, hypertension and obstructive sleep apnoea, all of whom may benefit from preoperative intervention.

Airway management is of prime concern to the anaesthetist, with the risk of reflux on one hand and difficulty in securing the airway on the other. Thus a thorough and unhurried pre-operative assessment must include careful evaluation of the airway enabling adequate planning for a difficult or failed intubation.[2]

Pulmonary aspiration occurs most commonly during induction and laryngoscopy when sub-optimal conditions, including multiple attempts at intubation, contribute to the risk. The role of cricoid pressure in the prevention of aspiration has been questioned, as it has been suggested that it may be ineffective and impede ventilation and intubation.[3] It is, however, essential that first class assistance is always available to help in securing the airway. The incidence of oesophageal reflux is high with a direct correlation between BMI and reflux. There is also a different pathophysiology in the obese with hyperacidity, hiatus hernia, raised intra-abdominal pressure as well as vagal abnormalities. Gastric banding itself may cause reflux (especially with slipping or erosion of the band). In patients undergoing band revision or gastroscopy it must be assumed that there is a full stomach. Removal of fluid in the band is also recommended for all patients undergoing elective surgery.

Management of post-operative pain is usually not difficult, but care must be taken with the use of sedatives or analgesics as excessive sedation can compound obstructive sleep apnoea and increase respiratory depression. Such drugs should be used carefully in a monitored environment. The need for postoperative ventilation in an Intensive Care Unit is rare, but there is a frequent requirement for a high dependency unit to manage patients with poorly controlled obstructive sleep apnoea, hypertension, diabetes, asthma and cardiac disease.

Occupational health and safety issues for staff handling heavy patients also need to be addressed. Provision of adequate staff is necessary and beds, lifting devices and operating tables should be designed for use with heavy loads. Whenever possible, patients should be encouraged to move themselves.

Staff education about the special needs of the obese should include recognition of the psychological impact of obesity on this socially marginalised group and issues of privacy and respect need to be reinforced.

JENNIFER CARDEN
(Vic)

**References**

**1** Health outcomes of severely obese type 2 diabetic subjects (one year after laparoscopic adjustable gastric banding). Dixon JB, O'Brien PE *Diabetes Care* 2002; 25:358-363

**2** Morbid obesity and tracheal intubation. Brodsky JB, Lemmens HJ, Brock-Utne JG, Vierra M, Saidman LJ *Anesth Analg* 2002; 94:732-736

**3** Strategies for prophylaxis and treatment of aspiration. Kalinowski CPK, Kirsch JR Best practice and research *Clinical anaesthesiology* 2004; 18: 719-737

# Midazolam Anaphylaxis

**Anaesthetists do not usually regard midazolam as a likely cause of anaphylaxis. This report and review of the literature reveals that it can occur, although very rarely.**

### Event Details

The patient was a 54 year old healthy ASA1 female undergoing major intra-abdominal surgery. There was no history of allergy or previous anaesthetic difficulties. Midazolam was administered for insertion of vascular lines and the epidural catheter. The anaesthetic procedure consisted of a combined general/regional with insertion of an epidural catheter at T9/10, mainly for postoperative analgesia. General anaesthesia was induced with a further dose of midazolam, alfentanyl, propofol and cisatracurium. Maintenance was with oxygen, air and desflurane and a total of 15mL of 0.25 epidural ropivacaine was administered over 1.5 hours. The airway had been assessed as Mallampatti II and on laryngoscopy there was a grade 3 view and intubation was achieved with the assistance of a bougie.

Following induction, she developed hypotension which responded to metaraminol and she was stable throughout the procedure until the end when tachycardia and hypotension were recorded. There was no rash or bronchospasm. Following extubation she became hypoxic and this was initially considered to be due to laryngospasm. Suxamethonium was administered and ventilation assisted. Oxygen saturation improved but upper airway obstruction became obvious with the development of gross oedema of the head, face and neck. The patient was re-anaesthetised with sevoflurane and laryngoscopy revealed massive oedema of the airway with swelling of the epiglottis which prevented passage of a bougie. Eventually the airway was secured with the use of an intubating laryngeal mask airway and fibreoptic bronchoscope. Anaphylaxis was diagnosed, the suspected agents being cephazolin, cisatracurium or gelofusine. She was transferred to ICU on an adrenaline infusion and extubated 48 hours later.

### Tests

Serum tryptase: 1 hour specimen was 16.9 ng/mL and 6 hour specimen was 45.5 ng/mL.

Subsequent intradermal skin tests revealed a positive response to midazolam but negative for all the other drugs employed. Prick tests were also negative for mannitol, gelofusine, betadine and chlorhexidine.

A literature review suggests that anaphylaxis to benzodiazepines is rare and that the Chromphor EL solvent is responsible for most reactions. Laxenaire and Mertes report on a two year survey of 467 patients diagnosed as suffering from anaphylactic or anaphylactoid reaction to anaesthetic agents[1], three patients (0.62%) had a reaction to midazolam. A subsequent study by the same group[2] reported on 789 patients, three of whom (0.57%) were sensitive to midazolam.

Case reports are rare. Fujita et al[3] report a case of a male with a history of allergy to several antibiotics who developed hypotension, tachycardia and widespread flush following intravenous midazolam. Haemodynamic stability was achieved after a four hour adrenaline infusion.

Uchimura et al[4] report a female with a history of atopy who developed pruritis and severe facial oedema which lasted for eight hours, although the airway was not compromised. It is suggested that angioedema may be a feature of anaphylaxis to midazolam.

REPORT FROM FELLOW


**References**

**1** Lazenaire MC, Mertes PM, Anaphylaxis during anaesthesia. Results of a 2 year survey in France. *Br J Anaesth* 2001; 87: 549-558

**2** Mertes PM, Alla F, Laxenaire MC, Anaphylaxis and anaphylactois reactions occurring during anaesthesia in France 1999-2000. *Anesthesiology* 2003; 99: 536-545

**3** Fujita Y, Ishikawa H, Yokota K, Anaphylactoid reaction to midazolam. *Anesthesia and Analgesia* 1994; 79: 811-812

**4** Uchimura A, Yogo H, Kudoh I, Ohmura A, Facial edema and pruritis after intravenous injection of midazolam. *Japanese Journal of Anesthesiology* 2006; 55: 76-78

# Obituaries

## David Komesaroff
## 1932-2007

Dr David Komesaroff

**David Komesaroff graduated from Melbourne University MBBS in 1956. He commenced practice as a general practitioner before training in anaesthesia. He completed his anaesthesia training in 1965 having passed both the Diploma of Anaesthetics (Melbourne University—the second last person to do so) and the FFARACS.**

He began an appointment at the Royal Melbourne Hospital in 1966, where he concentrated on thoracic anaesthesia. He was a very enthusiastic teacher and showed an interest in registrars by giving them tutorials at a time when formal in-service teaching was rare.

He devised a system for answering Physiology questions, which he passed on to Kester Brown, who subsequently taught it to many other trainees. It was a plan for a summary which could be applied to any topic in Physiology, whether in written papers or in oral examinations.

Definition
Anatomical points which might be relevant
Normal values
Measurement
Control: Neural, Humoral, and Chemical
Systems affected
Factors affecting, eg. age, sex, pregnancy, altitude and pressure, temperature, drugs, IPPR etc.
Relevant pathophysiology

David had a flair for developing equipment. His enthusiasm for presenting his ideas and developments sometimes appeared a little too entrepreneurial for some anaesthetists who became antagonistic, but fortunately there were many who recognised his talents and who continued to support him. One of his first inventions was the quick release adjustable tourniquet, that is now widely manufactured and in almost universal use. He also developed a very early pulse meter, along with intravenous infusion monitors and devices for respiratory and asthma therapy.

In the early 1970s, he was a proponent for the development of a research group. Colleagues who supported the idea eventually established the Anaesthetic Research Group for the few who were involved at the time. The Group began in 1977 and continued for some 10-12 years, by which time many departments were developing a research base and their own critical mass of researchers. David did not become heavily involved, because he had begun his own enterprise in research and development.

He still maintained his clinical work with appointments at Royal Melbourne Hospital, and became Director of Anaesthesia at Sandringham Hospital. He was a great supporter of non-specialist anaesthetists, and wrote a text book for them entitled 'Anaesthesia for the Non-Specialist'.

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

One of his major developments was a simple closed circuit anaesthetic machine for use with methoxyflurane which became widely used in some less affluent countries and in ambulances where low dose methoxyflurane provided analgesia for injured people. His continued interest in this drug led to his manufacturing it when other sources ceased so that now it can still be used in many Emergency departments. He recently reintroduced a simple disposable methoxyflurane inhaler for use in procedural pain and in ambulances.

He eventually gave up anaesthesia to devote himself fully to his company—Medical Developments. Together with many of the items mentioned above, he made other major contributions to resuscitation and to veterinary anaesthesia. He devised simple constant flow cylinder regulators, and oxygen flow meters that were accurate in any position. He developed vaporisers and anaesthetic machines for veterinary practice. He also entered a joint venture with the Royal Childrens Hospital Anaesthetic Department to manufacture and market the Clare paediatric anaesthesia ventilator.

David was always enthusiastic in his discussions and was unashamedly passionate when presenting his concepts to colleagues.

He made a significant contribution to our specialty, to the Australian Resuscitation Council, the ambulance service and Australian Standards.

He was an accomplished tennis player, and is survived by his wife, Jenni and two daughters.

ROD WESTHORPE
KESTER BROWN
AND PAT MACKAY

## Dr David Komesaroff, MBBS, DA, FFARCS, FANZCA, Honorary Consultant Physician to the Royal Melbourne Hospital, died on 14 July 2007, after battling a serious illness for some months.

**David was a physician of many skills and talents, and leaves a legacy of significant contributions to medicine in Australia.**

The father of effective ambulance pain relief in Australia, David's Penthrox® medication and associated inhaler have brought relief to many tens of thousands in pain and suffering from illness or injury in ambulances. He was a highly ethical and dedicated man, a valued colleague, and a close and valued friend for over thirty years. David had a belief in helping others, an ever-enquiring mind, and his ability to develop new ideas was still in evidence days before his death.

David Komesaroff completed with Honours his first year training as an engineer, but then moved to medicine. He qualified MBBS Melbourne in 1956, DA 1966, FFARACS in 1967 and FANZCA in 1992, winning the Renton prize along the way, and research grants in Bacteriology and Anaesthesia. He became a Specialist Anaesthetist and Research Fellow at the Royal Melbourne Hospital, where he trained registrars, and taught practical anaesthesia to general practitioners from the country. Because there was no suitable text for GPs, he wrote one. This was provided to those doing the training, and published as 'Anaesthesia for the Non-Specialist'.

David was a strong proponent of closed circuit anaesthesia, at which he was expert. He would look at the equipment around him, and with his engineering skills, he would think of ways in which he could improve design. He would repair to his workshop, and redesign or make alternatives, later acquiring a part-time engineer, then others to assist him. He designed and built the closed circuit Komesaroff anaesthesia machine, which was later adapted to be the oxygen resuscitator for the Melbourne Ambulance service. Equipped with a Goldman vapouriser, it also provided controlled methoxyflurane pain relief in ambulance until the arrival of plastic disposable fixed concentration inhalers.

Over the years, the firm grew and finally he had a small specialised business, Medical Developments. They developed anaesthetic machines for human and veterinary use, new CO2 absorbers, and they are the only manufacturer of oxygen resuscitators and therapy units in Australia. Later, Medical Developments took more of his time, but he was still on the staff of the Royal Melbourne and also at Sandringham Hospital, becoming Director of Anaesthesia there.

Dr Komesaroff became involved with the Victorian and Tasmanian Ambulance services, for which he was an honorary adviser in several roles. He also wrote the little red text, 'Cardiopulmonary Resuscitation'. David was Medical Director of the Royal Life Saving Society in the 1980s, and helped create an episode of the TV soap 'Cop Shop', to promote CPR.

In the late 1970s, there was little available effective pain relief for ambulance patients. David developed a method of administering methoxyflurane—a drug then still used in anaesthesia—in low, safe, sub-anaesthetic concentrations, to provide relief of ambulance pain and suffering. This is now the main analgesic agent used in every ambulance service in Australia and in all Australian Defence Forces, and it is being adopted elsewhere outside Australia. When the only manufacturer, in the United States, ceased manufacturing, David saw a vital need to continue supply. With CSIRO he developed a production method, then up-scaled the pilot plant to a commercial size, now the only production plant in the world.

David was always motivated by the need to make things work better, and to help others. He developed a range of asthma products, oxygen equipment, and veterinary anaesthesia equipment that sells world wide. The firm is promoting the Penthrox® pain relief system to alleviate pain and anxiety in dentistry and many other innovative areas. The company was eventually sold, then floated as a public company—Medical Developments International—but David still consulted there, with new ideas and new medical developments.

David Komesaroff was a man of immense energy, a meticulous researcher, an innovative thinker and a voluntary contributor to anaesthesia, ambulance and resuscitation. He was a member of many learned societies, served on many committees including the Australian Resuscitation Council, and Australian Standards committees. He was very fit, a tennis player of considerable ability, and enjoyed his golf.

David is survived by his devoted wife, Jenni, and two daughters. He will be sorely missed, by family, staff, friends, and colleagues in Australia and internationally.

HARRY OXER
FANZCA

## Dr John Henry Taylor
1902-2007

**John Henry Taylor, an unsung hero in the development of specialist anaesthetics practice in Northern Tasmania, died in Hobart on 17 July 2007, aged ninety-five years.**

It was my privilege to have been his registrar at Poplar Hospital in East London (1955-56) and at The London Hospital, now The Royal London (1956-57).

In my registrar days, he was my idea of the epitome of the English consultant—tall, good looking with a military bearing. His suit was always flawless and he wore pigskin gloves and a hat as he returned to his spotless car in the consultants' parking area at the front of The London! These personal attributes were matched by excellent clinical judgment and enviable technical dexterity.

It came as quite a surprise one morning when he announced as we were about to start a list, 'Miss Brophy, you will be interested to know that I am migrating to Australia'. My startled reply was, 'That is wonderful, sir. Where are you going to, Sydney or Melbourne?' I could not hide my amazement when he said, 'To Burnie', as I asked 'Do you know how small Burnie is?' I had done a student elective in Launceston and remembered Burnie as cold and inhospitable in December, and having only a timber mill and a jetty!

But migrate he did, with his wife Joyce and three young daughters, Sue, Jenny and Celia. Ever gracious and friendly, John and Joyce even accepted the challenge of my cooking when I invited them to a farewell dinner at my flat at Clapham Common.

John was appointed Director of Anaesthetics for North West Tasmania. As the only specialist anaesthetist in that area, he had the responsibility not only for the clinical service, but also for the training of medical and nursing staff in five hospitals—Burnie, Wynyard, Devonport, Ulverstone and Latrobe.

Always dedicated to improvement in patient care, he attached high priority to the introduction of better drugs and improved techniques of anaesthesia, hence his enthusiasm for the introduction of epidural anaesthesia to Tasmania—a philosophy he had espoused at Poplar when any 'spinal' technique was viewed suspiciously after the Woolley and Roe saga. In 1967, with a cardiologist Dr Don McTaggart, John developed the first Intensive Care Unit in Tasmania, a commitment that involved long hours of demanding care.

John Henry Taylor was born in London in 21 January 1912. He was educated in Switzerland from the age of eight years until he was fourteen years old, and completed his education at St George's Co-educational School in Hertfordshire.

On leaving school, he travelled and worked in North America, an early indication of his interest in the environment and his zest for travel, as well as providing the opportunity to meet people from different cultural backgrounds. But a family friend persuaded him to study medicine. Gaining entrance to The London Hospital Medical College, University of London, he graduated MRCS LRCP in 1937. On completion of his House Officer posts at Royal Victoria Hospital Bournemouth, he undertook training in anaesthetics at Christchurch Hospital Bournemouth. He obtained the Diploma at Anaesthetics RCP and RCS in 1940.

From 1940 until 1947 he served as a Major in the Royal Army Medical Corps with tours of duty in Middle East and European theatres.

Just after the cessation of hostilities, he married Joyce Winfred Lyne, a serving officer in the Queen Alexandra Nursing Corps whom he had met in Belgium several months earlier. Theirs was a long and happy life together.

**In 1967, with a cardiologist Dr Don McTaggart, John developed the first Intensive Care Unit in Tasmania, a commitment that involved long hours of demanding care.**

John achieved consultant status at his Alma Mater, The London Hospital 1946-1957 (including a Merit Award), as well as at Poplar 1947-1957 and at May Day Hospital Croydon 1947-1957. He was admitted as FFARCS in 1953 and as a Fellow of the Royal College of Anaesthetists in 1995. The Faculty of Anaesthetists Royal Australasian College of Surgeons elected John to its Fellowship in 1963 and he was admitted to Fellowship of the Australian and New Zealand College of Anaesthetists in 1992.

John Taylor's lasting memorial will stay with the countless patients who benefitted from his professional expertise and emotional support, and the medical and nursing staff whom he trained and who have promulgated the standards he set.

Modest and unassuming, John Taylor was, above all, a family man devoted to Joyce and their three daughters, Sue, Jenny and Celia. As we offer them our sympathy, they will take their comfort from the goodness that was his life and his service to medicine and the community, particularly in Northern Tasmania.

TESS CRAMOND
Director
Multidisciplinary Pain Centre
Royal Brisbane Hospital

# Report of Audit of 2006 MOPS Returns

**The participation rate in Maintenance of Professional Standards (MOPS) among the Fellows over the past 12 months has decreased slightly, down to 51% in 2006 (cf 54% in 2005). New Zealand continues to have the highest rate of participation at 89%, an increase from 88%.**

**Slight increases in participation have been recorded in only two States: ACT from 60% to 61% and WA from 31% to 32%. The participation rate across the majority of States has decreased slightly in 2006: NSW from 69% in 2005 to 61.5%; QLD from 47% to 45.5%; VIC from 53% to 50.5%; SA from 44% to 41%; TAS from 65% to 64% and NT from 53% to 47%.**

Of those returns submitted 92% met all criteria.

There were fewer non-fellows participating in 2006, from 157 down to 114. Almost 59% of these are from New Zealand.

**1** 40 participants were randomly selected for auditing. The participants audited came from NZ (2), NSW (14), QLD (4), VIC (11), SA (2), TAS (3), WA (1), ACT (1) and HONG KONG (2).

Of those selected, the average number of CME/TTR points was 155 and the average number of QA points was 80.

**2** The audit was performed by staff in the Continuing Professional Development (CPD) Office, with guidance from the CPD Officer when necessary.

**3** The returns were audited according to the criteria set out in the program manual, which are the accuracy of returns and the relevance of activities to the participants practice.

**4** Results: (thus far, with documentation for four participants not yet received)

> 32 were satisfactory;
> 3 participants have been asked to provide further documentary evidence;
> 1 participant declined to participate in this year's audit;
> 0 returns had significant errors in documentation.

**5** As per previous audits, the 2006 audit demonstrated that participants had taken part in a good range of activities. Occasionally, participants under-claimed their points; they submitted documentation for more points than claimed on their Annual Return.

**6** Errors noted:

> Frequently, activities were claimed under incorrect codes, although generally this did not affect their total points.
> Some participants claimed CME and QA activities for which they could not provide supporting documentation.
> Documentation supplied did not always clearly match activities claimed.

**7** It was noted that the majority of audit participants were able to supply over and above the evidence actually required.

**8** Recommendations:

> To note the confusion regarding activities claimed and codes to specify, and to aim to simplify the Annual Return process in the new CPD Program;
> The new CPD Program should indicate clearly what evidence needs to be retained —particularly for rural practitioners;
> Following the revision of the audit process for the new CPD Program, it is suggested that staff in the CPD Office continue to perform the audit, referring to the CPD Officer when difficulties arise.

**9** Any issues worth mentioning to participants were raised by letter when documentation was returned to the participant.

**10** The audit process for the new CPD Program will benefit from the experience of MOPS audits of this and previous years.

DR FRANK MOLONEY
Continuing Professional Development Officer
Australian and New Zealand College of Anaesthetists
31 July 2007

# ANZCA Maintenance of Professional Standards Program

## 2006 Participation Details

All Participants

| | Returns Submitted | Met All Criteria | Average CME Points | Average QA Points | Met Due Date |
|---|---|---|---|---|---|
| NZ | 458 | 97% | 215 | 65 | 95% |
| ACT | 29 | 93% | 165 | 49 | 100% |
| NSW | 601 | 92% | 156 | 50 | 94% |
| NT | 9 | 100% | 221 | 65 | 100% |
| QLD | 270 | 84% | 169 | 52 | 96% |
| SA | 104 | 89% | 185 | 58 | 96% |
| VIC | 381 | 94% | 167 | 59 | 96% |
| WA | 90 | 83% | 225 | 56 | 99% |
| TAS | 55 | 95% | 157 | 57 | 94% |
| HK | 28 | 82% | 212 | 66 | 96% |
| SIN | 3 | 67% | 324 | 81 | 100% |
| MAL | 2 | 50% | 472 | 101 | 70% |
| Other | 25 | 96% | 195 | 57 | 100% |
| Total | 2055 | 92% | 179 | 57 | 95% |

All Fellows

| | Active Fellows | Returns Submitted | Met All Criteria | Average CME Points | Average QA Points | Met Due Date |
|---|---|---|---|---|---|---|
| NZ | 432 | 387 | 97% | 222 | 66 | 90% |
| ACT | 46 | 28 | 96% | 165 | 49 | 86% |
| NSW | 941 | 587 | 91% | 157 | 50 | 87% |
| NT | 19 | 9 | 100% | 221 | 65 | 60% |
| QLD | 554 | 254 | 83% | 169 | 52 | 88% |
| SA | 250 | 101 | 90% | 185 | 59 | 87% |
| VIC | 733 | 372 | 94% | 169 | 60 | 93% |
| WA | 264 | 85 | 84% | 228 | 56 | 88% |
| TAS | 81 | 52 | 98% | 151 | 55 | 84% |
| HK | 162 | 28 | 82% | 212 | 66 | 92% |
| SIN | 56 | 3 | 67% | 324 | 81 | 100% |
| MAL | 44 | 2 | 50% | 472 | 101 | 100% |
| Other | 185 | 21 | 95% | 199 | 56 | 92% |
| Total | 3769 | 1929 | 92% | 181 | 57 | 89% |

All Non Fellows

| | Returns Submitted | Met All Criteria | Average CME Points | Average QA Points | Met Due Date |
|---|---|---|---|---|---|
| NZ | 68 | 94% | 172 | 59 | 93% |
| ACT | | 100% | | | 100% |
| NSW | 8 | 100% | 155 | 42 | 95% |
| NT | | % | | | % |
| QLD | 16 | 100% | 159 | 52 | 100% |
| SA | 2 | 100% | 190 | 35 | 100% |
| VIC | 9 | 100% | 99 | 43 | 100% |
| WA | 5 | 80% | 172 | 64 | 83% |
| TAS | 3 | 33% | 459 | 196 | 100% |
| HK | | % | | | % |
| SIN | | % | | | % |
| MAL | | % | | | % |
| Other | 4 | 100% | 177 | 58 | 100% |
| Total | 115 | 94% | 166 | 56 | 94% |

# 2007 ANZCA ASM

**With a record attendance of 1,879 registrations, the 2007 Annual Scientific Meeting has been acclaimed as a great success. Held at the Melbourne Exhibition and Convention Centre from 26-29 May, the theme of this year's event was 'Perioperative Medicine: Evidence and Practice'.**

**The Foundation speakers were Professor Bruce Spiess (Anaesthesia) and Professor Martin Koltzenburg (Pain Medicine), who gave outstanding lectures on 'Blood Transfusion and Outcome' and 'How Science is Informing the Management of Pain'. Professor Alan Merry was the Australasian Visitor and delivered several exceptional presentations, including 'The Prodigal Sim'. One of the highlights of the meeting was the 'Great Debate: Oxygen versus Nitrous Oxide' between Professor Paul Myles and Professor Dan Sessler. Complementing the didactic sessions were a number of very successful workshops and PBLDs—all well attended. The meeting also saw the introduction of Quality Assurance sessions, which were very well received.**

On behalf of the Organising Committee, our thanks are extended to all our colleagues who generously donated their time and expertise to contribute to the meeting. Their contribution undoubtedly plays an integral role in the success of the meeting.

The social program included the Conference dinner at The Function Centre, Melbourne Park, where the dance-floor filled to the sounds of 'Reverend Funk and the Horns of Salvation'. The College Ceremony was held at the Melbourne Convention Centre where 146 New Fellows were presented from ANZCA and FPM. The oration was delivered by Oscar award winning Director, Adam Elliot of Harvie Krumpet fame, who engaged the audience with an entertaining and amusing account of his struggles to succeed in an oration entitled 'Overcoming the Odds: A Story of a Dream where Passion, Commitment and Talent Equals Success'.

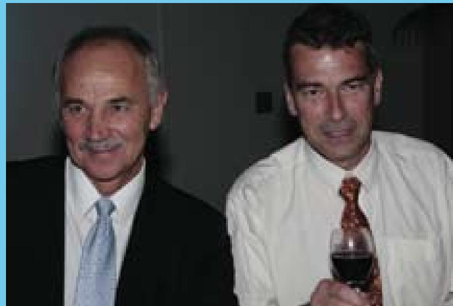
The meeting also acknowledges the continued generous support of all our sponsors and exhibitors.

I am sure you will join me in looking forward to the 2008 meeting, 'Anaesthesia: Science, Art and Life', which will be held in Sydney from 3-7 May 2008.

ROWAN THOMAS
Convenor, 2007 ANZCA ASM

# 2007 ASM

PHARMATEL



# 2007 ASM

## Foundation Visitor's Visit to WA

**Following the ASM in Melbourne, the 2007 Foundation Visitor Professor Bruce Spiess visited WA as part of his regional visit from 29 May to 1 June.**

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**On 30 May Professor Spiess visited the Submarine Escape Training Facility at the Royal Australian Naval Base HMAS Stirling, followed by a visit to the Department of Diving and Hyperbaric Medicine at Fremantle Hospital. On the evening of 30 May, Professor Spiess gave an informative presentation to WA Fellows and Trainees entitled 'The Future of Perfluorocarbon Blood Substitutes: Brains, Hearts and Submarines'. He also had some time during his visit to do some sightseeing around Perth.**

3

Top, left to right
**1** A group of WA Fellows
**2** Prof Speiss giving his presentation
**3** Dr John Faris, Professor Speiss and WARC Deputy Chair Dr David Wright

# Western Australian Regional Committee

## Winter Scientific Meeting 07

**On Saturday 30 June 2007, the Western Australian Regional Committee hosted the Winter Scientific Meeting at the University Club of WA. The main theme of the meeting was a Resuscitation Update. The meeting was a great success with around 80 people registering for the meeting.**

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Top, left to right
**1** Winner of the Nerida Dilworth Registrars Prize - Dr Russell Clarke with Dr Nerida Dilworth
**2** Mr James Preuss and Dr Stefan Lauer
**3** Convenor Dr David Wright welcoming delegates to the meeting
**4** Sponsor Smiths Medical representatives with Dr Sai Fong
**5** Free Paper presenters Dr Stefan Lauer, James Preuss and Drs Ed O'Loughlin and Wim Smithies

**This Scientific Meeting was the first of the 2007-2009 Winter Scientific Meeting Lectureship named in honour of our esteemed colleague Dr Nerida Dilworth. The Dr Nerida Dilworth Lecturer for 2007 was Associate Professor Ian Jacobs, Head of Emergency Medicine at the University of Western Australia. Associate Professor Jacobs delivered the keynote address entitled 'Resuscitation Guidelines: The Science Revisited'. The presentation outlined the evidence evaluation process, the science which underpinned the resuscitation guideline changes and highlighted the controversies. Associate Professor Jacobs also gave an informative presentation on the research directions currently being undertaken in the area of resuscitation.**

The Free Paper session followed after morning tea, with presentations from Anaesthetic Registrars Drs Russell Clarke, Stefan Laurer, Ed O'Loughlin and Wim Smithies. Mr James Preuss also gave a presentation in this session. Congratulations go to Dr Russell Clarke who was awarded the Nerida Dilworth Prize for his presentation on anaesthesia trainees' exposure to airway management in a tertiary adult teaching hospital. Dr Nerida Dilworth was 'on hand' to present the prize.

After lunch, Dr Divya-Jyoti Sharma, a Consultant Anaesthetist from Sir Charles Gairdner Hospital, gave an international perspective on anaesthesia providers. This was followed by Dr Justine Waring a Respiratory Physician from Royal Perth Hospital who spoke about tuberculosis and its implications for anaesthetists.

The Committee would like to thank Associate Professor Jacobs, Dr Sharma and Dr Waring for their contribution to the WA academic program. Thanks also go to the sole sponsor for the event Smiths Medical Australasia and to the Convenor Dr David Wright.

# Laughing gas safety concerns

JANE BUNCE

THE safety of nitrous oxide, the common anaesthetic known as laughing gas, is under a cloud after a new study linked it to higher rates of pneumonia, wound infections and possibly heart attacks.

The Australian-led research team found patients kept unconscious during surgery with anaesthetics other than nitrous oxide suffered fewer life-threatening complications.

Yet nitrous oxide remained "near routine" in surgeries, despite accumulating evidence of its dangerous side-effects, the researchers warn.

The study looked at 2000 patients undergoing major surgery in 13 hospitals in Australia and six others in the UK, Asia and the Middle East.

Patients receiving nitrous oxide as part of their anaesthetic were about one third more likely to suffer wound infection than patients who did not receive the gas, the researchers found.

They were twice as likely to suffer pneumonia, nausea and vomiting and about 25 per cent more likely to have a fever.

Overall, 210 patients, or 21 per cent of those given nitrous oxide, suffered a major complication compared with 155, or 16 per cent, of those who were not given the gas.

"The evidence is sufficiently compelling to convince me to change my practice," Australian and New Zealand College of Anaesthetists quality and safety committee chair Alan Merry told *New Scientist* magazine.

The study also found patients who received nitrous oxide had double the rate of heart attacks and three times the death rate.

However, anaesthetists believe the gas remains safe where exposure is minimal, such as for very minor surgery and women in labour.

Research leader Paul Myles of Melbourne's The Alfred Hospital said the side-effects probably occur because the gas interferes with vitamin B12, folic acid and DNA synthesis, which are important for the immune system and wound healing.

It could also occur because administering the weak gas at its standard 70 per cent concentration limits the amount of beneficial oxygen that could be given to the patient.

The results were published in the latest issue of the journal *Anesthesiology*.

AAP

# Gas in surgery no laughing matter

Janelle Miles
HEALTH REPORTER

NITROUS oxide, better known as laughing gas, is the cornerstone of anaesthesiology but a landmark Australian study has questioned its routine use in major surgery.

The study of more than 2000 adult surgical patients worldwide found removing nitrous oxide from the anaesthetic cocktail significantly reduced the risk of major post-operative complications.

Researchers reported a lower incidence of fever, pneumonia, wound infection, severe nausea and vomiting in patients undergoing major surgery where nitrous oxide was avoided.

The study, published in the August edition of Anesthesiology, is expected to trigger fierce debate in the profession given nitrous oxide has been used for more than 150 years.

"It would be fair to say all anaesthetists will read this Australian study with great interest across the world," said Brisbane specialist Patrick See, director of the St Andrew's Medical Institute.

"It will be a landmark article that will stimulate a lot of discussion."

An estimated one million Australian patients and more than 10 million in the US are administered nitrous oxide annually. But the study's chief investigator Paul Myles, head of anaesthesia at the Alfred Hospital in Melbourne, expects that to plummet on the basis of the findings.

"I think this study is going to reduce the use of nitrous oxide by about five to tenfold right now," Professor Myles said.

"Our bottom line is that we should stop using nitrous oxide routinely in major surgery involving adults.

"Some anaesthetists stopped using it a number of years ago because they had concerns about it but we've now got hard data."

Professor Myles stressed the results did not apply to patients having minor surgery, women in labour, dental procedures or operations involving children.

All patients in the study were at least 18 and underwent surgery lasting two hours or more. They were randomly assigned to receive a nitrous oxide-based anaesthetic or one free of laughing gas.

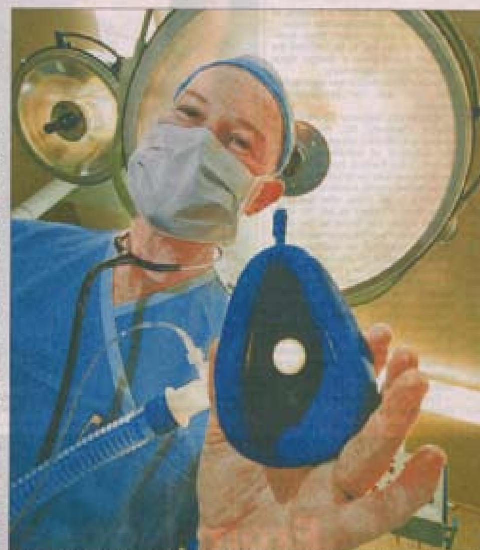
The study authors reported slightly more heart attacks and deaths in the nitrous oxide group but Professor Myles said follow-up research was needed to back up those findings.

"The numbers are too small for us to make any firm conclusions," Professor Myles said.

The research team has already launched another study of 7000 patients with a $2.8 million grant from the National Health and Medical Research Council.

Dr See, who was not involved in the research, said he had started using nitrous oxide on fewer patients "some years ago" because of emerging concerns.

Nevertheless, Dr See expects the Australian study to raise eyebrows among some anaesthetists.



IN spotlight ... Dr Patrick See questions the use of laughing gas. Picture: Sarah Marshall

"Our bottom line is that we should stop using nitrous oxide routinely in major surgery involving adults"

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# Fed: Safety of laughing gas no joke

**The safety of the common anaesthetic known as laughing gas is under a cloud after a new study linked it to higher rates of pneumonia, wound infections and possibly even heart attacks.**

The Australian-led research team found patients kept unconscious during surgery with anaesthetics other than nitrous oxide suffered fewer life-threatening complications. Yet nitrous oxide remained "near routine" in surgeries, despite accumulating evidence of its dangerous side-effects, the researchers warn.

The trial, one of the world's largest anaesthesiology studies ever conducted, involved 2,000 patients undergoing major surgery in 13 hospitals in Australia along with six others in the UK, Asia and the Middle East.

Patients who received nitrous oxide as part of their anaesthetic were about one third more likely to suffer a wound infection than patients who did not receive the gas, the researchers found.

They were twice as likely to suffer pneumonia, nausea and vomiting and about 25 per cent more likely to have a fever.

Overall, 210 patients, or 21 per cent of those given nitrous oxide, suffered a major complication compared to 155, or 16 per cent, of those who were not given the gas. "The evidence is sufficiently compelling to convince me to change my practice," Australian and New Zealand College of Anaesthetists quality and safety committee chair Alan Merry told New Scientist magazine.

"I would think very carefully before using nitrous oxide in patients (undergoing major surgery)."

The study also found patients who received nitrous oxide had double the rate of heart attacks and three times the death rate, although the trial was too small to say whether the figures were meaningful.
A follow-up trial in 7,000 patients at risk of coronary artery disease will test if the risk of such serious post-operative complications were truly higher.

But anaesthetists believe the gas remains safe where exposure is minimal, such as for patients undergoing very minor surgery and women in labour.

Research leader Paul Myles of Melbourne's The Alfred Hospital said the side effects probably occur because the gas interferes with vitamin B12, folic acid and DNA synthesis, which are important for the immune system and wound healing.

It could also occur because administering the weak gas at its standard 70 per cent concentration limited the amount of beneficial oxygen that could be given to the patient.

"Regardless of whether the risk reduction is a result of nitrous oxide toxicity or direct benefits of supplemental oxygen, anesthesiologists should question the inclusion of nitrous oxide as part of their anesthetic regimen," Professor Myles said.

The results have been published in the latest issue of the journal *Anesthesiology*.

AAP jb/sb/it/mn

# Nitrous Oxide

## Nitrous oxide is no laughing matter

"There would be fewer potentially life-threatening complications if nitrous oxide were replaced in the mix of gases inhaled"

# Study blackballs anaesthetic gas

## Nitrous oxide may not be a laughing matter

By **CHRISTIAN CATALANO**
HEALTH REPORTER

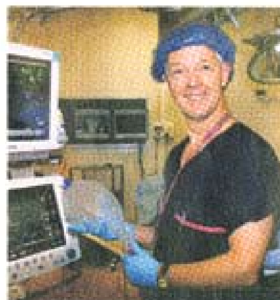
NITROUS oxide, the basis of anaesthetic treatment for the past 160 years, could soon be phased out of major surgery after a Melbourne study revealed that it increases the risks of serious, post-operative complications.

An analysis of 2000 surgical patients at 18 hospitals found there was a 30 per cent greater chance of suffering wound infection, pneumonia or lung collapse after surgery when a patient was put to sleep using nitrous oxide, commonly known as laughing gas.

In contrast, patients recovered faster when nitrous oxide was removed from the usual mix of anaesthetics, and the concentration of pure oxygen increased.

"For decades we've been working towards the Rolls-Royce of anaesthetics, the perfect one that would avoid all of these complications," said Professor Paul Myles, head of anaesthesia at The Alfred hospital. "I think we're one step closer to that ideal today."

More than 2 million Australian surgical patients are given an anaesthetic every year, the majority receiving a nitrous-oxide based treatment.



Professor Paul Myles at The Alfred yesterday. PICTURE: PENNY STEPHENS

Nearly all anaesthetists at The Alfred have already stopped using nitrous oxide routinely but persuading all doctors to change decades-old methods of anaesthesia would happen more slowly, Professor Myles said.

"A lot of people are resistant because have been using nitrous oxide their whole careers," he said. "We are really challenging one of the medical profession's most loyal subjects."

Other anaesthetists hailed the findings, but cautioned that more evidence was needed before the gas was regularly omitted.

Professor Larry McNicol, head of anaesthesia at the Austin Hospital, said the study was important but there was not enough evidence to say that nitrous oxide should not be used any more.

The Australian & New Zealand College of Anaesthetists, which helped fund the research, also stopped short of recommending that its 3200 fellows phase out the use of nitrous oxide. It said it would wait for the results of a follow-up study of 7000 surgical patients, now under way.

Professor Kate Leslie, who chairs the college's research committee, said it was still ground-breaking research. "The continued use of nitrous oxide may have had its day in patients having major surgery," she said.

The study, published in the US journal *Anesthesiology*, also showed that the rate of severe nausea and vomiting after surgery was halved when patients received nitrous-free anaesthetic. The impact on overall length of stay in hospital after surgery was negligible.

# Report following the Council Meeting

Of the Australian and New Zealand College of Anaesthetists held on 23 June 2007

**DEATH OF FELLOW**

Council noted with regret the death of Dr Ranu Basu (SA) – FFARACS 1971, FANZCA 1992.

**HONOURS, APPOINTMENTS AND HIGHER DEGREES**

Council noted the following:

- Dr Leona Wilson (NZ) was awarded a Master of Public Health (MPH).
- Dr Kevin Moriarty (Vic) was awarded a Medal of the Order of Australia (OAM) in the Queen's Birthday Honours List.
- A/Prof Kate Leslie (Vic) gained Fellowship of the Australian Institute of Company Directors.

**FACULTY OF PAIN MEDICINE**

**FPM Delegation Document**

This document clarifies the powers and functions which have been delegated to the Faculty, as well as reporting requirements, especially in relation to Board Minutes and financial reports.

A Faculty Regional Committee has been established in Queensland.

**EDUCATION AND TRAINING**

**Training Agreement**

Council approved this document which sets out the rights, responsibilities and obligations of trainees and the College with regard to the ANZCA training program.

**Membership of Education and Training Committee to include Assistant Assessor**

Membership of the ETC was amended to include the Assistant Assessor.

**Module 11 – Formal Project Working Party**

Membership of this group was approved as follows:

- Dr Kerry Brandis, Councillor (Chair)
- Dr Frank Moloney, Assistant Assessor
- A/Prof Kate Leslie, Chair of Research or her nominee
- The Director of Education
- Dr Annabel Orr

The aim of the Working Party is to make recommendations about how the Education and Scientific component of FANZCA Training should be undertaken, in particular whether the Formal Project should be retained in its current format.

**Tenders for development of distance education materials to support a clinical module**

In December 2006, Council resolved to call for competitive tenders for the development of distance educational materials to support learning towards the completion of one of the clinical modules of the FANZCA Program. Council supported A/Prof Philip Siddall's tender titled: Tender for distance education materials for a clinical module in Pain Medicine for vocational trainees in anaesthesia. Support was granted for initial development and for the period 2008 - 2010, at which time ANZCA's commitment to the project will be reviewed.

**EXAMINATIONS**

**Proposed Revisions to the Final Examination Format**

Council approved the following changes to the format of the Final Exam:

- The medical clinical will held the day after the written examinations
- The medical clinical will be of 18 minutes duration

In 2008, the examinations will be held in Brisbane, Sydney, Melbourne, Adelaide, Perth, Auckland and Hong Kong. Following review of the new format, Council noted there is a possibility for expansion outside these areas.

**CONTINUING EDUCATION AND QUALITY ASSURANCE**

**ASM Committee**

**Conference Handbook – Abstracts to Delegates on CD**

It was agreed that all delegates will be given a copy of the abstracts from the ASM on CD and have the option of receiving a hard copy of the abstracts on the registration form.

**2010 ASM – Christchurch**

The Regional Organising Committee for the 2010 ASM was approved by Council:

Convenor – Dr Ross Kennedy
Scientific Convenor – Dr Richard French
Social Convenor – Dr Sue Nicoll
Industry Liaison – Prof Ted Shipton

## INTERNAL AFFAIRS

### ANZCA Representative to the Board of Australian Prescriber

Dr Kerry Brandis was appointed as ANZCA representative to this Board.

### International Scholarships

Following an enquiry from a potential applicant, Council agreed that applications from Indonesia may be considered for the International Scholarship.

### Appointment of Director of Professional Affairs

Following Professor Teik Oh's resignation as DPA, Council supported the appointment of part-time DPAs in the second half of 2007 to undertake primarily the Assessor role and to have responsibility for reviewing and updating the Regulations for Council.

## PROFESSIONAL

### Professional Documents

### PS43 – Statement on Fatigue and the Anaesthetist

Following the normal review process, Council approved the updated version of this document.

## ANAESTHESIA CONTINUING EDUCATION CO-ORDINATING COMMITTEE (ACECC)

### Chair of ACECC

Council supported Dr Greg Deacon's appointment as Chair of ACECC.

## WORKFORCE

Council supported the request for a proposal for external agencies to undertake a workforce study identifying the supply and demand for anaesthesia services in Australia. The study has been developed jointly by the College and the ASA and will not be restricted solely to Fellows and ASA members. Following this study, a similar study will be considered for New Zealand.

## RESEARCH

### ANZCA Foundation

Council supported a strategy for developing a database of potential and actual donors.

It was agreed that recruitment of an Administrative Officer for the Foundation would be commenced shortly.

The following naming and recognition of donations was accepted by Council:

| Level | $ | Name | Recognition |
|---|---|---|---|
| 1 | Up to $1,000 | Contributor | Foundation annual report, Bulletin |
| 2 | $1,000 - $25,000 | Donor | Level 1 plus video display in foyer, functions |
| 3 | $25,000 - $50,000 | Sponsor | Level 2 plus grant named after donor |
| 4 | $50,000 for 5 years | Major Sponsor | Level 3 plus invitation to visit ANZCA House and award made at ASM 2009 |
| 5 | $50,000 for 5 years | Founder Sponsor | Level 4 plus mentioned at launch and ASM 2008 |
| 6 | >$200,000 in 1 year | Principal Sponsor | Special recognition by negotiation |

## HOSPITAL ACCREDITATION COMMITTEE

### Formal Agreement between College and Hospitals

Council approved this Agreement which recognises the joint responsibility of ANZCA and accredited training hospitals in the provision of a high quality training environment where high standards of excellence, transparency and accountability are paramount.

DR WALTER R THOMPSON
President
DR LEONA F WILSON
Vice President

# Report following the Council Meeting

Of the Australian and New Zealand College of Anaesthetists held on 18 August 2007

**DEATH OF FELLOWS**

Council noted with regret the death of the following Fellows:

> Dr Richard Stephen Bruce (WA) – FFARACS 1977, FANZCA 1992
> Dr Peter Henry Caldwell (NZ) – FFARACS 1971, FANZCA 1992
> Mr Raymond Arthur Chapman (Vic)– FFARACS 1989, FANZCA 1992
> Dr Geoffrey Cameron Darby (Vic) – FFARACS 1956, FANZCA 1992
> Dr David Komesaroff (Vic) – FFARACS 1967, FANZCA 1992
> Dr Warren Ronald Saunders (Vic) – FANZCA 1996
> Dr Richard Gibson Francis Lloyd Seed (UK) – FFARACS 1986, FANZCA 1992
> Dr Margaret Stuart Smith, OBE (NZ)– FFARACS 1952, FANZCA 1992 (Dr Smith was our last surviving Foundation Fellow)
> Dr John Henry Taylor (Tas) – FFARACS 1959, FANZCA 1992

**HONOURS, APPOINTMENTS AND HIGHER DEGREES**

Prof Alan Merry (NZ) and Prof Paul Myles (Vic) have been awarded Honorary Fellowship of the Royal College of Anaesthetists.

**COLLEGE AWARDS**

The **Orton Medal** was awarded to Professor Teik Oh (WA). This is the highest award the College can bestow on one of its Fellows, and is in recognition of his extensive contributions to review of the FANZCA. Training and MOPS Programs, development of the CPD Program and his work in the initial development of the OTS Process.

An **ANZCA Medal** was awarded to Dr Barrie McCann (Qld) for his involvement over many years in the areas of Medical Education and Assessment, and especially his contributions to the Final Examination.

These awards will be presented at the College Ceremony during next year's ASM in Sydney.

**EDUCATION AND TRAINING**

**Rural Videoconferencing**

The Rural Advanced Specialists Trainee Scheme (RASTS) will be completed, with Commonwealth funding, this year. Council agreed that consideration should be given to implementing a videoconference education series for rural trainees in Australia and New Zealand from 2008, at a cost of some $50,000 per annum. This initiative is to be considered further through the Education and Training Committee.

**Trainee Illness**

To assist with enquiries from trainees related to personal illness which may either interrupt or affect their training, the Education and Training Committee will work towards development of a policy on this topic.

**Timing of Changes to the FANZCA Training Program**

Council supported the concept of introducing Training Program revisions at a single point in the training year, and 1 January was agreed. To allow publicity of proposed changes, all revisions to the Training Program must be ratified by Council no later than the October Council meeting. To ensure that trainees are fully informed of proposed changes, a communications strategy is to be developed through the Education and Training Committee.

**Modular MCQ and SAQ Assessment**

A web-accessible, modular-based MCQ and SAQ bank is to be developed by 2009. This initiative will complement the implementation of the proposed Revised FANZCA curriculum and provide suitable written formats for the enhancement of both formative and summative assessment processes.

**Educational Innovation Grants**

Council supported the establishment of Educational Innovation Grants to cover requests for financial assistance received from Fellows for educational initiatives. Such requests generally relate to small workplace-based projects requiring small funding amounts. The total value of the grants will be $40,000 (indexed) per annum, and support will be considered for individual projects for $5,000 to $10,000.

**Supervisor of Training and Module Supervisor Workshops at the 2008 ASM**

A/Prof Patsy Tremayne will present this workshop on the topic of trainees who fail on more than one or two attempts at examinations.

## CONTINUING EDUCATION AND QUALITY ASSURANCE

### Continuing Professional Development

Council agreed that participation in a formal CPD Program should be mandated for all active ANZCA Fellows from the commencement of 2009. It was agreed that Fellows would not be restricted to the College CPD program but could participate in any formal program that is relevant to their practice.

### 2008 New Fellows' Conference

The theme for next year's NFC is '*Fitness to Practise – Achieving Career Longevity*'. The meeting will be held in the Hunter Valley and will include involvement by external facilitators.

## INTERNAL AFFAIRS

A policy on **Intellectual Property** was approved by Council.

### Code of Professional Conduct

The Code of Conduct was approved by Council. The Code will be revised from time to time and it is planned that the first reconsideration will occur when the Australian Medical Council (AMC) releases its proposed Code of Conduct, and the Medical Council of New Zealand (MCNZ) releases its revision to its Code.

### Educational Visits to Papua New Guinea

Council approved the concept of funding two two-week visits by Australian and/or New Zealand anaesthetists to PNG in 2008, for the purposes of education and training support to anaesthetists working in PNG. A commitment was made to continue the program in 2009 and 2010, with support in subsequent years subject to a review of the three-year program.

### AMC Accreditation

The College has received confirmation from the Australian Medical Council of its ongoing accreditation to 31 December 2012.

DR WALTER R THOMPSON
President
DR LEONA F WILSON
Vice President

# New South Wales Regional Committee

ANNUAL REPORT APRIL 2006 TO MARCH 2007

**OFFICE BEARERS & MEMBERS**

**Chair**

Dr Joanna Sutherland

**Deputy Chair**

Dr Stephen Barratt

**Secretary/Treasurer**

Dr Michael Amos

**Regional Education Officer**

Dr Tracey Tay

**Formal Project Officer**

Dr Stephen Barratt

**Continuing Education Officer**

Dr Mark Priestley

**Attendance at Regional Committee Meetings**

| | |
|---|---|
| Dr Michael Amos | 5:6 |
| Dr Margaret Bailey | 4:6 |
| Dr Stephen Barratt | 5:6 |
| Assoc Prof David Cottee | 3:5 |
| Dr Richard Halliwell | 6.6 |
| Dr Stafford Hughes | 6:6 |
| Dr Richard Morris | 6:6 |
| Dr Blair Munford | 4:6 |
| Dr Gregory O'Sullivan | 5:6 |
| Dr Keith Streatfeild | 4:5 |
| Dr Joanna Sutherland | 6:6 |
| Dr Tracey Tay | 5:6 |

**EX-OFFICIO MEMBERS**

**Councillors**

Dr Francis Moloney

**ASA Representative**

Dr Michael Levitt & Dr Anthony Padley

**Joint Faculty of Intensive Care Medicine Representative**

Dr Ray Raper

**Faculty of Pain Medicine Representative**

Dr K E Khor

**ACT Representative**

Dr Clifford Peady

**New Fellows Representative**

Dr Natalie Smith

**Trainee Committee Representative**

Dr Philip Black

**Course Organiser – Primary**

Professor Peter Kam

**Course Organiser – Final**

Dr Timothy McCulloch & Dr Andrew Watts

**REPRESENTATIVES ON EXTERNAL COMMITTEES**

Dr Joanna Sutherland
Committee of Chairmen of NSW State Committees of Medical Colleges
Standing Committee of College Chairmen
NSW State Committee, Royal Australasian College of Surgeons

Dr Michael Amos
Committee of Management, Australian Society of Anaesthetists
Greater Metropolitan Clinical Taskforce

Dr Tracey Tay
Working Party – Institute of Medical Education & Training

**NSW Regional Co-ordinator**

Janice Taylor

**Course Co-ordinator & Administrative Officer**

Annette Strauss

**Total Number of Regional Committee Meetings for Year: 6**

**Offices and Secretariat**

117 Alexander Street,
Crows Nest NSW 2065

**REGIONAL EDUCATION OFFICER**

Dr Tracey Tay

**The past year has been dominated by the Institute of Medical Education and Training (IMET) Review of anaesthetic training in NSW. ANZCA has been consulted at both state and national levels, and final recommendations have been submitted by IMET to NSW Health. While the time frame for a response from NSW Health is uncertain in an election year, IMET wishes to continue to engage with ANZCA to develop the proposed Training and Education Agreement and the guidelines by which it would be assigned.**

With the demise of the NSW Part II Long Course due to falling attendance, a reassessment of the needs of Part II trainees is being undertaken, including the needs of those on rural rotations. Options being considered include videoconferencing and streaming of Part II focused sessions.

The next Clinical Teaching Course 'Teaching in the Operating Theatre' will be held on 16 March 2007. It will be followed by the Supervisors of Training Meeting. Thank you to all NSW Supervisors of Training for your time and energy. Hopefully, the IMET recommendations for greater recognition of the importance and cost of your role will be accepted.

**FORMAL PROJECTS**

**Dr Stephen Barratt**

After many years of stewardship as the Formal Project Officer, Dr Richard Morris passed the baton onto myself. This was not quite as intimidating as I first thought, as I was one of Richard's principal reviewers. Most of the secondary reviewers have been preserved, though I have conscripted many reviewers north of the harbour to try and share the workload.

All formal projects submitted which matched the submitted plan passed, though about 10% required re-submission after minor editing. Publications and abstracts presented at meetings during training only

required primary review, and these all passed. Completed degrees prior to commencement of ANZCA training are an issue. For example an accounting degree was submitted, though could not be accepted. Whilst it may relate well to day-to-day practice, it was felt to be too far removed from the more theoretical aspects of anaesthetic practice. ANZCA does not wish to make the formal project process too punishing as it discourages any interest or enthusiasm towards scientific method which should form a foundation of clinical practice.

Generally projects were of a good standard, though only a quarter submitted would be potentially publishable. Particularly pleasing were a couple of projects which were part of a multi-centre study and this should be encouraged. It is simply unrealistic to expect a clinical anaesthetist to have extensive experience in laboratory-based work. On the other hand, a modest contribution to a multi-centre study is an excellent learning experience and, at the end of the day, invaluable for the anaesthetic community and society at large. There has always been a concern about the exact contribution made by the trainee, though this can be easily checked. A multi-centre study typically has the advantage that another trainee can also use this as their formal project. These submissions will be considered favourably, without discriminating against the 'conventional' self-contained projects.

The projects submitted for the period of this report were –

**1 V Fraser**
CXR interpretation for the Anaesthetist.

**2 J Harrison**
Out Cold – a novel solution to the poor public image of the anaesthetist.

**3 A Howard**
Emergency surgical airway: a review.

**4 E Darbar**
The attitudes of Anaesthetists to random drug testing.

**5 P Chung**
Review Article – Pregabalin: Pharmacology and its use.

**6 J Vieusseux**
Major haemorrhage complicating use of the Laryngeal Mask Airway.

**7 F Sun**
Pre-operative testing: an audit of the pre-anaesthetic clinic at Shoalhaven District Memorial Hospital, and a review of the current literature and published guidelines.

**8 A Burke**
Intrathecal Morphine for Caesarean Section Analgesia – a systematic review of the literature on optimal dose, adverse effects and patient satisfaction.

**9 J Cummings**
The relationship between Tracheal Pepsin and Oxygenation in ventilated ICU patients – an observational study.

**10 P Allsop**
Peri-operative Use of Transoesophageal Echocardiography (TOE) in the Non-Cardiac Surgical Population.

**11 T Bookallil**
A pilot study to determine the relationship between Tuffier's Line and the Conus Medullaris in the Flexed Position.

**12 M Narayanaswamy**
Postoperative confusion in elderly patients using PCA: Morphine vs Fentanyl.

**13 A Chuan**
Audit of Peripartum Hysterectomies at Westmead Public and Westmead Private Hospitals and Review of Management.

**14 S Pickering**
Relationship between the Anaesthetist and the Coroner.

**15 D Duke**
The relevance of Quarter Power Allometric Scaling to Human Anaesthesia and Intensive Care.

**16 R Hackett**
Botulinum Toxin, Pharmacology and Clinical Developments – a review of the literature.

**17 K King**
5U Bolus Oxytocin at C/Section in women at risk of Atony.

**18 P Whiting**
Audit of the Acute Pain Service at Nepean Hospital. 2004 & 2005.

**19 C Padget**
Electrosurgery: a review of principles and anaesthetic implications.

**20 W Choi**
Does the use of Bupivacaine in Peribulbar Blocks increase the incidence of Prolonged Diplopia in cataract surgery patients.

**21 D Goh**
Culture-negative Endocarditis due to Houston Complex Bartonella henselae acquired in Noumea, New Caledonia.

**22 S Satchi**
Case report – types of anaesthetic options available for a patient with known Unclipped Cerebral Aneurysm in pregnancy.

**23 J Chien**
Anaesthetic technique for Aortopexy – the experience at Sydney Children's Hospital.

**24 G Millar**
Anaesthetic audit, literature review and design.

**25 C Garfinkel**
Remifentanil for Caesarean delivery under general anaesthesia – a review of the literature.

**26 B Cartwright**
Local anaesthetic wound infiltration in paedatric open appendicectomy.

**27 K Seipolt**
Pre-Hospital Emergency Thoracotomy – a case report and review of the literature.

**28 Ji Shim**
Hyponatraemia: its management and complications.

**29 C Wong**
Masters of Medicine (Clinical Epidemiology).

**30 K Hall**
Activity of rFVIIa in an Acidotic and Hypothermic Environment.

**31 J Barker-Whittle**
Epidural Test Dose survey.

**32 D Woods**
Minimising desaturation on induction of anaesthesia: A focus on the evidence for perioperative fasting policies and cricoid pressure.

**33 R Venclovas**
Case report – general anaesthesia for MRI scan in a paediatric patient presenting with severe Hypernatraemia (190 mmol/L).

# New South Wales Regional Committee

ANNUAL REPORT APRIL 2006 TO MARCH 2007 continued

**34 J Tan**
Caesarean section audit: literature review and audit design.

**35 A Dubyk**
Embolisation of laryngeal tumour into lower airway during fibreoptic intubation.

**36 M L Buenaventura**
Post Dural Puncture Headache: participation in a multinational multicentre randomised control trial, literature review and formalisation of departmental management.

**37 S Kabir**
A retrospective audit of Emergency Caesarean Sections at Liverpool Hospital over a 30 month period.

**38 R Lewin**
Anaesthetic care in Banda Aceh following the 2004 tsunami.

**39 J Mulvey**
Earthquake injuries and the use of ketamine for surgical procedures; the Kashmir experience.

**40 M Friend**
The predictive value of Anaerobic Threshold in Lung Resection Surgery.

**41 R Gupta**
A comparison of the management of post partum haemorrhage in a rural base hospital and in a metropolitan hospital including the use of Recombinant Factor Seven.

**42 S Williams**
Critical illness polyneuropathy and myopathy in pediatric intensive care: A review.

**43 N Gupta**
B-aware trial morbidity & mortality follow-up study.

**44 A Phillips**
Case report & literature review – Boerhaave's Syndrome: don't miss it.

**45 M Tey**
Survey to assess anaesthetists' opinions on partner presence during Lower Segment Caesarean Sections under general anaesthesia.

**CONTINUING EDUCATION – Dr Mark Priestley, Chairman NSWACE**

In 2006, we held two meetings in Sydney and a weekend rural meeting in Shoal Bay. We continued the popular skills update format which was included in the workshop section of each meeting. This year, we were also able to provide access via a workshop at all three meetings to the Harvey cardiac simulator. NSW ANZCA and NSW ASA—through the NSWACE committee—had been able to contribute to the purchase of this simulator, which allows training in the diagnosis and management of murmurs and relevant cardiac pathology.

The first meeting for the year on Saturday 20 May 2006, entitled 'Blood, Sweat and Tears' was held at the Menzies Hotel in Sydney. It allowed anaesthetists to be updated in the important area of transfusion medicine. The essential skills workshop at this meeting covered the use of defibrillators.

The second meeting on 12-13 August 2006, entitled 'Obstetric Anaesthesia… Labouring the Point', was held at the Shoal Bay Resort, Shoal Bay. The venue was a new one for NSWACE and proved to be extremely popular, overcoming concerns that NSWACE meetings may lose support if held further away from Sydney than the traditional venues. Such popularity has given us the confidence to run the 2007 rural meeting in Orange, which has fantastic social and conference facilities to offer those willing to go the slightly extra distance to attend. As always the obstetric content proved very popular, as did the skills update covering the management of the difficult airway. Attendees also appreciated the input from the non-anaesthetic speakers, in this case an obstetrician and a renal physician, which is a component of each meeting the NSWACE committee is keen to include where appropriate.

The final meeting of the year, entitled 'Teach Thyself – Staying Up-to-Date and Out-of-Trouble', was held at the Sydney Convention and Exhibition Centre, Darling Harbour in Sydney on Saturday, 4 November 2006. Whereas most NSWACE meetings attempt to introduce new content or refresh important existing knowledge, this meeting attempted to cover concepts of learning and self-education that would allow anaesthetists to improve their own knowledge and understanding of anaesthesia, wherever there was a deficiency. Although the attendance for this meeting was slightly lower than usual, the feedback from those who attended was very positive, suggesting that the concept was a worthwhile one. Once again, anaesthesia-related lectures were complemented by information from other areas, this time with a discussion on underperforming doctors from a member of the NSW Medical Board. There were two skills update topics included in the workshops: malignant hyperthermia and informed financial consent. The venue, being a purpose built convention centre, also proved extremely popular.

The NSWACE committee is a vibrant enthusiastic group of anaesthetists who strive to meet the continuing education needs of the NSW anaesthetic community. Its ranks were boosted this year with the addition of Stephen Barratt, who, as a member of the NSW ANZCA Regional Committee, will allow closer liaison with NSW ANZCA. The relationship of NSWACE with both ANZCA and the ASA is now very strong, and NSWACE activities continue to reflect the interests of both organisations. Suggestions for future meetings, be they about topic content, venues or social activities, are always welcome, and many of the successful recent meetings have been

generated from suggestions from NSW anaesthetists to the committee. If you have comments or suggestions please send them to **nsw@anzca.edu.au** or by mail to the ANZCA office at 117 Alexander Street, Crows Nest, NSW 2065, or alternatively contact one of the committee members directly. The current members are Mark Priestley (chair), Stephen Barratt, Michael Bennett, Tsung Chai, Richard Connolly, Catherine Downs, David Elliott, Stephen Gibson, Chris Jones, David Kinchington, Tony Padley and Leonie Waterson.

**PROFESSIONAL AFFAIRS – Dr Joanna Sutherland**

As we go to press, a state election is imminent in NSW. Traditionally the run-up to such an election has been a quiet time for Regional Committees. However the last 12 months has been a time of great activity in NSW Health in general, and for the NSW Regional Committee in particular. Some areas of activity which have required our input include the following:

**1** IMET, the Institute for Medical Education and Training, was formed from a merger of the Post Graduate Medical Council and the Medical Training and Education Council in 2005. IMET is a semi-autonomous body established under the corporations' power of the Director General of Health, and reporting to the Director General. In July 2005, the Minister for Health requested IMET undertake a review of anaesthesia training in NSW as part of a comprehensive review of specialist training in NSW. ANZCA has had representation at regular meetings with IMET, and Council has made written submissions to IMET, and met with them in October 2006. The recommendations arising from the review of training in anaesthesia are currently with the Minister. These recommendations appear likely to include the following:

**a** IMET will oversee, co-ordinate and implement anaesthesia training in NSW. ANZCA will be consulted as required to advise on curriculum content and design, and examination processes.

**b** Training networks will be developed, aligned with Area Health Service boundaries.

**c** IMET will enter into Training and Education agreements with all trainees. These will be separate to the agreements currently being designed by ANZCA for its use.

Clearly, the arrival of IMET heralds a wholesale change to the way anaesthesia training is delivered in NSW. While the proposed changes have some very clear advantages, particularly to those trainees who are currently independent of the metropolitan teaching hospital training programs, the risk for ANZCA is that it will become an advisory body, albeit with a very fine curriculum and examination system. The NSW Regional Committee is also concerned that IMET has been established, at least in part, to solve the problem of under-performing hospitals, with the aim of allowing these institutions access to 'high quality' trainees in order to improve clinical service. Our committee firmly believes that hospitals must first be appropriately resourced and staffed for training purposes, and comply with ANZCA criteria to ensure high quality training, rather than allowing trainees to be sent to under-resourced hospitals in the mistaken belief that the presence of trainees will be a 'magic bullet'.

**2** Another area where the Regional Committee has been asked to contribute has been the Sedation Working Party under the auspices of the Greater Metropolitan Clinical Taskforce. This body, driven by a small number of proceduralists, has concerns with the disparity of anaesthesia service offered between patients in public and private hospitals undergoing gastrointestinal endoscopic procedures. The NSW Regional Committee shares these concerns. The Working Party's initial solution to this problem was to suggest the establishment of a pilot trial for non-anaesthetist providers of sedation, in hospitals where anaesthesia services are under-resourced. Interestingly, such pilot trials were to be closely supervised by the anaesthetists from the same hospitals where anaesthesia services are currently under-funded or unavailable. With input from ANZCA NSW and the ASA, we are pleased that the Sedation Working Party has agreed that the 'gold standard' provision of such services is the presence of trained anaesthetists, as most commonly occurs in the private sector. Dialogue continues.

**3** More recently, NSW Regional Committee has considered the issue of accreditation for sub-specialty anaesthesia, specifically paediatric anaesthesia. In one Area Health Service, such accreditation is to become part of the appointment process. Whilst the Regional Committee is aware that such accreditation is best practice in the UK and elsewhere, we are concerned that if the accreditation becomes an overly prescriptive process, it may limit the flexibility of service provision in rural and regional centres.

**4** On Saturday 10 February, the NSW Regional Committee together with the ASA (NSW) organised a program of introduction for new trainees in anaesthesia. This was the inaugural 'Induction of Anaesthesia' Course (or Part Zero Course). Attendance was in excess of 60, including trainees with spouses or family and friends (and one baby), Department Directors and Supervisors of Training. Our aim was to address some of the more challenging areas of work-life balance, and the occupational stressors associated with a career in anaesthesia. We were addressed by a number of informative and entertaining speakers, with our keynote address given by Professor Gordon Parker, Director of the Black Dog Institute—a clinical and research facility associated with the University of NSW and specialising in mood disorders. Feedback has been positive, and we plan to make the course an annual event. I thank Tracey Tay for her effort and enthusiasm in instigating this course, and for making it such a successful and worthwhile event. Liz Feeney, representing the ASA, also provided much valuable input and support.

**5** Finally, the process of providing teams for regular hospital accreditation and Area of Need supervision continues unabated. During the year, staff and Committee members have worked tirelessly on behalf of ANZCA. I join all members of the NSW Regional Committee in thanking Jan Taylor and Annette Strauss for their commitment and professionalism, particularly with our tendency to require them to work most unfriendly hours.

As the most populous state, we had been somewhat disadvantaged until recently with no local Council member, however we are fortunate that Dr Frank Moloney, a past Chair of the NSW Committee, has seen the light and agreed to serve on Council. We are most grateful to Frank (and Kate) for his presence in Melbourne.

I would particularly like to thank all members of the Committee for their efforts and commitment, and to thank the previous Chairman, Dr Michael Jones, for his accessibility, insight and encouragement. NSW is a big place, and our Fellows are busy people. We need input at all levels if ANZCA is to continue to have a strong voice in issues affecting our region.

# Dean's message

Dr Richard Lee

## The Future

**As mooted in previous Bulletins it is time to consider the future of JFICM.**

DR RICHARD LEE

**The specialty as a whole has matured with the formation and development of powerful branches consisting of:**

- **>Databases (APD, ANZPIC, ARCCCR)**
- **>Foundation (IC Foundation)**
- **>Journals (Critical Care and Resuscitation, Anaesthesia and Intensive Care)**
- **>Research group (CTG)**
- **>Specialist society (ANZICS) and**
- **>Training body (JFICM of ANZCA and RACP)**

**Each part is integral to the whole.**

The joining of the two training bodies in 2002 has proven to be a watershed in the history of Intensive Care Medicine in our region and has led to a time of consolidation. The tribalism of years ago has dissipated with time and the joining of other dual Fellows (eg FACEMs and FRCAs) has created a group unified by its role in the ICU. The next step of development needs to be decided now.

It is time therefore to weigh up the advantages and disadvantages of forming a separate training body for the specialty and determine if there is a strong mandate for change.

By the time Fellows are perusing this message, I hope that all Fellows will have received the Discussion Paper and Survey in the mail and acted on them. These documents are phrased to provide a clear answer to a dichotomous question, but behind the necessarily bare documents exist complex circumstances, propositions and questions that require simple, decisive action and expression of opinion. The documents give the current Fellows the opportunity to have their say but the needs and desires of the trainees and the specialty, as a whole should also be considered.

Dependent on the result of the Survey, extra labour and financial support may also be required in the future.

Other options for change in the macro-structure of the Joint Faculty have not been listed so that the picture is not clouded by too many choices. But what is certain is that we should maintain strong relationships with ANZCA and RACP whatever the final decision.

Meanwhile we are not sitting at the crossroads wondering, for there is work to be done.

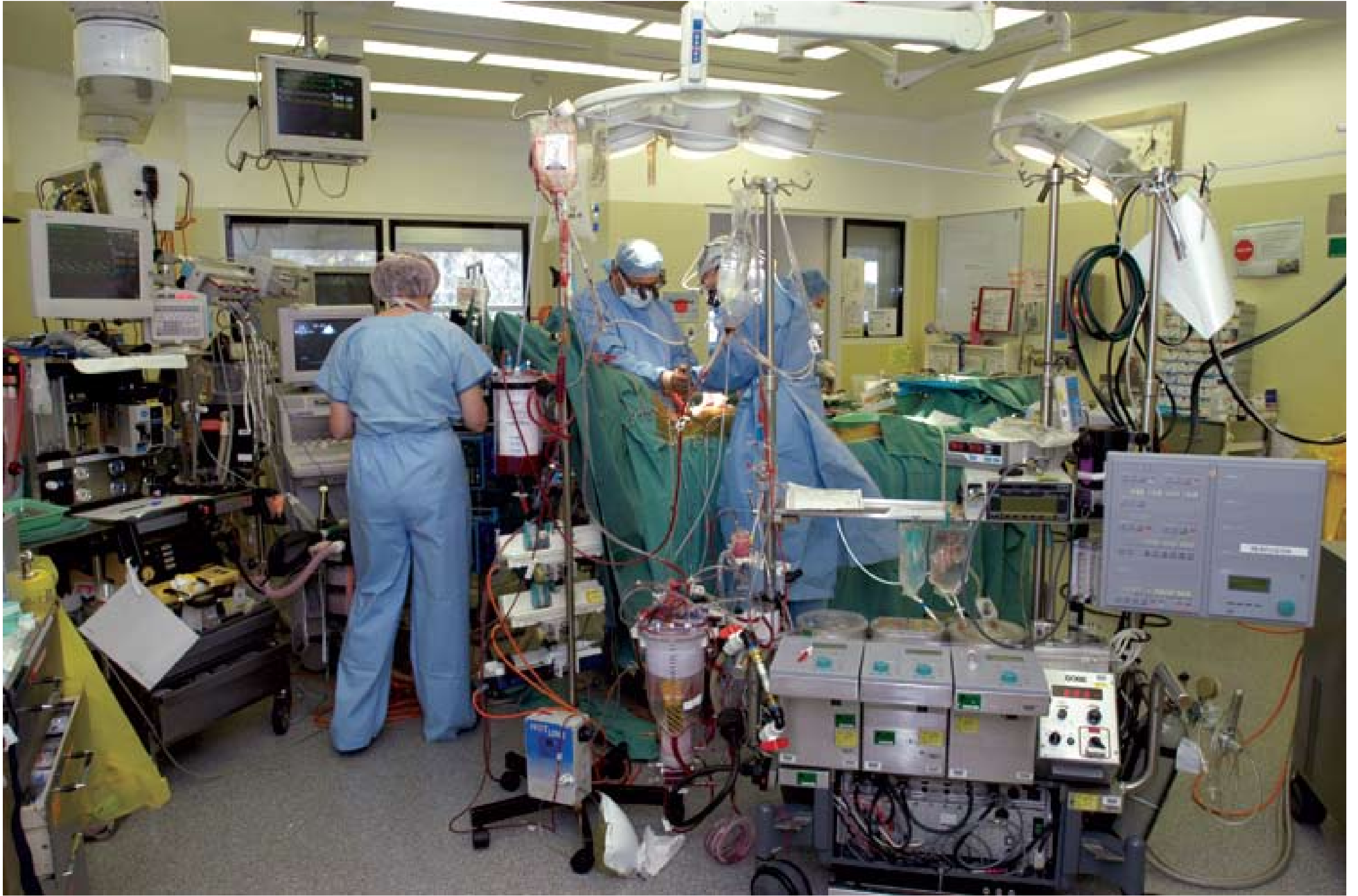
- >The Board has unanimously approved the appointment of Professor Rinaldo Bellomo as Editor of our Journal, Critical Care and Resuscitation, from 2008. He will succeed Professor Vernon van Heerden, who has performed a magnificent job raising the profile of the Journal and achieving indexation after the pioneering work of Tub Worthley.

The draft 'Objectives of Training for Basic and Advanced Training' are with Regional Committees and Supervisors for input. Once that is completed it is planned to further review our assessments and the way in which education is delivered at each stage of training.

> 'It is time therefore to weigh up the advantages and disadvantages of forming a separate training body for the specialty and determine if there is a strong mandate for change.'

- >The role of courses (ADAPT, BASIC etc) in the training program is under review.
- >As agent of JFICM, I have signed the Cooperation Agreement with ANZICS. This agreement clarifies the roles of each group and lists challenging new roles for both to share.
- >The Fellowship Examination, under the guidance of the Examination Committee, is evolving to maintain its practicality and its rigorous nature in the face of increasing numbers of candidates (>100/year). For example, OSCEs will be consolidated into the Written Papers and the Vivas. See Bala Venkatesh's article in this issue.
- >A new Continuous Professional Development program is being planned to replace MOPS. The next issue of the Bulletin will provide updates on each of these issues.

DR RICHARD LEE
Dean
Joint Faculty of Intensive Care Medicine



# JFICM ANZICS ASM 2007

## The heart of the matter

The Annual Scientific Meeting of the Joint Faculty of Intensive Care Medicine in association with the Australian and New Zealand Intensive Care Society was held at the Sofitel Wentworth, Sydney from 1-3 June 2007. The event was highly successful, with 330 delegates in attendance.

This meeting entitled the 'Heart of the Matter' featured a number of outstanding international and local speakers, all of whom I would like to thank for their exceptional contribution. The meeting featured a series of lectures and debates and focused on the spectrum of problems in intensive care, including acute heart failure, interventional cardiology, cardiac surgery and the post cardiac ICU, congenital heart disease, cardiac monitoring, echocardiography and more.

The Conference Dinner at the stunning Great Hall, University of Sydney included the presentation of New Fellows and awards as well as an oration by Dr Ron Trubuhovich.

On behalf of Dr Craig French and the Organising Committee, I encourage all Fellows and Trainees to attend the 2008 ASM. This will be held at the Sofitel Melbourne, from 30 May to 1 June with the theme 'Blood and Blood Product Usage'.

IAN SEPPELT
Convenor, 2007 ASM

Outcomes of ESRF patients
on dialysis admitted to ICU

# Highlights from the Board Meeting

JUNE 2007

## EDUCATION AND TRAINING

### Intensive Care Primary Examination

The Board noted the first Primary examination was imminent with an encouraging number of candidates enrolled. Trial exams and orals are being posted to the website to assist the first candidates.

### Intensive Care Primary Examination requirement – assessment of exemption

The Board noted a report from the Censor on the current state of exemption from the Primary Examination and its effect on training and exam results. In order to clarify the assessment of exemption a recommendation was made to the ANZCA and RACP Councils, to amend Regulation 7.4.7.3(c), thus, effective immediately.

Successful completion of a postgraduate basic training program (involving at least 3 years in addition to Post-Graduate Year 1) which is accepted by the Board as having a curriculum and assessment process which ensures that the trainee has knowledge and skills equivalent to that of a successful candidate of the JFICM basic training program including the JFICM Primary Examination.

### Ongoing development of the General Fellowship Examination

The Examination Committee report to the Board discussed issues relating to the increased number of candidates and the protection and maintenance of standards. Approximately 120 candidates will present for exams in 2007. This tests the practicality of mounting what is a labour-intensive exam.

### Development of JFICM Curriculum

The revised drafts of the 'Objectives of Basic Training' and 'Objectives of Advanced Training' were noted. The documents are being forwarded to Regional Committees and both College Education departments for comment before final acceptance.

### JFICM Trainee Committee

The Terms of Reference for the JFICM Trainee Committee were endorsed and under the chairpersonship of Dr N Blackwell (New Fellow Representative on the Board) the committee will be considering vital training issues.

### ADAPT Program for Intensive Care Specialists

The ADAPT course was discussed in terms of the Faculty's specific needs. Consideration is being given to making the course a mandatory component of Basic Training.

### Formal Project Requirements

These have been amended to require submissions be in English, and that theses are expected to have a minimum content of a single, well constructed and reported scientific study.

## PROFESSIONAL

### RACP Governance Review

The governance review is nearing completion and has resulted in a new College constitution. The next stage is the drafting of new by-laws for all RACP Divisions and Faculties. Changes will also include harmonisation of education within the Faculties and Divisions. With the appointment of Professor Kevin Forsyth as the new Dean of Education, important new educational processes are being introduced to maximise the educational experience. There will be increased support for the Faculties, SOTs and trainees to streamline the process.

### Director of Professional Affairs

The Board noted a report from the Director of Professional Affairs on current activities. These include collaboration on the two new training documents; contribution to the National Health Workforce Forum; preparation of the 'Review of C24 classifications' document for Board discussion and ongoing review of Policy documents.

### MOPS

The Board continues to closely examine adoption of a CPD program to replace MOPS, modelled on the updated ANZCA program. Changes to the on-line operation of the MOPS program were advised.

### Disaster Response Taskforce

The Board endorsed the terms of reference of the Taskforce, which met at the ASM. It will provide expert opinions and guidelines on ICU involvement in mass casualty and chemical/biological/radiation situations.

### ANZICS Statement on Death and Organ Donation

The Society's 3rd edition of the document is due for publication soon with an official launch in October.

### ANZICS Intensive Care Echocardiography Committee

The Committee has prepared a guidelines document for 'Intensive Care Echocardiography' which has now been ratified.

### Travelling Scholarship

The Board is exploring a proposal to award a 'travelling scholarship' to a neighbouring developing country, in conjunction with ANZICS.

## RESEARCH

### CTG

The Board noted that Professor D Jamie Cooper is the new Chair of the ANZICS Clinical Trials Group.

### Intensive Care Foundation

The Board noted the proposed changes to the Intensive Care Foundation which would see the JFICM Dean and ANZICS President invited to be Foundation directors for their term of office.

## CONTINUING EDUCATION

### Annual Scientific Meetings

The JFICM ASM 2007 was very successful with increased attendance and support over previous years. The next JFICM ASM is 30 May to 1 June 2008 and is being held in Melbourne. Dr C French is the appointed convenor. JFICM sessions contributed to the scientific program of the ANZCA ASM in May 2007 and will again participate in the 2008 meeting.

An invitation from RACP to participate in the International Congress of Internal Medicine in March 2010 has been accepted.

## INTERNAL

### Amendment to Regulations

The Board approved amendments to Regulations pertaining to the Formal Project and Primary Examination exemptions.

### Staff changes

Larraine Bamford and Lisa Davidson recently commenced working at the Faculty office; Larraine in the position of Administration Officer – Training and Examinations and Lisa, Administrative Assistant.

# Eligibility for Advanced Training – Amendment to Regulation 7.4.7.3 (c)

**At its recent meeting, the Board of Faculty considered an amendment to the Regulations for Training, relating to eligibility for Advanced Training, and exemption from the requirement to complete a suitable Primary Examination.**

**This amendment was introduced in view of the establishment of the JFICM Primary Examination, and the difficulty in applying exemptions to trainees from diverse range of overseas backgrounds now registering with the Joint Faculty. Regulation 7.4.7.3 (c) has been amended and now reads:**

Successful completion of a postgraduate basic training program (involving at least 3 years in addition to Post-Graduate Year 1) which is accepted by the Board as having a curriculum and assessment process which ensures that the trainee has knowledge and skills equivalent to that of a successful candidate of the JFICM basic training program, including the JFICM Primary Examination.

Thus Regulation 7.4.7.3 now reads as follows and is effective as of 1 September 2007:

**7.4.7.3** Eligibility for Advanced Training and presentation for the Fellowship Examination will be dependent upon candidates having achieved one of the following:

**(a)** Success at the JFICM or ANZCA Primary Examination.

**(b)** Basic physician training and success at the RACP Written and Clinical (adult or paediatric) examinations.

**(c)** Successful completion of a postgraduate basic training program (involving at least three years in addition to Post Graduate Year 1) which is accepted by the Board as having a curriculum and assessment process which ensures that the trainee has knowledge and skills similar to that of a successful candidate of the JFICM basic training program including the JFICM Primary Examination.

The Examination must be passed during the BTYs or in some circumstances, ATY1, before training progression. Exemptions will be granted for the purposes of intensive care training only.

C J CUNNINGHAM-BROWNE
Executive Officer

# AMENDMENT

## TO JFICM REGULATIONS

**Intensive Care Primary Examination requirement – assessment of exemption**

The Board has recommended to the respective Colleges that Regulation **7.4.7.3(c)** be amended thus:

**7.4.7.3 (c)** Successful completion of a postgraduate basic training program (involving at least 3 years in addition to Post-Graduate Year 1) which is accepted by the Board as having a curriculum and assessment process which ensures that the trainee has knowledge and skills equivalent to that of a successful candidate of the JFICM or ANZCA Primary Examination or RACP basic training ~~and examination basic training program including the JFICM~~ Primary Examination.

**Amendment – Formal Project**

**7.4.9** To satisfy the requirements of advanced training, a Formal Project must be completed by all Joint Faculty of Intensive Care Medicine (JFICM) trainees, as detailed in the document 'Formal Project Requirements'. Trainees completing this requirement will be eligible for consideration of the award of the Felicity Hawker Medal (refer Regulation 15).

**Amendment – The Felicity Hawker Medal**

This Regulation has been updated to clarify the requirements for the award. The Board amended Regulation 15 as follows:

**15. THE FELICITY HAWKER MEDAL**

The Felicity Hawker Medal was established in 2004 to honour Dr Felicity Hawker, inaugural Dean of the Joint Faculty of Intensive Care Medicine. It is awarded to the Trainee, or Fellow within 1 year of award of the Diploma of Fellowship, who is judged to make the best contribution at the Formal Project Session held as part of the Annual Scientific Meeting.

15.1 The Felicity Hawker Medal will be awarded to the Trainee, or Fellow within 1 year of award of the Diploma of Fellowship, who is judged to make the best contribution at the Formal Project Session held as part of the JFICM/ANZICS Annual Scientific Meeting (ASM).

15.2 Eligibility for the Prize will be limited to current or past JFICM-registered trainees presenting material related directly to their Formal Project Report.

15.3 Application to present at the Formal Project Session must be accompanied by an abstract of the material to be presented. The Formal Project Report must be submitted for evaluation at least one month prior to the scheduled date of presentation. Whilst all criteria for submission of the Report apart from the presentation (clause 2.5) must be met, it is not essential that the Project Report has been fully assessed and accepted prior to application.

15.4 The Board shall, from time to time, appoint three adjudicators for the Prize in addition to the Chairman of the Education Committee who will Chair the Adjudication Panel. This task may be delegated to the Chairman of the JFICM/ANZICS ASM Committee. Adjudicators may co-opt additional adjudicators at the ASM should one or more of the appointed adjudicators be unable to attend.

15.5 If, in the opinion of the adjudicators, no presentation attains a sufficiently high standard, the Medal will not be awarded.

15.6 If necessary, the ASM Scientific Convenors will pre-select presentations for the Formal Project Session on the basis of the submitted abstracts. A ten minute presentation, followed by five minutes of questions, will form the basis on which each entry for the Medal is considered by the adjudicating panel. The presentation must be based on the material submitted in the trainee's Formal Project Report.

# Changes to the Fellowship Examination effective from 2008

For the attention of Fellows, Supervisors of Training and Trainees

**Two major changes to the General and Paediatric Fellowship Examination will come into effect from 2008.**

## 1. CHANGES TO THE STRUCTURE AND FORMAT OF THE EXAMINATION

At a recent meeting of the Examinations Committee and Board, it was decided to change the structure and format of the Fellowship Examination. Essentially the changes involve:

**a**) Merger of the Written Section with unmanned components of OSCEs;

**b**) Merger of some of the manned OSCEs with the Viva day;

**c**) Increasing the emphasis on the clinicals (with incorporation of clearer assessment process into the ICU cases, for those skills previously examined in cold cases); and

**d**) Reduction of the duration of the exam.

The following resolutions have been approved and will apply from the April/May 2008 sitting to both the General and Paediatric Fellowship Examinations.

**1** That the Written Section incorporate the non-manned component of the OSCE Section.

**2** That the Written Section comprise two papers of Short Answer Questions, and include data analysis and interpretation, monitoring and equipment.

**3** That a pass of 50% or more in the Written Section is required in order to be invited to the Oral Section.

**4** That the Procedure and Communication stations of the OSCE Section be incorporated into the Viva Section which would then be comprised of eight stations.

**5** That the Clinical Section comprise two ICU cases of 20 minutes duration each, and that the two cold cases be removed.

**6** The distribution of marks be as follows:
- Written Section (30 marks)
- Viva Section (40 marks)
- Clinical Section (30 marks).

**7** That the pass criteria will be:
- A minimum of 50% or greater total mark
- A fail in not more than one section
- A score of 40% or greater in the clinical section.

## 2. REQUIREMENT FOR COMPLETION OF FORMATIVE ASSESSMENTS BEFORE APPLYING TO SIT THE FELLOWSHIP EXAMINATION

To optimise candidate preparation for the Clinical Section of the Fellowship Examination, the Board has resolved that Supervisors of Training (SOT) or their nominees should ensure that candidates have been formatively assessed performing four (4) 'Clinical Cases', including clinical examination, presentation of findings and an appropriate management plan in an examination type setting prior to presenting for the Fellowship Examination.

Therefore the Board has resolved, that as from 2008:

In the six months prior to the closing date for the Fellowship Examination, each candidate should be certified by a SOT or nominee as having been formally assessed on four separate ICU cases. Documentary evidence of this should be submitted along with the application form. The candidate should perform an observed clinical assessment of a critically ill patient in a critical care facility; present their clinical findings to 'the assessor' with an appropriate discussion of relevant management issues (suggested time = 20 minutes). An additional 10 minutes should then be set aside after each case to provide the candidate with feedback regarding their performance and allow for relevant discussion regarding the clinical scenario.

For candidates who are unsuccessful in the Fellowship Examination:

>Recertification of completion of four formative cases is required for each attempt at the Fellowship Examination.

>Application to sit the Fellowship Examination will not be accepted without documentary evidence of completion of the formative assessments.

This requirement will also apply to OTS assessment.

B VENKATESH
Chair, Examinations

# Development of Objectives of Training and Competencies for Basic and Advanced Training in Intensive Care Medicine

**Over the last six months, new 'Objectives of Training and Competencies' for Basic Training and Advanced Training have been developed as part of a major curriculum review. These Objectives have been distributed to Regional Committees and Supervisors of Training for comment.**

The establishment of clear and comprehensive updated Objectives of Training and Competencies, particularly for Basic Training, is important for many reasons including:

**1** Increasing numbers of trainees are doing single JFICM training and therefore need a useful Basic Training program with aims, teaching and assessment before transit into Advanced Training. The JFICM program was originally designed as a post-Fellowship program for anaesthetists and physicians who had completed other training.

**2** The diverse origins of trainees make it difficult for the Censor to accurately assess prior training, particularly overseas training, for movement of trainees into Advanced Training. Clear objectives provide standards for assessment.

**3** It is currently possible for trainees to move into Advanced Training without relevant skills, attitudes and qualities and with limited ICU experience.

**4** Supervisors of Training have highlighted the lack of preparedness of trainees for Advanced Training, particularly those coming from overseas.

**5** Often the Fellowship Examination is relied on too heavily to filter trainees and drive learning. This can concentrate the trainees' awareness of the program in their final years only and may overly distract them during their two years of Core Training.

**6** The Fellowship exam is becoming increasingly difficult to mount because of its labour intensity due to multiple exposures and multiple assessment modes, its otherwise inherent strengths. The aim is not to de-emphasise the Exam, but to engage the trainees with courses, active teaching and preparation throughout their training rather than a rush at the end of training.

**7** Course organisers have noted that trainees are leaving acquisition of essential ICU skills to the last weeks before the Exam and rely on courses to intensively train themselves.

**8** It will only be possible to build new teaching and assessment processes (ie. blueprinting) for Basic and Advanced Training once we have clarified the specific aims of each stage of training.

The next stage in curriculum development —once the Objectives of Training and Competencies are finalised—will be incremental linking of educational endeavours (courses, simulations) and assessment (ITAs, e-tests, exams) to the Objectives of Training and Competencies. The aim will be to ensure that those trainees a) completing Basic Training (BT) and entering Advanced Training (AT) have the skills to benefit from the limited two core Advanced Training years of training, ie. basic sciences knowledge, professional qualities, early ICM experience; and b) that those trainees completing training have achieved a safe level of independent practice in the many facets of intensive care medicine. Inherent in this is the concept that they are not 'the finished product', but have gained the skills to continue to grow and learn whilst maintaining safe practice.

R P LEE
Dean
P T MORLEY
Education Officer

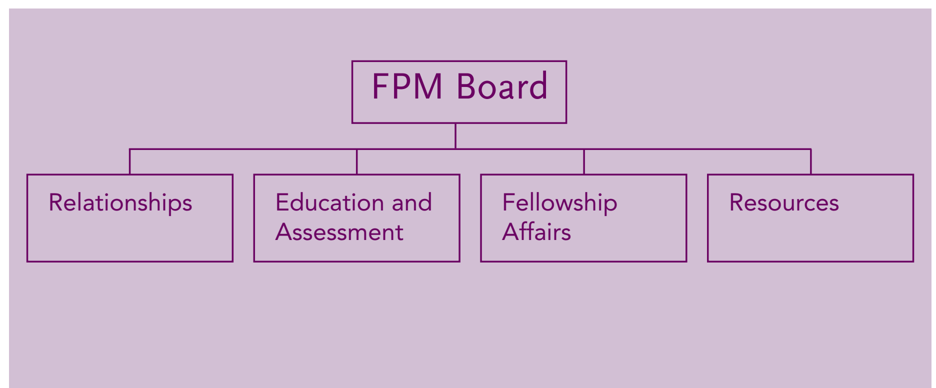
# Dean's message

Dr Roger Goucke

DR ROGER GOUCKE

## What can the Faculty do for Fellows?

**The College and Faculties quite rightly spend a lot of time focusing on the needs of Trainees, for example in our, examination, training and accreditation committees. The Faculty, though, is made up mainly of Fellows. So what does the Faculty do for Fellows? This question has been asked several times at Board level and following the Strategic Planning Meeting last year, a decision was made to restructure the Board so that there would be a specific focus on Fellows. To this end, following the AGM of the Faculty in May 2008, it is proposed that the Board have four committees:**




The Board is confident that this will maintain a focus on our Fellowship. Currently the ASM and Refresher Course Day are the major educational initiatives that attract Fellows. This year sees the inaugural Spring Meeting in Queensland and in 2008 there will be a Spring Meeting in association with the Acute Pain Special Interest Group (SIG) of ANZCA/ASA and very likely the Acute Pain SIG of IASP.

The Faculty website contains many useful resources and I would urge Fellows to explore this site. Recent educational documents such as Childhood Maltreatment and Chronic Pain In Adult Life; Cognitive Behaviour Therapy For Persisting Pain; Psychosocial Assessment of Patients with Chronic Pain; Epidemiology; The Use Of 'Off-Label' or Drugs Beyond License In Pain Medicine and The Conduct Of Diagnostic Cervical And Lumbar Medial Branch Blocks are available. The College Library now has many online journals both of a general and pain specific nature.

Many Fellows will be aware that the IASP nominated Pain in the Older Person for 2006-2007 year. Next year will be declared for Pain in Women. This is a much neglected area and it is hoped that a joint collaboration with our colleagues in the Royal Australian and New Zealand College of Obstetricians and Gynaecologists can develop educational documents on pelvic pain.

Those of you who participated in the workshops at RACS at the Melbourne ASM demonstrated significant enthusiasm for outcomes based assessment tools. The Research Committee has plans to deliver these and updates on progress will be available in Synapse.

The Education and Training committee is developing a suite of patient education leaflets, which should be of value for Fellows and our patients.

Following the extensive and ultimately successful application to the Australian Medical Council and the Federal Government for recognition of Pain Medicine as a medical specialty in Australia, an application to the Medical Council of New Zealand is underway.

Continuing Professional Development (CPD) is an area which often polarises medical practitioners including some Fellows! We must all accept our responsibility to keep up to date and ensure our practice can stand up to scrutiny. Increasingly CPD is being mandated by regulatory authorities, for example, the NSW Medical Board and the Medical Council of New Zealand.

The Board of this Faculty, in 2004, mandated CPD as a requirement for our Fellowship with the understanding that we should be strongly encouraging Fellows to participate while leaving any enforcement role to the regulatory authorities. A recent audit of 5% of Fellows has shown pleasing results. (It is anticipated that when National Registration is introduced in Australia that CPD will be mandated.)

ANZCA has recently completely redesigned its MOPS program under Professor Teik Oh's direction and rebadged it as a CPD program.

The Board has reviewed and endorsed this program and urges Fellows to use it in order to demonstrate their undoubted commitment to Continuing Professional Development. The ANZCA documents have been edited and now fit the style of a Pain Medicine Practitioner and are available on the Faculty website.

Fellows are not obliged to use the FPM program and can use the program offered by their primary specialty College or any of the specialty societies.

The Faculty has adopted the journal, *Pain Medicine*, as our official journal, which it shares with the American Academy of Pain Medicine. Fellows will be pleased to note the steady rise in the Impact Factor of this journal which now exceeds that of *Anesthesia and Analgesia, Spine*, and the *Journal of Pain and Symptom Management*. I think this reflects the interdisciplinary nature of this journal and the wide audience it is reaching.

I have described some of the Faculty's achievements directed primarily for Fellows. We are a young and vibrant Faculty with many exciting challenges ahead of us. The more Fellows we can engage in our activities, the more we will be able to do.

ROGER GOUCKE
Dean

# Highlights from the Board Meetings

Held on 24 and 27 May and 20 August 2007

**The Faculty Board met on 24 May and 20 August to transact usual business; the 'new' Board met on 27 May for the purpose of appointing office-bearers and committees.**

## BOARD

Dr Geoff Booth retired from the Board, one year short of completing his three year term. Dr Chris Hayes, Director of the Hunter Integrated Pain Service, Newcastle, has been co-opted to complete Dr Booth's term.

Dr Kerry Brandis replaced Professor Garry Phillips as the Council's nominated representative to the Board. Drs Hayes and Brandis were welcomed to the Board.

## FELLOWSHIP

In May, four Fellows were admitted to Fellowship by training and examination and one by Alternate Pathway. Dr Anthony Espinet, FRCA (Qld) was admitted to Fellowship by Election.

## CENSOR ISSUES

There was extensive discussion of overseas trained doctors/overseas trained specialists and the Faculty's training program. Administrative Instructions (AIs) are being developed, however, because of the complexity of assessing five medical specialty groups, it has been agreed that the assessment of an overseas specialty qualification's comparability be assessed by the respective colleges and Faculty. Admission to the training program will be permitted. Individuals may take the Faculty examination, as with Australian Trainees. Successful candidates in the examination will be given a certificate similar to that given by ANZCA to successful candidates in the ANZCA second part examination, acknowledging that they have satisfied the examination requirements: AI 6.7. Admission to Fellowship will require acknowledgement from the relevant founding College that the candidate is of an equivalent status to one of their own Fellows. IMGs will need to meet all other Faculty requirement for Fellowship by examination and training.

## FINANCE

Management Reports to 30 June 2007 were accepted. A number of initiatives planned for 2008 will be included in the budget bid for 2008, which is required by September.

The Board resolved in May that Fellows paying a full subscription to their primary specialty but not practising any Pain Medicine be eligible for a 50% concession on their Faculty subscription for that year.

## EDUCATION AND TRAINING

### Educational Documents

Three educational documents were accepted for promulgation and are now available on the Faculty's website:

**The Use of 'Off Label' or Drugs Beyond Licence in Pain Medicine**

**Conduct of Diagnostic Cervical and Lumbar Medial Branch Blocks**

**Guidelines on Continuous Quality Improvement**

### FPM Training Program

The Board considered a draft Training Agreement and draft Trainee Performance Review, adapted from the recently developed ANZCA documents. These documents will be further revised and reconsidered at the October Board Meeting. A Trainee newsletter is under development.

### Supervisors of Training

A Supervisor of Training Workshop was convened during the ASM in Melbourne focusing on the Examination, including examination failure, Case Reports and developing a Mini Clinical Exercise to give trainees guidance on how to talk to patients on neuropathic pain. The Faculty is keen to support SoTs further with a second workshop for 2007 to be held in conjunction with the Spring Meeting.

### MCQs for College Exams

A small bank of MCQs has been finalised for circulation to participating Colleges for use.

### AAPM and Pain Medicine Journal

The FPM Senior Editor, Prof Colin Goodchild presented a report to the August Board Meeting which will be published in Synapse. Pain Medicine Abstracts from the ASM are in press. A section on Pain in the Elderly has been created and Fellows with expertise in this area are encouraged to contribute.

The benefits of the association with the journal were acknowledged. Opportunities for further liaison with the AAPM are to be explored with the possibility of a joint meeting in Hawaii in 2009.

### Continuing Professional Development

The revised ANZCA/FPM CPD Program will be launched in January 2008. Documentation associated with the new CPD Program is available on the website. An audit of 5% of the Fellowship, randomly selected, has been undertaken. Those selected will be required to submit a copy of their 2006 annual return and supporting documentation.

The Faculty is investigating an institutional subscription to the Royal College of Psychiatrists (UK) online CPD learning modules.

### Objectives of Training and Reading List

An updated document is in the final stages of revision. The Reading List will focus on 'landmark' articles that changed Pain Medicine practice.

**Blueprinting**

A workshop with multidisciplinary representation was convened to progress the development of a blueprint; a document that clearly outlines and links the educational objectives of the Fellowship program to assessment. The workshop was facilitated by Professor Brian Jolly, Director; Centre for Medical and Health Science Education, Monash University. The process is expected to take approximately 12 months.

**Acute Pain**

The Board wishes to focus on not only chronic pain medicine but also acute pain medicine. To this end, a number of initiatives will be advanced over the next twelve to eighteen months. These will involve; a closer liaison with ANZCA's Hospital Accreditation Committee and the Faculty's Training Unit Accreditation Committee, offering a closer involvement with Module 10, perhaps through the Supervisor's of Training network; holding the 2008 Faculty Spring Meeting in association with the ANZCA Acute Pain SIG and supporting Dr Pam Macintyre as Chair of the Acute Pain Management: Scientific Evidence 3rd Edition.

## EXAMINATION

Four new examiners were appointed. The dates for the 2007 examination were confirmed as 28-30 November, however the examination will now be held in Geelong, Victoria. The closing date for applications is 12 October. The pre-examination workshop was confirmed as 28-29 September at the Royal Adelaide Hospital.

## TRAINING UNIT ACCREDITATION

In May, the Bayside Pain Service: Caulfield Pain Management and Research Centre and Alfred Anaesthesia was accredited for pain medicine training. This takes the number of accredited units to 22. Five units are due for re-accreditation before the end of the year.

The Victorian Pain Medicine Training Rotation has been established and positions filled to mid 2008.

## RESEARCH

A Dean's Prize/FPM Free Papers session was held during the ASM, concurrently with the Gilbert Brown Prize session, however the inaugural Dean's Prize was not awarded in 2007. As a result of the general high quality of Free Papers presented, the Research Committee have subsequently recommended that, should sufficient papers be submitted, the Faculty hold a Dean's Prize Session and a Free Papers Session, to be run consecutively.

The Faculty, in conjunction with the APS and ASCEPT, will participate as a section society in the Australian Health and Medical Research Congress in Brisbane in November 2008.

## PROFESSIONAL

**Intercollegiate Relationships**

Draft MoUs have been circulated to the participating colleges with the aim of engaging at a committee level, where appropriate, and improving communications. Responses have been positive and MoUs and activities to promote these aims will be progressed. Links with the Australasian Chapter of Addiction Medicine, including opportunities for reciprocal training will also be explored.

Liaison with the Australian and New Zealand Pain Societies continues through teleconference meetings and joint initiatives, including a meeting with the federal Minister for Ageing and for the Global Year against Pain in the Older Person.

**Welfare of Pain Physicians**

A document on Pain Medicine Practitioners and Wellbeing was accepted for publication on the web for feedback from Fellows.

**Opioid Prescribing**

The Faculty presented information to the Victorian Parliament's inquiry into misuse/abuse of benzodiazepines and other pharmaceutical drugs. The interim report of that committee has focused on proscriptive and legislative areas with only a limited view on educational activities. The Faculty feels that, as this is not only a Victorian issue, that there will be scope to call for a national working group to address some of the problems raised.

## CONTINUING EDUCATION

**2007 ASM Melbourne and Refresher Course Day**

The Faculty's 2007 Annual Scientific Meeting in Melbourne was a great success and the satellite Refresher Course Day had a record attendance. A highlight of the ASM program was the Sunday afternoon rotating series of lectures, workshops and simulations held at the RACS, which focused on neurosurgical and anaesthetic interventions for chronic pain and development of development of key outcome indicators for chronic pain. Abstracts and slides from these meetings can be viewed on the Faculty Website:
www.anzca.edu.au/infocentres/asm2007/index.htm
www.fpm.anzca.edu.au/meetings/arc07.htm

**Inaugural Spring Meeting 12-14 October 2007**

Organisation of the Faculty's inaugural Spring Meeting, in conjunction with the Medico-Legal Society of Queensland is well advanced. A registration brochure was circulated with the June Bulletin.

**Spring Meeting 2008**

The 2008 Spring Meeting will be held in conjunction with the ANZCA/ASA Acute Pain SIG and almost certainly with the IASP Acute Pain SIG. The meeting will be held at the Uluru Meeting Place, Ayers Rock Resort on 19-21 September. The theme will be Acute Pain and will focus on the wide interaction between Acute and Persistent pain.

## CORPORATE AFFAIRS

Following on from the Faculty's Strategic Planning Meeting late in 2006, the Board began considering a proposal to restructure the Board; the focus being to have four major groupings namely; Relationships, Education and Assessment, Fellowship Affairs and Resources. The new structure will take effect from May 2008.

**Delegations Document**

The Council of ANZCA has agreed to delegate certain powers and functions to the Faculty of Pain Medicine, the delegations document was accepted by the Board.

**Regional Committees**

The Board endorsed the formation of a FPM Queensland Regional Committee and the appointment of the interim Chair and other appointed Members. Fellows in other regions are encouraged to form Regional Committees.

**2008 Board Election**

There will be four vacancies for election/re-election. A call for nominations will be circulated in December.

**Visitors to the Board**

In May, Professor Napier Thomson, President RACP, met with the Board and outlined details of recent constitution changes at the RACP which had been accepted at their recent AGM.

Opportunities for collaboration, particularly with regard to educational issues and the opportunity to incorporate pain into RACP assessment processes. There was agreement to formalise an arrangement to ensure continuity in the longer term.

In August, Mr John Biviano, ANZCA Director of Policy, met with the Board to discuss opportunities for involvement of this new role in supporting the Faculty in its efforts to raise the profile of the Faculty, develop regional and jurisdictional relationships and to promote initiatives through the appropriate mechanisms that the Faculty feels would benefit the community.

**BOARD MEMBERS/ANZCA COMMITTEES:**

**Board Members/Officers:**

Dean Dr Roger Goucke

**Vice Dean / Chairman Examination Committee**

Dr Penelope Briscoe

**Censor**

Dr David Jones

**Assistant Censor**

Dr Carolyn Arnold

**Chairman Education and Training**

Prof Ted Shipton

**Chairman Training Unit Accreditation Committee**

Dr Brendan Moore

**Chairman Research Committee**

Dr Carolyn Arnold

**Treasurer**

A/Prof Leigh Atkinson

**CPD Officer**

A/Prof Milton Cohen

**Member**

Dr Frank New

**Co-opted Member**

Dr Chris Hayes

**Co-opted Member representing ANZCA**

Dr Kerry Brandis

**ASM Officer**

Prof Stephan Schug (non Board Member)

**Senior Editor Pain Medicine**

Prof Colin Goodchild (non Board Member)

**EXAMINATION COMMITTEE:**

**Chair**

Dr Penelope Briscoe

**Deputy Chair**

Dr Ray Garrick

**Dean (ex officio)**

Dr Roger Goucke

**Chairman Education and Training Committee**

Prof Ted Shipton

**Members:**

**RANZCP**

Dr Frank New
Prof George Mendelson

**AFRM (RACP)**

Dr Carolyn Arnold

**RACS**

A/Prof Leigh Atkinson

**RACP**

A/Prof Milton Cohen
Prof Robert Helme

**ANZCA**

Dr Meredith Craigie

**New Fellow Representative**

Dr Eric Visser

**EDUCATION AND TRAINING COMMITTEE:**

**Chair**
Prof Ted Shipton

**Dean (ex officio)**
Dr Roger Goucke

**Chair Examination Committee**
Dr Penelope Briscoe

**Members:**

**ANZCA**
Dr Jane Trinca
Dr Paul Wrigley

**RACP**
A/Prof Milton Cohen
Dr Michael Butler

**RANZCP**
Dr Faizur Noore
Dr Frank New

**RACS**
A/Prof Leigh Atkinson
Prof Peter Teddy
Dr Owen Williamson

**BDSc**
Dr Mina Borromeo

**ASM Officer**
Prof Stephan Schug

**Supervisor, SoTs**
Dr Tim Semple

**New Fellow Representative**
Dr Mark Schutze

**Director of Education, ANZCA**
Dr Russell Jones

**TRAINING UNIT ACCREDITATION COMMITTEE:**

**Chair**
Dr Brendan Moore

**Dean**
Dr Roger Goucke

**Censor**
Dr David Jones

**Chair, Examination Committee**
Dr Penelope Briscoe

**Chair, Education and Training Committee**
Prof Ted Shipton

**Members:**

**ANZCA**
Dr David Gronow
Dr Melissa Viney

**AFRM (RACP)**
Dr Carolyn Arnold

**New Fellow Representative**
Dr Pauline Waites

**RESEARCH COMMITTEE:**

**Chair**
Dr Carolyn Arnold

**Dean**
Dr Roger Goucke

**Members:**

**RACP**
Dr Anthony Schwarzer
Prof Robert Helme

**ANZCA**
Prof Stephan Schug
Dr Julia Fleming
Dr Chris Hayes
Dr Tim Pavy
Dr Malcolm Hogg

**AFRM (RACP)**
Dr Dianne Pacey
Dr Guy Bashford

**MBBS,PhD**
A/Prof Philip Siddall

**Univ of Adelaide (non Fellow)**
Prof Andrew Somogyi

**Univ of Qld (non Fellow)**
Prof Maree Smith

**Senior Editor, Pain Medicine Journal**
Prof Colin Goodchild

**REPRESENTATION ON ANZCA COMMITTEES:**

**Primary Examination**
Dr Penelope Briscoe

**General Examinations**
Dr Penelope Briscoe

**Education**
Prof Ted Shipton/ Dr Jane Trinca

**CE&QA**
A/Prof Milton Cohen

**Communication and Fellowship Affairs**
A/Prof Leigh Atkinson

**ASM Scientific Convenor 2008**
Dr Charles Brooker

**ASM**
Prof Stephan Schug

**Research**
Dr Carolyn Arnold

**ACECC**
Dr Jane Trinca

**Clinical Trials Group**
A/Prof Philip Siddall

**Library**
Dr Pam Macintyre

**Clinical Indicators Working Party**
Dr Paul Wrigley

**OTS**
Dr David Jones

**REGIONAL COMMITTEES:**

**Queensland**
Dr Brendan Moore

**New South Wales**
Dr K E Khor

**Victoria**
TBC

**Tasmania**
Gajinder Oberoi

**South Australia**
TBC

**Western Australia**
Dr Roger Goucke

**New Zealand National Committee**
Dr David Jones

**EXTERNAL COMMITTEES & ORGANISATIONS:**

**Australasian Anaesthesia**
Dr Robyn Campbell

**Neuroscience Trials Australia (NTA)**
Prof Robert Helme

# FACULTY OF PAIN MEDICINE PROFESSIONAL DOCUMENTS

| | | |
|---|---|---|
| **PM1** | (2006) | Policy for Trainees Seeking Faculty Approval of Programs for Training in Multidisciplinary Pain Medicine |
| **PM2** | (2005) | Guidelines for Units Offering Training in Multidisciplinary Pain Medicine |
| **PM3** | (2002) | Lumbar Epidural Administration of Corticosteroids |
| **PM4** | (2005) | Guidelines for Patient Assessment and Implantation of Intrathecal Catheters, Ports and Pumps for Intrathecal Therapy |
| **PM5** | (2006) | Policy for Supervisors of Training in Pain Medicine |
| **PM6** | (2007) | Guidelines for Longterm Intrathecal Infusions (Analgesics/Adjuvants/Antispasmodics) |
| **PS3** | (2003) | Guidelines for the Management of Major Regional Analgesia |
| PS38 | (2004) | Statement Relating to the Relief of Pain and Suffering and End of Life Decisions |
| **PS40** | (2005) | Guidelines for the Relationship Between Fellows and the Healthcare Industry |
| **PS41** | (2007) | Guidelines on Acute Pain Management |
| **PS45** | (2001) | Statement on Patients' Rights to Pain Management |
| **PS48** | (2003) | Statement on Clinical Principles for Procedural Sedation |
| **PS49** | (2003) | Guidelines on the Health of Specialists and Trainees |

**ANZCA Professional Documents adopted by the Faculty:**

| | | |
|---|---|---|
| **PS4** | (2006) | Recommendations for the Post-Anaesthesia Recovery Room (Adopted February 2001) |
| **PS7** | (2003) | Recommendations on the Pre-Anaesthesia Consultation (Adopted November 2003) |
| **PS8** | (2003) | Guidelines on the Assistant for the Anaesthetist (Adopted November 2003) |
| **PS9** | (2005) | Guidelines on Conscious Sedation for Diagnostic, Interventional Medical and Surgical Procedures (May 2002) |
| **PS10** | (2004) | The Handover of Responsibility During an Anaesthetic (Adopted February 2001) |
| **PS15** | (2006) | Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery with amendment to the title to read Recommendations for the Perioperative Care of Patients Selected for Day Care Procedures (Adopted February 2001) |
| **PS18** | (2006) | Recommendations on Monitoring During Anaesthesia (Adopted February 2001) |
| **PS20** | (2006) | Recommendations for Responsibilities of the Anaesthetist in the Post-Operative Period (Adopted February 2001) |
| **PS31** | (2003) | Recommendations on Checking Anaesthesia Delivery Systems (Adopted July 2003) |
| **T1** | (2006) | Recommendations on Minimum Facilities for Safe Anaesthesia Practice in Operating Suites (Adopted May 2006) |

# AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

ABN 82 055 042 852

# PROFESSIONAL DOCUMENTS

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

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

# PS43

(2007)

## STATEMENT ON FATIGUE AND THE ANAESTHETIST

### INTRODUCTION

The provision of anaesthesia requires a high level of knowledge, sound judgement, fast and accurate responses to clinical situations, and the capacity for extended periods of vigilance.

In the interests of patient safety, it is important that anaesthetists are aware of the following principles and their responsibilities in respect of working while fatigued.

### PRINCIPLES

1. Fatigue has been demonstrated to impair vigilance and accuracy of response[1,2,3]. Decreased performance of motor and cognitive functions in a fatigued anaesthetist may result in impaired judgement, late and inadequate responses to clinical changes,[4,5,6,7] poor communication and inadequate record keeping. The decrement in cognitive psychomotor performance after 17 hours of sustained wakefulness is equivalent to the performance impairment observed with a blood alcohol level of 0.05%, and after 24 hours to a blood alcohol level of 0.1%[8].
2. Fatigue may contribute to adverse events and critical incidents[9,10]. In other industries these have been shown to be commonest in a bimodal distribution between 0300 and 0700 and between 1300 and 1600, when circadian drowsiness is greatest[2,11].
3. Adults require (on average) eight hours of sleep each night (range 6-10 hours)[2]. Fatigue will occur with sleep debt; this sleep debt is cumulative and does not dissipate. Short sleep nights (4 - 6.5 hours) are associated with a cumulative impairment in the performance of psychomotor tasks requiring vigilance[12]. Sleep efficiency decreases with increasing age[11]. Ageing reduces the capacity to recover from fatigue[13].
4. Many individuals find it difficult to reset their body time clocks to allow for effective daytime sleep after night duties. Daytime sleep is typically shorter and of inferior quality compared with sleep at night[13]. Minimising the effects of night-time shift work may be achieved by taking a two hour afternoon sleep prior to the night duty, taking a 20-30 minute nap during the duty time, ensuring proper meals, and sleeping as soon as possible after the duty[14].
5. Individuals are often unable to recognise fatigue and their reduced capacity to continue working safely[13,15,16]. "Microsleeps", a sign of extreme fatigue, may be equally unrecognised[17].
6. Use of caffeine and other stimulants is an attempt to combat rather than to prevent the problem and as such is not recommended. Sleep loss-induced deterioration in performance is only mitigated by naps (30-45 min) and caffeine (100-600 mg) for the first 24 hours of continuous wakefulness[2,18,19,20]. Naps are followed by a period of "sleep inertia" (drowsiness after waking) associated with reduced performance which dissipates over 15-30 minutes[21,22].
7. Health facility employers have a responsibility under occupational health and safety legislation to provide a safe working environment for their employees[23,24,25,26].
8. Inappropriate work practices and rosters that contribute to fatigue may put employees at risk of accidents to themselves and their patients while at work, and while travelling to and from work[1,2,27].

**RESPONSIBILITIES**

1. Anaesthetists have a responsibility to organise their lives in a way that ensures fatigue does not regularly impact on clinical duties[1,2,4]. Individuals and Departments must have knowledge of fatigue related risk categories, as set out in the Australian Medical Association National Code of Practice (March 1999)[28]. Anaesthetists have a moral and ethical responsibility to consider not proceeding with clinical duties if physical or mental fatigue, stress or ill health, alone or in combination, might interfere with safe patient care.
2. When working out-of-hours results in significant disturbance to normal rest and sleep, the anaesthetist should ensure that any clinical commitments on the subsequent day are either covered by another anaesthetist or postponed until there has been the opportunity for an adequate rest period.
3. For shift work, forward-rotating shifts (mornings -evenings -nights) are associated with the least disturbance to normal sleep patterns[2,21]. Many individuals cannot[21,29] readily reset their biological clock to accommodate night shifts. These individuals should be aware that a prolonged period of night shifts may result in serious sleep deficit. Anaesthetists who are involved in shift work, particularly overnight shifts, should be aware that clinical performance may potentially be affected by increasing fatigue due to altered sleep routines and should be prepared to call for assistance if fatigued.
4. Departments, hospitals and groups of anaesthetists should have a management plan to address the short-term consequences of anaesthetists being unavailable for clinical duties because of fatigue following "on-call" work.
5. Long-term work patterns should be based on the following principles:

**5.1** Adequate time must be available for leisure activities, and for rest and sleep.

**5.2** Adequate breaks must be taken during a day of clinical work

**5.3** Rosters for shift and weekend work must be available for a significant time ahead to permit planning for leisure activities.

**5.4** Recreation leave should be taken regularly.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**11** Dement WC. The Perils of Drowsy Driving. *New England Journal of Medicine* 1997; 337: 783-784.

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(2007)

**19** McEvoy RD, Lack LL. Medical staff working the night shift: can naps help? *Medical Journal of Australia* 2006; 185: 349-350.
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**COLLEGE PROFESSIONAL DOCUMENTS**

College Professional Documents are progressively being coded as follows:

| | |
|---|---|
| **TE** | Training and Educational |
| **EX** | Examinations |
| **PS** | Professional Standards |
| **T** | Technical |

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

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

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

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

*This document has been prepared having regard to general circumstances, and it is the responsibility of the practitioner to have express regard to the particular circumstances of each case, and the application of this document in each case.*
*Professional documents are reviewed from time to time, and it is the responsibility of the practitioner to ensure that the practitioner has obtained the current version.*
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