

THE  
**ANZCA**  
BULLETIN

- 2007 Research grant
- AIMS 'Old originals'
- Peri-operative drug errors
- Primary examinations
- Final Fellowship examinations

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

DECEMBER: 2006

JOINT FACULTY OF INTENSIVE CARE MEDICINE  
FACULTY OF PAIN MEDICINE



#### THE ANZCA BULLETIN EDITORIAL

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



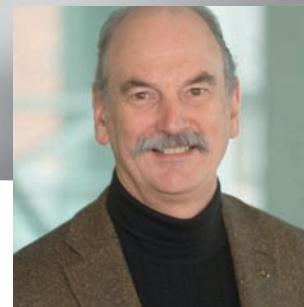
## CONTENTS

<b>LETTER FROM THE EDITOR</b>	<b>2</b>
Dr Rod Westhorpe	
<b>AIMS 'OLD ORIGINALS'</b>	<b>3</b>
<b>PRACTICE SURVEY 2005</b>	<b>4</b>
<b>PRESIDENT'S MESSAGE</b>	<b>6</b>
Dr Walter Thompson	
<b>CEO'S REPORT</b>	<b>8</b>
Dr Mike Richards	
<b>EDUCATION REPORT</b>	<b>10</b>
Professor Russell Jones	
<b>ANZCA FOUNDATION DONATIONS</b>	<b>12</b>
<b>RESEARCH REPORT</b>	<b>14</b>
Ornella Clavisi	
<b>SERIES ON PAST DEANS AND PRESIDENTS</b>	<b>16</b>
<b>ANNUAL REPORT TO THE PUBLIC: MOPS</b>	<b>18</b>
Professor Garry Phillips	
<b>2007 RESEARCH GRANT AWARDS</b>	<b>22</b>
<b>PERI-OPERATIVE DRUG ERRORS</b>	<b>26</b>
Dr Pat Mackay	
<b>REPORT ON ANAESTHETIC MORTALITY</b>	<b>27</b>
Dr Neville Gibbs	
<b>COLLEGE LIBRARY</b>	<b>30</b>
<b>OBITUARIES</b>	<b>34</b>
<b>PRIMARY EXAMINATION</b>	<b>38</b>
<b>FINAL FELLOWSHIP EXAMINATION</b>	<b>42</b>

<b>COUNCIL HIGHLIGHTS</b>	<b>44</b>
<b>VRC CHAIRMAN'S NEWSLETTER</b>	<b>48</b>
Dr Winifred Burnett	
<b>WA REGIONAL COMMITTEE</b>	<b>51</b>
Dr David Wright	
<b>GEOFFREY KAYE MUSEUM</b>	<b>53</b>
<b>JFICM DEAN'S MESSAGE</b>	<b>54</b>
Dr Richard Lee	
<b>HIGHLIGHTS: OCTOBER BOARD MEETING</b>	<b>55</b>
<b>MAINTAINING YOUR MOPS</b>	<b>58</b>
MS Robertson	
<b>JFICM POLICY DOCUMENTS</b>	<b>60</b>
<b>FACULTY OF PAIN MEDICINE DEAN'S MESSAGE</b>	<b>64</b>
Dr Roger Goucke	
<b>HIGHLIGHTS AND BOARD MEETINGS</b>	<b>66</b>
<b>FPM PROFESSIONAL DOCUMENTS</b>	<b>69</b>
<b>FUTURE MEETINGS</b>	
Australia and New Zealand	70
Overseas	74
<b>ANZCA PROFESSIONAL DOCUMENTS</b>	<b>76</b>

# LETTER FROM THE EDITOR

How we see them, and how they see us



DR ROD WESTHORPE

**The preanaesthesia consultation is arguably the most significant consultation experienced by a patient about to have an anaesthetic. Yet, many healthcare facilities and some anaesthetists still consider the preanaesthesia consultation to be a minor event.**

The evidence for the medical importance of the preanaesthesia consultation is overwhelming. The four reports on anaesthesia mortality so far published by the Australian and New Zealand College of Anaesthetists, covering the years 1991 to 2002, all refer to the need for increased attention to preanaesthesia assessment.

So, why should the preanaesthesia consultation be cursory? Is it because of time constraints, imposed by hospitals or surgeons, or is it related to inadequate facilities, or is it a reticence to engage with the patient or family in more than a basic clinical interaction?

As anaesthetists, we are often the brunt of criticism in relation to efficiency in time management in an operating theatre. The time spent seeing patients before anaesthesia is unseen and not considered, and the time taken to ensure that a patient is safely placed in the care of postoperative recovery room staff, leaves an idle operating room. As the doctors primarily responsible for the safety and well-being of patients under our direct care, we must resume and maintain our control of time. The commencement of an anaesthetic must be determined by the readiness of the patient and the anaesthetist, and not by the clock.

To undertake a preanaesthesia consultation effectively, we must also demand proper facilities, with adequate provision of privacy. Your general practitioner does not conduct his or her consultations in the waiting room, and yet many hospitals expect us to do just that.

The recent introduction of new items in the Medicare Benefits Schedule in Australia, more adequately addressing the needs of prolonged preanaesthesia consultations, and providing benefits for out-of-hospital preanaesthesia consultations, goes a long way to reducing the financial disincentive to undertake such consultations before the day of the planned procedure. These changes have been brought about after many years of intense lobbying by the Australian Society of Anaesthetists.

We have been provided with a new opportunity to undertake preanaesthesia consultations prior to the date of admission. This has the potential for huge cost savings to healthcare facilities, both in last minute cancellations for medical reasons, and in eliminating delays due to unforeseen prolonged assessments. Anaesthetists and patients can now be better prepared, especially when careful medical planning is required.

But the preanaesthesia consultation is not just an assessment. It must be seen as a unique opportunity to engage with the patient and their family in an environment that is less stressful, and where detailed explanations are not overwhelmed by the complex events and anxiety that accompanies admission to a hospital. It is the opportunity to calmly provide explanations and invite questions regarding preparation, the anaesthesia itself, pain relief, postoperative care, financial matters, and the patient's (or family's) fears and concerns.

More than that, it is the opportunity to ensure that the role of the anaesthetist in the care of the patient is understood and appreciated. No media campaign can substitute for the potential effectiveness of the one-on-one interaction that exists in such circumstances.

I draw your attention to the article in this Bulletin written by Dr Stephen Brazenor of the ACT, who outlines the audit process that he used to evaluate his practice after establishing a preanaesthesia consultation service in private rooms in 2003.

How patients and their families see us, is as important as how we see them.

Dr Rod Westhorpe - The Editor

*'As the doctors primarily responsible for the safety and well-being of patients under our direct care, we must resume and maintain our control of time.'*

## AIMS ‘Old Originals’

**On Saturday 28th October, ANZCA House hosted a reunion of AIMS ‘Old Originals’, Fellows who had been involved with the Australian Patient Safety Foundation since its inception, and who had been instrumental in the establishment of the AIMS project.**

The Seminar was introduced by ANZCA President, Dr Wally Thompson, who also gave a short presentation on AnLet, an educational newsletter published during the Second World War for American service anaesthetists who were trained under a fast-track training program.

The ‘Old Originals’ all gave short and interesting presentations on a variety of subjects relating to safety in anaesthesia. The presenters were: Dr John Williamson, convener of the reunion seminar, Dr Pat Mackay, Professor John Russell, Dr Noel Cass, Dr Craig Morgan, Dr Bob Webb, Professor Ross Holland, Dr Lyn Currie, and Dr Rod Westhorpe. Mr Peter Hibbert, Manager of APSF, also gave a presentation outlining the extensive activities currently being undertaken by the organisation, still under the direction of Professor Bill Runciman, who was unable to attend due to a prior commitment in Africa.

*‘There was remarkable consensus of those attending the workshop, not only in formulating guidelines for monitoring, but in taking control of the issue rather than allowing local standards to be determined through legal argument’*

At the end of the presentations and discussion, Professor Runciman joined the event by telephone, and informed the ‘Old Originals’ that they had all been elected to Life Membership of the APSF, in recognition of their services over almost 20 years.



In 1987, Professor Runciman convened a ‘Patient Safety and Monitoring’ symposium in Adelaide - a three day workshop of some sixty invited anaesthetists from all over Australia and New Zealand. The workshop was convened specifically to gain a consensus view among those present, as to what should be considered appropriate monitoring in anaesthesia practice. This followed directly on from the publication in 1986 of the American ‘Minimum Monitoring Standards’, and which were considered by many Australian and New Zealand anaesthetists to be in need of modification for local practice. In particular, the American standards placed great emphasis on routine ECG monitoring, and this feature had gained elevated status

among the medico-legal industry. There was remarkable consensus of those attending the workshop, not only in formulating guidelines for monitoring, but in taking control of the issue rather than allowing local standards to be determined through legal argument.

From that landmark event in 1987, the APSF was established, the Australian Incident Monitoring Study was born, and the first draft guidelines on minimum monitoring for anaesthesia were developed. The latter were then taken up by the Faculty of Anaesthetists, RACS, and introduced as Policy Document P18 ‘Monitoring During Anaesthesia’ in 1988. ●

# PRACTICE SURVEY 2005

After establishing a private practice three years ago and making the decision to open professional rooms in order to see patients prior to hospitalisation, patients were surveyed to assess their satisfaction with the service being provided.

Patients operated on during two calendar months were contacted by the rooms and asked whether they would be happy to receive a survey form and all but one of the sixty-seven patients agreed. The two month period was chosen as it represents two cycles of hospital sessions. Of the sixty-seven patients surveyed, fifty-four patients (80%) returned their surveys.

## QUESTIONS

The questions were directed to assess staff performance, documentation, practice procedures (including estimates, billing and settlement) and the patients' experience specifically and overall.

The survey presented these questions chronologically under the headings:

1. First Contact (included the preoperative consultation)
2. On the Day of Surgery
3. The Account and all that....
4. Overall Experience

The questions on staff performance sought to gain a candid and open appraisal of the helpfulness, ease of contact, performance and professionalism of both the anaesthetist and administrative staff. The scrutiny of the performance of the anaesthetist must be at least as rigorous as that of the administrative staff to demonstrate that it is the practice overall which is being assessed.

The general format for answers was to circle the most appropriate response from:

- > Not at All
- > A Little
- > Reasonably
- > Very
- > Extremely

A small number of questions required selection from a specific list eg Who was your surgeon? These are denoted by an asterisk (\*) in the question listing. At the end of each section, patients were given the opportunity to add comments as to how they felt care could be improved.

## QUESTIONS SURVEYED

### 1. Basic Demographics

- Surgeon \*
- Patient Age Range \*
- Did your surgeon inform you that Dr Brazenor was to be your anaesthetist? (Y/N)

### 2. Documentation

- Was the Patient Health Questionnaire (Red) form easy to understand and fill in?
- Was the Statement of Risk (Green) form informative & easily understood?
- Was the Estimate of the service fee clear & accurate?
- Were the final account and the estimated fee similar?
- Was the account easily understood?
- How satisfied were you with the documentation overall in the practice?

### The Preoperative Consultation

- Where was the preoperative consultation performed?\*
- Did you have an opportunity to ask all the questions you had at the consultation?
- Were you reassured by the pre-operative consultation with Dr Brazenor?
- Overall, how satisfied were you with the preoperative consultation?
- Open Question: Any way the first contact could be improved?

### 3. Experience of the Day of Surgery

- How satisfied were you with Dr Brazenor's ability to put you at ease?
- How satisfied were you with Dr Brazenor's technical skill?
- Were you satisfied with Dr Brazenor's communication with you?



Stephen and Cher Brazenor in the consulting rooms

- Were your relatives contacted - if so, were they satisfied?
- How satisfied were you with the pain relief provided by Dr Brazenor?
- How satisfied were you with the anti-nausea therapy provided?
- Did you see Dr Brazenor after the operation? Did you expect to see him?\*
- Overall, how satisfied were you with Dr Brazenor's care on the Day of Surgery?
- Open Question: How could Dr. Brazenor improve his care on the day of surgery?

### 4. Estimate, Billing and Accounts Matters

- Were the final account and the estimated fee similar?
- Was the account easily understood?
- Were the payment methods provided satisfactory?
- In settling the account, were you satisfied with Dr Brazenor's staff?

### Open Question:

How could we improve our service particularly in relation to financial matters?



# LETTER TO THE EDITOR

The Editor  
The ANZCA Bulletin  
ANZCA House  
630 St Kilda Road  
Melbourne Victoria 3004

## Re: A fat lot of use to an anaesthetist.

Dear Rod,

I can only fully support the efforts of the College in the struggle against the obesity epidemic and thought your letter very informative. However I thought the highlighted quote..

'Are obese adults and children compromising the ability of our highly trained specialists to deliver the world's best healthcare?'...  
...makes us sound a bit precious.

Surely the obese patients do not compromise our ability in any way. They may cause increased demands on our technical and intellectual skills and they may add to the stress of the job. However the only compromise they create is with their outcomes.

It is a bit like smokers. We might also like to warn them of increased risk, advise them to stop and prefer to avoid them in our practices. We may defer the cases. We might wish them on someone else's list. We might usefully take this important moment in their lives to impart advice on behaviour change.

But at some point they will need this or another operation or bariatric surgery and as (fortunately for them) 'highly trained specialists' we just have to get on and do it, and deliver that 'world's best healthcare'!

Respectfully,  
**Patrick Hughes**

## 5. Staff-Related Questions

- Were Dr Brazenor's staff clear & helpful in arranging an appointment?
- In settling the account, were you satisfied with Dr Brazenor's staff?
- Were you satisfied with the ease of contact of the rooms?
- How satisfied were you with the friendliness of Dr Brazenor & his staff?
- How satisfied were you with the professionalism of Dr Brazenor's practice?
- Were you satisfied with the ease of contact of the rooms?

## 6. Overall Experience

- Were you satisfied with the ease of contact of the rooms?
- How satisfied were you with the friendliness of Dr Brazenor & his staff?
- How satisfied were you with the professionalism of Dr Brazenor's practice?
- How satisfied were you with documentation(forms/accounts) in the practice?
- Would you recommend Dr Brazenor's anaesthetic service to friends/relatives?

## CONCLUSIONS

Overall my clients were very or extremely happy with the service provided. There was however some practices which patients were unhappy with and these are the study's most valuable outcomes.

Documentation was flagged as an area requiring attention with patients having some problems in understanding both the Patient Health Questionnaire and the Statement of Risk sent out prior to their preoperative consultation. We have amended these and

specifically targeted discussion of the Risk Statement during the consultation. We now also discuss the estimate and factors which may result in the final account being different to the estimated fee.

The patients' experience of the day of their surgery was satisfactory with over 90% rating their experience of the service as very or extremely satisfied. However four patients who expected and did not receive a postoperative visit were clearly disappointed. Some effort has been made to explain to patients that a postoperative visit is not always possible (eg day surgical lists), but will be provided where possible.

Relatives were contacted postoperatively to reassure them that the patient was now clear of the operation and awake and comfortable in the recovery room. This was achieved in only 58% cases. Once again there were a small percentage of relatives who expected a call which did not come or was delayed. Consequently, I now explain that an attempt will be made to call, but that there are circumstances which may cause delay in the timing of this call. Better organization is targeted to improve the percentage of patients whose relative(s) is contacted.

The most satisfying aspect to the survey was in discovering that the practice staff, both administrative and anaesthetic, was perceived as easily contacted, friendly, helpful and professional. We were proud of our service.

I recommend a frank and open survey as a valuable tool in fine tuning a practice.

Dr Stephen Brazenor VMO Anaesthetist, ACT. ●

**'In particular, we must give urgent attention to deficiencies in two related matters, which seriously inhibit the scientific development and the organizational influence of our specialty. I refer to academia in anaesthesia and the status of anaesthetists.'**

That quote is from the 1988 Geoffrey Kaye Oration given by Dr Ben Barry. He went on to advocate for the formation of a College of Anaesthetists. Much has been achieved but much more needs to be done. Ben died in September after a long illness.



DR WALTER THOMPSON

## PRESIDENT'S MESSAGE

### RESEARCH

Professor Ian Frazer, the 2006 Australian of the year, delivered the Kester Brown Lecture at the recent National Scientific Congress of the Australian Society of Anaesthetists. The lecture was entitled 'Can We Call Ourselves Doctors If We Are Not Doing Medical Research?' and he pointed out that medical research is a long term but very potent investment in the future health of our children and families, as it returns some \$7 for each dollar invested. He also asserted that a cultural shift is required if medical research is to once again become an integral part of clinical care and suggested that for such a shift to occur we would need the 5 M's (Methods/Mentorship/Mateship[teamwork]/Morals and Money) in order to provide the time, infrastructure, employment conditions, teamwork, social responsibility and support that is required for successful medical research.

It is encouraging to note that the College received 37 applications requesting a total funding of \$1,558,262.55 for research projects in 2007. In October, following review by and recommendations from the Research Committee, the College Council was pleased to agree that \$612,463.80 be provided for Research Awards in 2007. The College through the ANZCA Foundation, which has been generously supported by Fellows, has been very successful in providing seed funding and initial support for a large number of research projects and investigators in the areas of anaesthesia, intensive care medicine and pain medicine. However, there remains a very significant 'funding gap' and clearly there is more that can be achieved. The College is planning a 'corporate' launch for the ANZCA Foundation in April 2007 in order to attract public and corporate donations to the Foundation.

More recently, as is reported elsewhere in the Bulletin, the Council was delighted to hear that Fellows of ANZCA, JFICM and FPM, many of whom had received initial support through the ANZCA Foundation, had achieved unprecedented success in the recent NHMRC Grant announcements for 2007. This is a clear sign that the strategies of the College and the Foundation for medical research are both maturing and starting to pay dividends for the specialties. Academia in anaesthesia, intensive care medicine and pain medicine has taken root and we must now ensure that it flourishes for the benefit of the community and the specialties. I trust that all Fellows will feel justifiably proud of these achievements and will continue to support the Foundation.

### PAIN MEDICINE

For years there has been a paucity of registrar positions in Victoria for trainees in pain medicine. The College, through the efforts of David Broadbent (Director of Government and Media Relations) and others, was able to secure funding for four registrar positions in Melbourne. This is an excellent outcome and should ensure that training in pain medicine in Victoria will flourish.

### Awards and Honours

Congratulations are extended to the following Fellows:

Professor Michael Paech on being awarded the 2007 Lennard Travers Professorship by the College and for the fact the he was recently awarded Honorary Fellowship of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

*'there remains a very significant 'funding gap' and clearly there is more that can be achieved. The College is planning a 'corporate' launch for the ANZCA Foundation in April 2007 in order to attract public and corporate donations to the Foundation.'*

Professor Michael Cousins on being awarded the Pugh Award for 'outstanding contributions to anaesthesia and related disciplines' by the Australian Society of Anaesthetists (ASA). This is only the second occasion that the medal has been awarded.

Dr James Bradley on being awarded Honorary Life Memberships of both the New Zealand Society of Anaesthetists (NZSA) and the ASA.

### 2006

This has been a very busy year for the College with the outcomes of the Taskforces and the ever increasing demands placed on the College by the various levels of governments in both countries and other external bodies, such as the Productivity Commission and the Universities. Following on from the appointment of the new CEO and the management restructure, 2006 has been a year of assessment and rebuilding for the College. Council is about to sign off in December on a Strategic Plan for the next three years.

As the CEO, Dr Mike Richards writes in his report, the Plan will ensure that the College:

- maintains its position as the primary source of specialist training in anaesthesia,



- continues to foster safety and quality patient care in anaesthesia, intensive care and pain medicine,
- provides further support for Fellows in their professional development
- improves communication and ease of dealing with the College for Fellows and trainees
- encourages Fellows and Trainees to participate in College activities
- can engage effectively with other key stakeholders in government and the health care systems
- has a Committee structure that is responsive to the strategic priorities of the College.

The plan is both relevant and progressive and when coupled with the outcomes from the Taskforces has highlighted the need for enhancement of the College infrastructure and resources, information

technology and staffing in addition to changes in the way in which external relationships are managed. It is very important to ensure that the College can deal effectively and professionally with all the external opportunities and threats, while continuing to provide world class training for Trainees and support for the Fellows in their professional development. The College had kept fees and subscriptions constant from 1998-2005 and as a result the College is administratively operating at 6.8% less in real terms that it was in 1998. In times of rising costs, increasing expectations and rising activity that position is clearly not sustainable, unless we decide to retreat from our duties to the community, Trainees and Fellows. Council has therefore agreed to support a 10% increase in the subscriptions and fees for 2007, in order to meet these challenges and position the College to deal positively with the changing political and bureaucratic environment.

2007 promises to be an interesting year as the College works through the issues National Registration and National Accreditation, the relationship with Universities and quality issues within health care. Within the College we will be pressing ahead with the initiatives of the Quality and Safety Committee and the re-activated Incident Reporting in conjunction with the ASA and the NZSA; the new Continuing Professional Program (CPD) will be out for comment plus there will be major developments both on the web site and in continuing education. I will keep you informed of progress on these developments and others as they are initiated.

In conclusion, I and the Council plus the college staff would like to thank you for your support of the College in the last year, and wish you and your families all of the very best for the Festive Season and for 2007.

.....  
**Dr Wally Thompson—President**  
.....





# CEO'S REPORT



DR MIKE RICHARDS

**Organisations need to be aware of the changes occurring around them and to assess the potential impact of these changes on their operations. The College is no exception. It has many stakeholders whose demands and expectations occasionally change, sometimes quite suddenly.**

As a College of specialist anaesthetists, we need to be aware of the agendas and expectations of a relatively wide number of stakeholder groups. These include:

- National and state governments—seeking to address areas of workforce shortage and to limit spending on health care;
- The public—increasingly demanding ready access to high quality health care and the use of the latest medical technology;
- Patients—less willing to tolerate the adverse outcomes that occasionally arise as a result of medical treatment;
- Other medical specialists (whose procedures are enabled by anaesthetists)—themselves having changing demands in response to changes in their own professional work environment; and
- Our Fellows and Trainees—also subject to changing attitudes and priorities as a result of generational change, increases in overseas-trained Fellows, and the aging of sections of the workforce.

From time to time, we need to take the opportunity to assess the impact of these and other factors on the workings of the College, and to develop strategies that prioritise and address the main issues facing the College.

Over the past few months, Council has been developing a Strategic Plan that considers the priorities of the College in the context of that external landscape. This process is well underway and the proposed Strategy should be finalised by Council at its December meeting.

Perhaps the most immediate challenges to ANZCA and the other specialist medical colleges are the demand of governments in regard to their health workforces. As discussed



by the president, Dr Wally Thompson, and Professor Garry Phillips in the last issue of *The Bulletin*, the Council of Australian Governments (COAG) made a number of decisions at its July meeting that will potentially affect ANZCA's future operations. COAG has agreed to:

- The establishment of a Taskforce on national health workforce;
- A single national accreditation scheme for health education and training, to be operational by July 2008;
- A single national registration scheme for all health professionals, also to operate from July 2008;
- A national overseas trained specialist (OTS) assessment process to operate from December 2006; and
- 'Better specialist training'—a system for trainees to undertake rotations through an expanded range of settings, including public, private, community and non-clinical facilities, to be in place by January 2008.

COAG also agreed that Health Ministers further consider the Productivity Commission's proposal to establish a high-level taskforce to collect data on demand for clinical training across all health professions, and to use this information to recommend specific changes to facilitate more transparent, coordinated and contestable clinical training arrangements. This could potentially lead to a decision to encourage universities to provide an alternative pathway to qualify to practise specialist anaesthesia in Australia.

In New Zealand, while there is no current pressure to introduce competition to the specialist medical college training programs, stakeholder expectations and the issues faced by the College are broadly similar to Australia.

The strategic plan anticipates these major changes and has been developed to guide the College's direction over the next 3 years. The plan has been developed by Council with the involvement of senior College staff, who will



*‘Perhaps the most immediate challenges to ANZCA and the other specialist medical colleges are the demand of governments in regard to their health workforces.’*

be charged with much of its implementation. It provides a clear statement of strategic objectives and required outcomes that will allow management to establish priorities and allocate resources as appropriate.

The Plan identifies a number of strategic objectives across six operational areas:

#### **EDUCATION (Pre-Fellowship Training)**

- Position ANZCA as the primary source of specialist training in anaesthesia.

#### **EDUCATION (Post-Fellowship)**

- Ensure that College Fellows continue to possess knowledge and skills relevant to the health care system in which they work.

#### **ANAESTHESIA MODEL OF CARE**

- Ensure that ANZCA’s position on the roles of anaesthetists and other health practitioners in providing anaesthesia care is widely understood by stakeholders, and supported by rigorous analysis.

#### **GOVERNMENT AND EXTERNAL RELATIONS**

- Position the College as a respected, constructive and thoughtful participant in the development of the Australian and New Zealand health care systems.
- Enhance the media’s (and, through them, the general public’s) understanding of the role of anaesthetists.

#### **SUPPORT FOR COUNCIL AND COMMITTEES**

- Ensure that the Committee structure is responsive to the Strategic priorities of the College.
- Redistribute some of the work currently undertaken by Council to appropriate Committees and other working groups.

#### **SERVICES TO FELLOWS AND TRAINEES**

- Improve communications and ease of dealing with the College.
- Increase opportunities for participation in College activities.
- Increase support for Trainees.

The actions required to achieve these objectives are now in the process of being finalised and will be incorporated in the Draft Strategic Plan, which will be considered by Council at its December meeting. While the Plan has a three-year horizon, many of the initiatives will be undertaken in the early part of 2007, so the outcomes of the strategy will be unveiled throughout the year.

I look forward to providing greater detail on the ANZCA 2007 Strategy in the next *Bulletin* once it has been considered and approved by Council.

(Dr.) Mike Richards—Chief Executive Officer

# EDUCATION REPORT

## Induction to the FANZCA Training Program for New Trainees



PROF RUSSELL JONES

The College will soon be implementing a distance education Induction Module for new Trainees. The purpose of this initiative is to encourage Trainees to familiarise themselves with information that is useful for them to know in relation to their training. This information includes, but is not limited to:

- Trainee responsibilities.
- Roles of the Regional Education Officer, National Education Officer, Supervisor of Training, Module Supervisor and Assessor.
- Material pertaining to the Learning Portfolio and Curriculum Modules.
- Information pertaining to College Professional Documents and Regulations.

Each Trainee who joins the FANZCA Training Program is currently provided with numerous educational resources and information including a Trainee Support Kit, Learning Portfolio, Curriculum Modules and various College Professional Documents. The information within these resources forms the basis of the Induction Module. The Induction Module is an online distance education initiative administered and maintained centrally at ANZCA House. It comprises 30 questions covering topics that Supervisors and existing Trainees have reported as potential sources of confusion for new Trainees. Figures 1 and 2 show screen dumps from the online module.

Upon joining the FANZCA Training Program Trainees will be asked to complete the Induction Module within three months. Because this initiative is centrally located at the College, no additional workload will be imposed upon Supervisors. Indeed, it is expected that working through the Induction Module will rapidly increase Trainee understanding of the FANZCA Training Program and therefore may decrease the workload for Supervisors. Completion of the module requires Trainees to log onto the ANZCA website where they will be provided with a timeframe in which to complete the module. Trainee performance (pass or fail) in the Induction Module will be automatically

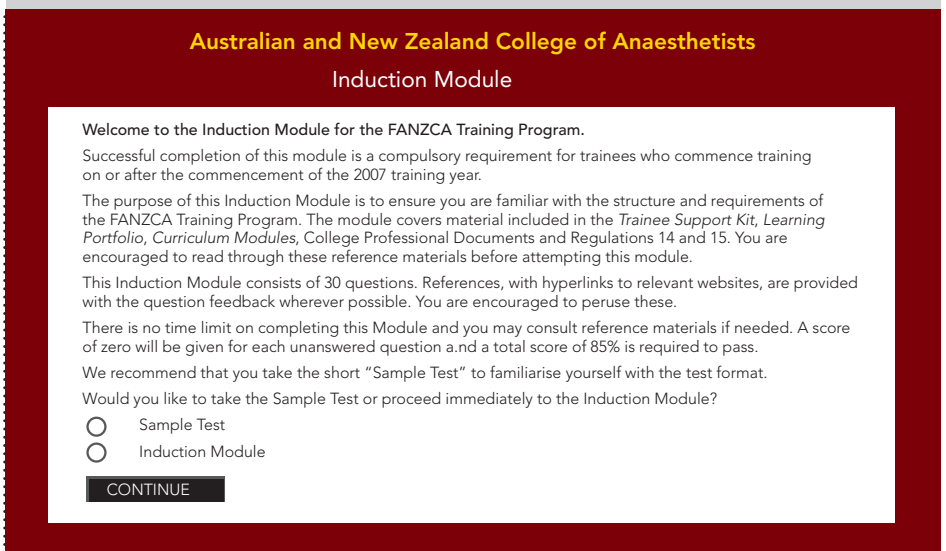


Figure 1. Illustration of the first page of the online Induction Module.

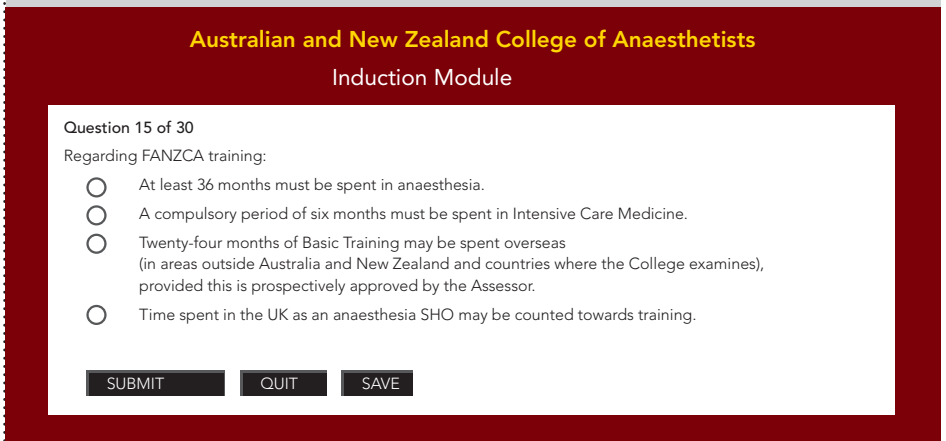


Figure 2. Illustration of a typical question from the online Induction Module.

fed back to the Trainee and the College. In the case of success, each Trainee will receive a notification of having passed the Induction Module and this notification is to be placed in the Trainee's Learning Portfolio. Assessment in the Induction Module is formative and unsuccessful Trainees are able to reattempt the module until they successfully master the induction information. Trainees are able to

work through the questions at their own pace and at their convenience.

I would like to thank those Fellows who have contributed material to the Induction Module; most notably Dr Lindy Roberts, Dr David Mecklem, Dr Ian Banks and Dr Andrew Needham.

Prof Russell Jones

# HONORARY FELLOWSHIP OF RANZCOG

## Professor Michael Paech

Professor Michael Paech, FANZCA was awarded an Honorary Fellowship of RANZCOG at the 2006 RANZCOG ASM ceremony on 15 October 2006. The citation from the ceremony follows:

‘Professor Michael Paech is a graduate of Adelaide University. He completed his specialist training in anaesthesia in both the United Kingdom and Australia. Whilst working in the United Kingdom in the early eighties, he gained a Diploma of Obstetrics from RANZCOG.

Professor Paech’s first Consultant appointment in anaesthesia was in New Zealand. Thereafter he moved to Perth and was appointed to the staff of King Edward Memorial Hospital (KEMH) for Women in 1988 and has continued as a Consultant Anaesthetist at KEMH since that time. During this period, he has served as Head of Department of Anaesthesia and has been an active and valued member of the Department.

Apart from fulfilling his clinical load at KEMH, Professor Paech has conducted extensive research and has a very large list of publications. The principle focus of his research has been aimed at improving pain relief methods and anaesthetic services for women, most particularly pregnant women.

He has been actively involved in continuing medical education at all levels from medical students to specialist anaesthetists. Professor Paech is frequently the speaker of choice for educational seminars on obstetric anaesthesia for health care professionals. He has also contributed to patient education, with involvement in ante-natal classes and in the production of a booklet for expectant mothers on their choices for labour.



(Right) Professor Michael Paech being presented with his honorary Fellowship of RANZCOG from RANZCOG President Dr Kenneth Clark.

Professor Paech was awarded his D.M. by the University of Western Australia (UWA) for a thesis on patient controlled epidural analgesia. His contribution and high regard has been recognised by UWA by awarding him a chair in Obstetric Anaesthesia. He is regarded as the pre-eminent Obstetric Anaesthetist by his anaesthesia colleagues in Australia. He enjoys an international reputation as reflected by the number of occasions he has been an invited speaker at international conferences and meetings.

# RESEARCH REPORT



ORNELLA CLAVISI

## Aspirin and Tranexamic Acid for Coronary Artery Surgery Trial – The ATACAS Trial

One of the biggest research initiatives of the ANZCA Trials Group is the Aspirin and Tranexamic Acid for Coronary Artery Surgery Trial (ATACAS); a large multicentre randomised controlled trial established to answer whether aspirin or tranexamic acid (TA), or both should be used in people having heart bypass surgery. Funded by the National Health and Medical Research Council (NHMRC) and the Australian and New Zealand College of Anaesthetists the Trial is headed by Prof Paul Myles and is jointly coordinated by the ANZCA Trials Group and the Alfred Hospital's Department of Anaesthesia. A full listing of the ATACAS investigators and research team is shown in box 1

### BOX 1

#### ATACAS INVESTIGATORS

##### Principal Investigator

Prof Paul Myles

##### Chief Investigators

Prof Julian Smith,

A/Prof John Knight

Prof Jamie Cooper

Prof John McNeil

A/Prof Brendan Silbert

##### Associate Investigators

A/Prof Donald Esmore

Prof Brian Buxton

Prof Henry Krum

A/Prof Andrew Forbes

Prof Andrew Tonkin

##### Research Team

Ornella Clavisi

Sophia Wallace

Marg Quayle

## Background

There are some compelling reasons to question the routine stopping of aspirin before elective CABG surgery. Although preoperative aspirin may increase bleeding, it may also reduce MI, other complications and death. TA prevents excessive bleeding and is likely to have other benefits. On the basis of cost and safety, the best antifibrinolytic agent to evaluate is TA.

When considering the cost and extent of CABG surgery in Australia and around the world, small differences in outcome would have major implications for healthcare delivery.

There are more than 20,000 heart surgery cases done each year in Australia. About 5% (1,000 patients) have a serious complication or die; this adds substantially to healthcare costs. For example, in the US complications after heart surgery cost more than \$15 billion per year.

Cardiac surgery activates blood cells (platelets) and clotting factors, but also blood clot breakdown pathways. Excessive bleeding and a need for blood transfusion are common. Excessive bleeding may also require emergency surgery, and this is associated with an increased risk of serious complications.

Patients treated with aspirin (which is common in those needing heart surgery) have increased bleeding during and after surgery. Thus it is routine practice in most cardiac surgical centres around the world for aspirin to be stopped about one week before surgery.

However, a study published in the *New England Journal of Medicine* in 2002 found that patients who received aspirin early after their heart surgery had a lower death rate, as well as less heart attacks, stroke, and kidney failure.<sup>1</sup> The authors believed that these beneficial effects could have occurred because aspirin prevents thrombosis (blood clots) in the blood vessels supplying the heart, brain and kidneys. Could it be that, although aspirin may cause more bleeding, there is a net benefit because of less thrombosis?

Another drug, tranexamic acid, is sometimes used to reduce bleeding after heart surgery. It works by blocking the clot breakdown that occurs early after heart surgery. This reduces bleeding, and the need for a blood transfusion. Importantly, there is some published information to suggest it is particularly effective in patients on aspirin. But we do not know whether or not tranexamic acid increases the risk of thrombosis (heart attack, stroke).

Given the evidence it is uncertain whether it is better to stop aspirin before heart surgery (to prevent bleeding), continue aspirin (to prevent thrombosis), or to use tranexamic acid (to prevent bleeding). There are no large trials to guide anaesthesia practice hence the need for a trial like ATACAS.

*'There are some compelling reasons to question the routine stopping of aspirin before elective CABG surgery'*

## Controversy surrounding aprotinin

Recent developments, which further strengthen the rationale for ATACAS, is the controversy surrounding aprotinin (an alternative to tranexamic acid). On the 29th of September 2006 the US Food and Drug Agency announced that Bayer, the manufacturer of aprotinin, failed to reveal the results of a large observational study which reported that the use of aprotinin may be associated with an increased risk of death, serious kidney damage, congestive heart failures and strokes. The FDA is currently evaluating the results of the study and will review whether the agencies advice, for the appropriate use of aprotinin, needs to be changed.<sup>2,3</sup>

Many of you would also have seen the Mangano study published in the January edition of the *New England Journal of Medicine*.<sup>4</sup> This group investigated aprotinin in cardiac surgery, with an observational study

involving 4374 patients undergoing CABG surgery. They used multivariate and propensity scoring to adjust for imbalances. They found that aprotinin was associated with a doubling in the risk of renal failure, as well as increased myocardial infarction or heart failure, stroke and encephalopathy. Interestingly, neither aminocaproic acid nor tranexamic acid was associated with these increased risks.

This study has received widespread coverage in the media, and has raised a lot of concern amongst cardiac surgeons and anaesthetists. Are the results believable? What constitutes good practice? How does this affect the ATACAS Trial? Firstly, it is worth reading an editorial in the *Lancet*, titled *The risk of aprotinin: a conflict of evidence* (*Lancet*. 2006 Apr 29;367:1376-7)<sup>5</sup> which highlights some of the potential weaknesses of this study – after all, it was not a randomised trial, and there are several important sources of major bias.

Box 2 provides a synopsis of the ATACAS Research Plan.

## BOX 2

### ATACAS Research Plan

**Design:** Large, multicentre, prospective, randomised double blind, factorial trial. Patients will be randomly allocated to aspirin, TA, aspirin + TA, or placebo.

**Primary End Point:** Composite: 30-day mortality or major ischaemic morbidity (myocardial infarction, stroke, pulmonary embolism, renal failure, bowel infarction).

**Secondary End Points:** Each of the above, plus bleeding complications and physical independence

**Sample size:** 4600 patients (alpha 0.05, beta 0.10), to detect a 30% (or greater) reduction in major complications or death.

**Outcomes & Significance:** There are some compelling reasons to question the routine stopping of aspirin before elective CABG surgery. Although preoperative aspirin may increase bleeding, it may also reduce MI, other complications and death. TA prevents excessive bleeding and is likely to have other benefits. On the basis of cost and safety, the best antifibrinolytic agent to evaluate is TA.

### Trial Update

The trial officially began on the 23rd March 2006. The Alfred hospital recruited the first patient: a 68yr old male undergoing CABG and mitral valve replacement performed by A/Prof Don Esmore. This was a good opportunity to test the telephone randomisation, study medication procedures and dispensing, and data collection process. All went smoothly. To date 62 patients have been randomised.

The Trial currently has 4 sites recruiting patients The Alfred Hospital, Monash Medical Centre, St Vincent's Hospital and The Austin Hospital. There are also 8 additional sites undergoing Ethics approval.

### Medication

There has been frustrating delays with obtaining a reliable supplier of Tranexamic Acid (TxA). This is now sorted out, but with the trial having to pay full cost of the drug. The additional unexpected cost prevents us from affording independent preparation and blinding, such as is typically provided by the hospital pharmacy department. Therefore each site must ensure they can prepare the TxA at the time of surgery, usually by the anaesthetists. This makes it essential to maintain blinding for the surgical team and follow-up research staff.

### Web based data entry

The ATACAS trial has begun with paper-based, fax data entry. We expect to have the web-based case report form up and running next month. This should simplify ongoing data entry and follow-up to ensure we have complete, accurate study data. Prospective sites will be able to submit their data online via the ATACAS web page which is currently under construction. Sites will also be able to access this page via a link on the College website.

### New Sites

To reach our target of 4600 we need more sites recruiting more patients so if you would like to be a site investigator please let us know. You can ring the Trial Coordinator Ornella Clavisi on 03 8517 5326 or email [oclavisi@anzca.edu.au](mailto:oclavisi@anzca.edu.au). If you would like some additional information regarding the trial a copy of the research protocol and procedures manual can be forwarded to you. Also the Trial has adopted the NHMRC's National Ethics Application Form (NEAF) as a way of reducing the time and effort required by site investigators to complete their own ethics application. In other words we give you the form and you submit it. Quite a lot of hospitals/institutes have adopted the form and we have had our first NEAF approval without any problems.

### References

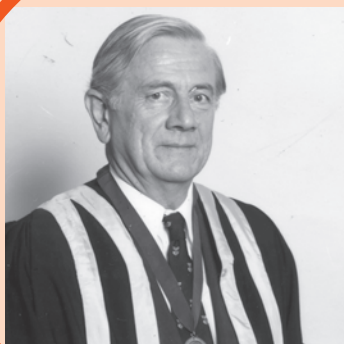
1. Mangano DT, the Multicenter Study of Perioperative Ischemia Research Group. Aspirin and Mortality from Coronary Bypass Surgery. *N Engl J Med* 2002; 347:1309-1317, Oct 24, 2002.
2. United States Food and Drug Agency. Aprotinin Injection (marketed as Trasylol) [updated September 29, 2006]. <http://www.fda.gov/cder/drug/infopage/aprotinin/default.htm> (accessed October 2006)
3. Harris G. FDA says Bayer failed to reveal drug risk study. (Published September 30 2006). *New York Times* <http://www.nytimes.com/2006/09/30/health/30fda.html?ex=1162008000&en=510b4488c5863975&ei=5070> (accessed October 2006).
4. Mangano D. T., Tudor I. C., Dietzel C., the Multicenter Study of Perioperative Ischemia Research Group and the Ischemia Research and Education Foundation. *N Engl J Med* 2006 Jan 26;354:353-65
5. Sedrakyan A, Atkins D, Treasure T. The risk of aprotinin: a conflict of evidence. *The Lancet* 367; (9520): 1376-1377



# SERIES ON PAST DEANS AND PRESIDENTS

Dr William John Watt

**Jack Watt was the first New Zealand Dean of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons. He was the twelfth Dean succeeding Dr Brian Dwyer and to be followed by Dr Maurice Sando.**



William John (Jack) Watt was born in Ashburton in New Zealand on the 26th October 1918. He was the eldest of three children born to Leslie and Gladys Watt. His primary schooling was at Ashburton Borough primary school from 1923-30 and then for secondary schooling attended St Andrews College, Christchurch 1931-32 and then onto Timaru Boy's High School. He attended Otago University graduating in 1943.

His internship was at Auckland Hospital in 1944. As a sign of the times, 1945 and half of 1946 were spent in the New Zealand Army Medical Corps. He spent 6 months at the New Zealand Maadi Camp Hospital and was then transferred to the 6th N.Z. General Hospital forming in Italy and then onto Japan. There was no anaesthetic experience involved in this period.

Jack returned to Auckland Hospital in September 1946 and 1947. Anaesthetic training was undertaken as a registrar in the Auckland Hospitals in 1948 and until August 1949. 'After completion of my house surgeon training I was quite undecided as to where my future lay. I applied for a position

*'After completion of my house surgeon training I was quite undecided as to where my future lay. I applied for a position as anaesthetic registrar without any particular knowledge, or in fact, interest in the specialty. But as the years progressed I became more and more interested and so began a career.'*

as anaesthetic registrar without any particular knowledge, or in fact, interest in the specialty. But as the years progressed I became more and more interested and so began a career.' Thereafter he travelled to the UK and furthered his anaesthetic experience at the Hammersmith Hospital for Postgraduate Medical Education and then the National Hospital for Nervous Diseases, Queen's Square, London, in 1951. He obtained the two part Diploma of Anaesthesia whilst in the UK.

Returning to New Zealand in 1952 Jack was appointed specialist anaesthetist to Green Lane Hospital a position he held until 1958. In 1958 he was appointed to the position of Director of Anaesthetic Services to Auckland Hospitals a position he went on to hold for 25 years until his retirement in 1983. When appointed as Director of Anaesthesia in 1958 there were four hospitals in the Auckland Group; Auckland Hospital, Greenlane Hospital, Middlemore hospital and the National Women's Hospital. Initially all anaesthetic services were based at Auckland Hospital. Gradually each hospital evolved it's own department with it's own Departmental

head. 'As Director I was responsible to the superintendent-in-Chief for staffing, and the overall provision of services, but the daily rostering of duties etc was the responsibility of the departmental head. I oversaw rostering at Auckland Hospital.' Jack was very active in his role as Director, establishing an anaesthetic registrar training programme in Auckland during the early 1960's, where there had been no formal training program previously.

Jack served on the Board of Faculty from 1968, holding the positions of Assessor from 1972-3, Vice Dean 1974-5 and Dean from 1976-78. It was during his term as Dean that the section of Intensive Care Medicine was formed. However Jack is quite adamant that it was Brian Dwyer who had laid the foundation for that event and feels that it was unfortunate that, due to some minor technicalities with the RACS, the section could not have been completed in Brian's Deanship.

Upon completion of his Deanship Jack was appointed as a consultant to the World Health Organisation to examine the South Pacific training programme based in Manila for South Pacific Island Graduates. Jack also whilst assessor presented a paper to the Board of Faculty that became the basis of the Approved Faculty Training Requirements. Jack and his wife Rosamund have four daughters and continue to live in Auckland

Dr Terry Loughnan

# Obstetric Anaesthesia

## Labouring the Point



Approx 130 Fellows plus families and partners attended the above conference organised by NSWACE held over the weekend 12th & 13th August, 2006, at the Shoal Bay Resort & Spa, Port Stephens, NSW. The conference sought to debunk some of the myths surrounding obstetric anaesthesia in the light of the latest research. Many topics were covered and included obstetric haemorrhage, monitoring the sick obstetric patient, the place of the test dose in epidurals, post-Caesarean analgesia and an update on pre-eclampsia. A range of workshops were included on many topics, including pregnancy and cardiac arrest, neonatal resuscitation and the 'glass spine', as well as hands-on use of the Harvey and Mediseus epidural simulators.



The Resort is a short drive north of Newcastle on the New South Wales Central Coast and the weather was beautiful for the whole weekend allowing guests to take advantage of the beach and the Resort's many pools and spas.

Our next 'out of town' meeting will be held in Orange over 21st & 22nd April, 2007. As this will be the final weekend of school holidays and the Good Food of Orange Week held in Orange each year, we hope you will mark it in your diaries now and plan to enjoy some country hospitality whilst attending our meeting titled, 'OOPS, WHAT HAVE I JUST DONE?' - Anaesthetic complications; their management and prevention'

NSWACE Committee



Top left: Essential skills update workshop - Assessing the pregnant patient with a heart murmur  
Top right: Overlooking one of the pool areas at Shoal Bay Resort & Spa  
Above: Essential skills update workshop - Managing the difficult airway  
Below: Obstetric trauma workshop - (neo mannequin)







f. Qualified Privilege is essential to the success of the MOPS program, and to the recruitment of more anaesthetists, aiming at greater than 90% participation. The public needs assurance that they are receiving anaesthesia services which are of the highest possible safety and quality. Participation in Quality Improvement Activities will be best achieved when these activities have the protection of Qualified Privilege.

Activities undertaken with this protection have been shown to enhance the attributes of anaesthetists in providing safe quality care.

#### 8. Information Management Policy

Anaesthetists participating in the Maintenance of Professional Standards program provide information about the quality improvement activities in which they are involved to the Committee.

The Committee considers this information at four meetings per year, and reports to the Council of the College, and monitors implementation of these recommendations. Minutes of the meeting state the members present, the deliberations of the committee and all other business of the meeting. The minutes of the meeting are submitted to the members of the Committee for confirmation of accuracy at the next meeting, when they are signed by the Chairperson of that meeting.

Records are retained securely in accordance with the Patient Information Retention and Disposal Schedule (Version 2, 2000). Committee members are cognisant of the Guidelines for quality improvement

committees seeking qualified privilege under the Health Services (Quality Improvement) Act 1994. In particular:

- a. They are aware that this Act specifically excludes the operation of the Freedom of Information Act 1992 in relation to the information and documents generated by declared quality improvement activities; that this exclusion prevents the Freedom of Information Act 1992 being used to obtain details, which although not admissible as evidence, could form the basis of a case prepared and supported by other materials; and that primary and source materials, such as medical records, remain accessible through the Freedom of Information process.
- b. They are aware that a person who acquires information solely as a result of a committee performing its function is neither competent or compellable in civil proceedings to divulge or communicate that information to any court, tribunal, board or person; that a document created by or at the request of the Committee, and solely for the performance of the Committee's functions, is not subject to discovery and is not to be used in evidence in civil proceedings before any court, tribunal, board or person unless the document has been made available to the public, the Minister or Council.
- c. They are aware that it is an offence for a person to make a record of, divulge or communicate information acquired solely as a result of the performance of the Committee's functions other than in the prescribed circumstances under the

Act; and that protection under the Act extends to cover persons who are not members of the Committee, but who act under the instruction or at the request of Committee members.

- d. They are aware that this privilege does not apply to a report which has been furnished, or information that has been made available, to a committee which does not disclose, either expressly or by implication, the identity of an individual. That this privilege does not apply to a report which has been furnished, or information that has been made available to a committee which does not disclose, either expressly or by implication the identity of an individual; and that privilege does not apply to a requirement made in proceedings in respect of any act or omission by a committee or by a member of a committee as a member.

Prof Garry Phillips  
 Director of Professional Affairs  
 and MOPS Committee member

# 2007 RESEARCH GRANT AWARDS

The following Research Grants for 2007, recommended by the Research Committee, were awarded by Council at the October Council Meeting:



**Assoc Prof M Chan (HK)**

**\$26,650.00** PeriOperative ISchemic evaluation (POISE) study. How does metoprolol prevent postoperative cardiac complications?

**Assoc Prof M Chan (HK)**

**\$58,652.40** Visualizing expired air dispersion during common respiratory therapy: a simulator model to assess the risk of nosocomial infection



**Assoc Prof K Leslie (VIC)**

**\$53,807.40** ENIGMA Trial Long-term follow-up study



**Professor M J Paech (WA)**

**\$15,149.00** The use of skin conductance monitoring to predict severe hypotension after spinal anaesthesia for elective caesarean section

**Professor M J Paech (WA)**

**\$45,549.00** Transfer of parecoxib into breast milk; a study of post-operative use following caesarean section



**Dr A J Davidson (VIC)**

**\$44,820.00** An international RCT comparing spinal and general anaesthesia on neurodevelopment outcome and apnoea in neonates

**Dr A J Davidson (VIC)**

**\$14,006.00** Explicit recall during anaesthesia in children



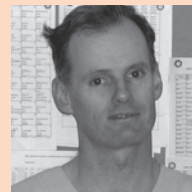
**Assoc Prof P J Siddall (NSW)**

**\$50,943.00** Activation of brain regions in people with neuropathic pain following spinal cord injury



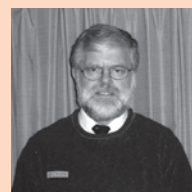
**Dr A N Pollock (NZ)**

**\$20,000.00** Pharmacological characterisation of malignant hyperthermia



**Dr P J Peyton (VIC)**

**\$40,000.00** Continuous non-invasive measurement of cardiac output in ventilated patients by the pulmonary capnodynamic method

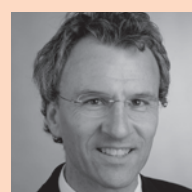


**Assoc Prof A W Quail (NSW)**

**\$40,000.00** The effects of volatile anaesthetic agents on bronchial dimensions and blood flow

**Dr D J Sturgess (QLD)**

**\$22,500.00** Comparison of BNP, Troponin and Tissue Doppler in the Evaluation of Ventricular Filling and Prognosis in Severe Sepsis



**Assoc Prof D J Cooper (VIC)**

**\$54,280.00** PROphylaxis for ThromboEmbolism in Critical Care Trial

**Dr M J Chapman (QLD)**

**\$35,965.00** Effects of glucagon-like peptide-1 on glucose levels and small intestinal transit in critically ill patients



**Professor P S Myles (VIC)**

**\$21,500.00** International Perioperative genetics and safety outcomes study in cardiac surgery (iPEGASUS)

That the **Harry Daly Research Award** be awarded to **Professor Paul Myles** for his project "International Perioperative genetics and safety outcomes study in cardiac surgery (iPEGAS2US)"

That the **Organon Research Award** be awarded to **Assoc Prof David (Jamie) Cooper** for his project "PROphylaxis for ThromboEmbolism in Critical Care Trial"

**2006 ACADEMIC ENHANCEMENT GRANT**



**Professor J Lipman**

**Professor C Kam**

The **2006 Academic Enhancement Grant** was awarded to both **Professor J Lipman**, Department of Anaesthesia, Royal Brisbane and Women's Hospital and **Professor C A Kam**, Department of Anaesthesia, Royal Prince Alfred Hospital, Camperdown, in the amount of **AUD\$45,000** each.

**2007 SIMULATION/EDUCATION GRANT**

The following Simulation/Education Grant award for 2007, recommended by the Research Committee, was awarded by Council at the October Council Meeting:

**Dr R W Frengley (NZ)**

**\$35,000** An intervention to improve rapid sequence intubation in intensive care teams



# PERI-OPERATIVE DRUG ERRORS

## Taking the Initiative

Descriptions of errors in drug administration in anaesthesia abound in the literature and have been a topic of discussion at most recent scientific meetings. In Australia in 1993<sup>(1)</sup> in the first 2000 case reports of the Anaesthesia Incident Monitoring Study (AIMS), 36% were related to pharmacological incidents.

While subsequent reports from AIMS have demonstrated a reduction of incidents related to hypoxia and other adverse events the figure for drug error continues to remain at the same level. This is despite a number of initiatives: the development of individual routines, the introduction of 5 ml. red barrel syringes to be employed only for relaxant agents, attempts at standardization of 'stick on' labels, institution of checking procedures, formal organization of the anaesthetic workspace and colour coding. Anaesthetists from New Zealand have been prominent in developing strategies for prevention of drug errors and a promising initiative has been the development of a system that includes bar and colour coding with automatic verification of the syringe labels prior to injection as well as automatic documentation on the anaesthesia record<sup>(2)</sup>. However human factors are still identified and include fatigue, distraction, work pressure, new environments and just plain inexplicable error. For example, in a recent report an anaesthetist drew up the relaxant in a red syringe and still administered it instead of midazolam.

*'Anaesthetists from New Zealand have been prominent in developing strategies for prevention of drug errors and a promising initiative has been the development of a system'*

In addition it is obvious that the peri-operative patient is subjected to the possibility of drug error not only by anaesthetists but by surgeons employing drugs usually prepared by nursing staff, errors in other procedural areas, recovery rooms, high dependency units and general wards, particularly in association with pain management. Drugs employed by surgeons or proceduralists are not always recorded and include local anaesthetics, vasoconstrictors, contrast media, anticoagulants or agents for haemostasis, topical antibiotics, hydrogen peroxide and other pharmaceutical agents. Monitoring of the details and dosage of such drugs is variable and frequently there is no adequate record in the patient history.

As a result of concern about the increasing number of reports relating to drug error received by the Victorian Consultative Council on Anaesthetic Mortality and Morbidity (VCCAMM), recommendations re Operating Suite Drug Policy have been published which could well be developed in other procedural areas. The policy involves the formation of an advisory group responsible to the Director of Anaesthesia (or nominee) in consultation with the Director of Pharmacy. Membership of the group would include the Directors of Anaesthesia and Pharmacy, Nursing manager of the operating suite, the Nurse Unit Manager or Technician in the anaesthetic department, a Surgical or procedural representative and appropriate business managers. The role would be to co-ordinate supply, storage, distribution and auditing of pharmaceuticals in the area concerned. Specific policies would include requirements for access and documentation of drugs of addiction, documentation of all drugs employed either in the anaesthesia

record or the medication chart and protocols for the preparation of all drugs administered by surgical staff during operative procedures. Specific guidelines would also be required to ensure appropriate choice, concentration and dosage.

Further details of a suggested template for a document as well as an example of a current Victorian Hospital drug policy document are available on the VCCAMM website at <http://www.health.vic.gov.au/vccamm/druginfo.htm>

In response to the concerns about errors in pain management in the wards, usually due to inexperience, the Victorian Quality Council of the State Government has subsidized an acute pain management review under the leadership of Dr Tony Weaver and Associate Professor David Scott, with the task of reviewing and implementing specific policies for measurement and documentation of acute pain as well as suggested strategies for avoidance of error. It is hoped that these can be adopted state-wide in Victoria and thus avoid the complications attributable to junior medical staff and to agency nurses working at multiple sites in both public and private hospitals. Other States could consider following suit when this program is published.

Thus it is argued that Anaesthetists are in the best position to adopt a leadership role, not only in research and training, but also in developing specific drug policies to guide staff in operating rooms as well as all other procedural areas. The time has come to take the initiative.

### References

1. Currie M, Mackay P, Morgan C, Runciman WB, Russel I WJ, Sellen A, Webb RK, Williamson JA: The Australian Incident Monitoring Study. The "wrong drug" problem in anaesthesia; an analysis of 2000 incident reports. *Anaesth. Intensive Care* 1993; 21: 596-601
2. Jensen LS, Merry AF, Webster CS, Weller J, Larsson L: Evidence-based strategies for preventing drug administration errors during anaesthesia. *Anaesthesia* 2004; 59: 493-504

Dr Pat Mackay



# REPORT ON ANAESTHETIC MORTALITY WORKSHOP

SEPTEMBER 2006



DR NEVILLE GIBBS

**One of the first activities of the new ANZCA Quality and Safety (Q&S) Committee was to organise a Workshop on Anaesthetic Mortality. This was held at College Headquarters on Saturday September 23, 2006. The aim of the Workshop was to increase the understanding of issues relating to Anaesthetic Mortality reporting in Australasia, and to formulate a plan to improve both Reporting and Education in Anaesthetic Mortality throughout the region.**

The Workshop was chaired by Dr Wally Thompson, President of ANZCA, and facilitated by Dr Neville Gibbs, Chairman of the West Australian Anaesthetic Mortality Committee. All State Chairs of Anaesthetic Mortality Committees were present (Dr Christopher Borton, New South Wales; Assoc Professor Larry McNicol, Victoria; Dr James Troup, Queensland, Professor Don Moyes, South Australia). Dr Margaret Walker represented Tasmania, Dr Cliff Peady represented the Australian Capital Territory, and Dr Leona Wilson, Vice President of ANZCA, represented New Zealand. Other attendees included Dr Greg Deacon, President of the Australian Society of Anaesthetists, Dr Graham Sharpe, President of the New Zealand Society of Anaesthetists, Dr Alan Merry, Chairman of the ANZCA Q&S Committee, Dr Patricia Mackay, Past President of the Victorian Consultative Council on Morbidity and Mortality (VCCAMM), Ms Pauline Berryman, Project Officer with the VCCAMM, Dr Christine Jorm, a member of the ANZCA Q&S Committee, and Mr Michael Gorton, ANZCA's Honorary Solicitor. The attendees made up one of the most comprehensive and influential groups ever to meet to discuss Anaesthetic Mortality issues in Australasia. We were particularly fortunate to have the Presidents of ANZCA, the ASA, and the NZSA in attendance.

In the first session, each State Chair or Representative presented an up to date summary on the current situation in relation to Anaesthetic Mortality Reporting in their State. This included mechanisms, funding, confidentiality, privilege, and perceived strengths and weaknesses. Dr Cliff Peady summarised the situation in the Australian Capital Territory, which currently has no

formal reporting procedures. Dr Leona Wilson presented a summary of the situation in New Zealand, which also has no formal reporting procedures currently. She also referred to a report on the current medicolegal issues related to Anaesthetic Mortality Reporting in New Zealand prepared by Mr Bruce Corkill, which was tabled. It was clear that reporting mechanisms varied considerably across the region. Several ideas for improving reporting mechanisms were discussed. The planned Royal Australasian College of Surgeons Audit of Surgical Mortality was also discussed. It was agreed that this could not replace the current methods of Anaesthetic Mortality Reporting, but that the Audit would have other benefits and should be supported.

In the second session, all attendees were given a list of brief scenarios involving a peri-operative death, and were asked to classify the deaths using the current ANZCA Classification of Anaesthetic Mortality. It appeared that there were several areas in the current classification that were ambiguous. It was agreed that the current classification would benefit from stricter definitions, and that this should be addressed by the ANZCA Mortality Committee.

The third and fourth sessions involved discussions on improving 'numerator' data and 'denominator' data in relation to Anaesthetic Mortality. Currently, most anaesthetic Mortality Reporting is voluntary, although it is likely that there is a high 'capture' rate in most regions. It was agreed that ensuring confidentiality and providing useful and timely feedback were essential to encouraging voluntary reporting. The current mechanism of obtaining denominator data on the number of anaesthetic procedures performed was discussed in detail. It was agreed that national mechanisms were

required. In Australia this can be achieved only from the Australian Institute of Health and Welfare (AIHW), which receives data on all anaesthetic procedures coded. The issues related to the accuracy of coding were discussed, but it was agreed that the AIHW probably represents the most accurate source at present.

*'It was clear that reporting mechanisms varied considerably across the region.'*

All who attended considered that the Workshop was both informative and worthwhile, and that the ANZCA Q&S Committee and the Mortality Committee could work together to improve Anaesthetic Mortality reporting and education. It was planned that both Committees could follow up the key issues identified at the Workshop.

After the completion of the Workshop, there was a meeting of the ANZCA Mortality Committee. In addition to other agenda items, it was agreed that the ANZCA Mortality Committee would remain separate to the Q&S Committee, but that it would report through the Q&S Committee.

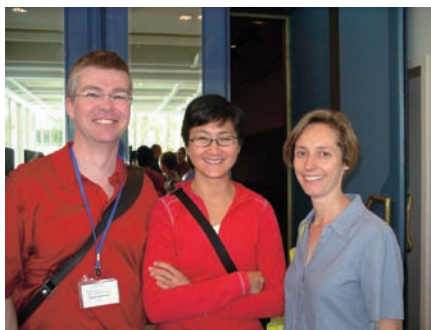
Overall there was great appreciation for the current strengths of Anaesthetic Mortality Reporting in the Region. There was also considerable resolve to accept the challenge to continue to improve data collection and feedback, especially in areas that have no formal procedures in place at present.

Dr Neville Gibbs  
Chairman, West Australian Anaesthetic  
Mortality Committee  
Member, ANZCA Q&S Committee

## 2006 COMBINED SIG MEETING

The 2006 meeting of the Medical Education, Simulation and Skills Training, Welfare of Anaesthetists and Anaesthetists in Management Special Interest Group was held on 29 September to 1 October at the Sheraton Mirage on the Gold Coast. The theme of the meeting was Attaining and Maintaining Competence in Education, Simulation, Welfare and Management. The international speakers were A/Prof Ira Cohen A/Professor of Anesthesiology and Pediatrics at Children's National Medical Center in Washington and Dr Ronnie Glavin, Scottish Clinical Simulation Centre, Stirling Royal Infirmary, Scotland. Dr Jackie Holt was also invited and presented a work-life balance session and David Broadbent presented sessions on dealing with the media.

The meeting was once again very successful attracting over 100 delegates and 25 presenters. The 2007 meeting will be held in Noosa in mid October.



# OTS

## Performance assessment

### SEPTEMBER 2006

The following candidates were successful at the recent Overseas Trained Specialist Performance Assessment and have completed the requirements of the OTS Assessment process:

Harald Gammelin	QLD
Manfred Thumm	NT
Oscar Naar Cifuentes	QLD
Sanjv Sawhney	QLD
Iftkhar Younis	QLD
Helmut Schoengen	QLD
Lucie Voldanova	QLD
William Campion Read	NZ

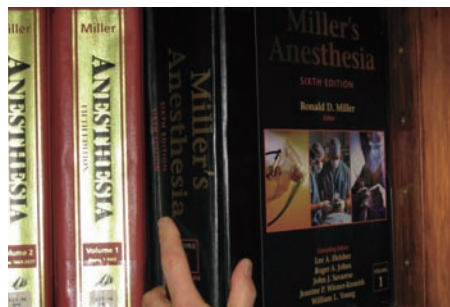
The following candidates were successful at the recent Overseas Trained Specialist Performance Assessment and are yet to complete the requirement of the OTS Assessment process:

Rajesh Brijball	QLD
Jeffrey Gadsden	QLD
Kurichi Marudhachalam	NSW
Natalie Rogoff	NSW
Amar Saluja	NSW
Jeffrey Singer	QLD
Drasko Zembic	QLD

### Certificate of Excellence

Dr Rajesh Brijball was awarded a Certificate of Excellence at the September 2006 Overseas Trained Specialist Performance Assessment.

# COLLEGE LIBRARY



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

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

## ONLINE JOURNALS

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## NOTICE TO NEW ZEALAND FELLOWS AND TRAINEES

A core collection of anaesthetic textbooks is available for loan from the New Zealand office of the College. Please check the library catalogue at <http://www.anzca.edu.au/libcatalogue/index.htm> for books held in New Zealand.

Contact details for the New Zealand office are as follows:

New Zealand National Committee (ANZCA)  
PO Box 7451  
Wellington South  
New Zealand  
Tel. (04) 385 8556  
Fax. (04) 385 3950  
Email: [anzca@anzca.org.nz](mailto:anzca@anzca.org.nz)

## NEW ADDITIONS TO THE COLLEGE LIBRARY

### NEW BOOKS

1. Anaesthesia : Awakening the sleeping giant : Celebration of William Russ Pugh's first anaesthetic in Launceston / ed by Paul A C Richards and Philip N Ogden - Launceston, Tasmania : Myola House of Publishing, 2006.
2. Anesthesia and orthopaedic surgery / ed by Andre P Boezaart - New York : McGraw-Hill, 2006.
3. Career decision making by postgraduate doctors : AMWAC medical careers surveys, 2004 : main report / Australian Medical Workforce Advisory Committee. / Australian Medical Workforce Advisory Committee - North Sydney : Australian Medical Workforce Advisory Committee, 2005.
4. Complications in anesthesia / ed by John L Atlee - 2nd ed. - Philadelphia : Saunders-Elsevier, 2007.
5. Effecting a cure : aspects of health and medicine in Launceston / ed by Paul A C Richards, Barbara Valentine and Tom Dunning -- Launceston, Tasmania : Myola House of Publishing, 2006.

6. Foundations of anesthesia : basic sciences for clinical practice / ed by Hugh C Hemmings and Philip M Hopkins - Philadelphia : Mosby Elsevier, 2006.
7. Geriatric anesthesia / ed by Frederick E Sieber -- New York : McGraw-Hill, 2007.
8. The ICU book / Paul L Marino - 3rd ed. - Philadelphia : Lippincott Williams and Wilkins, 2007.
9. McGraw-Hill's pocket guide to lung function tests / B Hancox and K Whyte - Sydney : McGraw-Hill, 2006.
10. Perioperative transfusion medicine / ed by Bruce D Spiess, Richard K Spence and Aryeh Shander - Philadelphia : Lippincott Williams and Wilkins, 2006.
11. Principles and practice of mechanical ventilation / ed by Martin J Tobin - 2nd ed. - New York : McGraw-Hill, 2006.
12. Simulation in anesthesia / Christopher J Gallagher, S Barry Issenberg and Tom Church - Philadelphia : Saunders-Elsevier, 2007.

### POPULAR BOOKS

1. Anesthesia and co-existing disease / Robert K Stoelting; Stephen F Dierdorf - 4th ed. -- New York : Churchill Livingstone, 2002.
2. The clinical anaesthesia viva book / Simon J Mills; Simon Maguire and Julian M Barker - London : Greenwich Medical Media, 2002.
3. Clinical cases in anesthesia / ed by Allan P Reed and Francine SYudkowitz - Philadelphia : Elsevier Churchill Livingstone, 2005.
4. Clinical teaching : a guide to teaching practical anaesthesia / ed by J David Greaves; Chris Dodds; Chandra M Kumar and Berend Mets - Lisse : Swets and Zeitlinger, 2003.
5. Concise anatomy for anaesthesia / Andreas G Erdmann - London : Greenwich Medical Media, 2002.
6. Crisis management in anesthesiology / David M Gaba; Kevin J Fish and Steven K Howard -- New York : Churchill Livingstone, 1994.



7. Equipment for anaesthesia and intensive care / WJ Russell – 2nd ed – Adelaide : W J Russell, 1997.
8. Ethics in anaesthesia and intensive care / ed by Heather Draper and Wendy E Scott – Edinburgh : Butterworth Heinemann, 2003.
9. Evidence-based practice of anesthesiology / ed by Lee A Fleisher – Philadelphia : Saunders, 2004.
10. Evidence-based obstetric anesthesia / ed by Stephen H Halpern and M Joanne-Douglas - Mass. : Blackwell Publishing, 2005.
11. Laryngeal mask anaesthesia : principles and practice / JR Brimacombe – 2nd ed. – Philadelphia : Saunders, 2005.
12. Ophthalmic anaesthesia / ed by Chandra M Kumar; Chris Dodds and Gary L Fanning – Netherlands : Swets and Zeitlinger, 2002.
13. Peripheral regional anesthesia : an atlas of anatomy and techniques / Gisela Meier and Johannes Buettner -- New York : Thieme, 2005.
14. Pharmacology for anaesthesia and intensive care / TE Peck; SA Hill and M Williams – 2nd ed – London : Greenwich Medical Media, 2003.
15. A practical approach to cardiac anesthesia / ed by Frederick A Hensley; Donald E Martin and Glenn P Gravlee – 3rd ed – Philadelphia : Lippincott Williams and Wilkins, 2003.
16. Practical perioperative transesophageal echocardiography / ed by David Sidebotham; Alan Merry and Malcolm Legget – Edinburgh : Butterworth Heinemann, 2003.
17. Regional nerve blocks and infiltration therapy : textbook and colour atlas / Danilo Jankovic – 3rd ed. -- Mass. : Blackwell Publishing, 2005.
18. Statistical methods for anaesthesia and intensive care / Paul Myles and Tony Gin -- Oxford : Butterworth-Heinemann, 2000.
19. Transoesophageal echocardiography in anaesthesia and intensive care medicine / ed by Jan Poelaert and K Skarvan – London : BMJ Books, 2004.
20. Yao and Artusio's anesthesiology : problem-oriented patient management / ed by Fun-Sun F Yao and Joseph F Artusio – 5th ed – Philadelphia : Lippincott Williams and Wilkins, 2003.

# Obituaries

Brendan Vincent LYNE

6th October 1918 – 4th October 2006

Auckland

FFARACS 1956, FANZCA 1992



BRENDAN LYNE

● With the passing of Brendan Lyne, just two days short of his eighty eighth birthday, Australasia said goodbye to one of the true gentlemen of anaesthesia.

Brendan was the eldest in his family of six. His father, Daniel, was the local doctor in the small fishing village of Castletown Bere, on the Beara Peninsula, County Cork, about 20km from the south western tip of Ireland. The Lyne family had lived in that area for generations. As a family they swam a lot and always had boats, row boats, motor boats, a yacht and even an 18ft naval whaling boat. It is not surprising that in Auckland he was able to continue this and with his family enjoy the sea and countryside. His eldest son crewed on one of the yachts in the 'Whitebread Round the World' yacht race.

From the age of 12 Brendan was sent to boarding schools. Near the end of his secondary education he knew that he wanted to be a doctor. He said that this was not just because his father was a doctor, but there was a chap at his school whose father was also a doctor who specialised in paediatrics. Perhaps from this friendship grew his own interest in paediatric anaesthesia. In 1937 he enrolled at the University College of Cork. He graduated M.B., B.Ch. from the University of Ireland in 1944. He went to England to undertake training in anaesthesia but during this time he

contracted tuberculosis. As this was in the days before antibiotics he had to take a year off from his training for recuperation. He gained the D.A., RCP, RCS, Ireland in 1947.

Towards the end of 1950 Brendan immigrated to New Zealand and was registered here in August that year. He was the first qualified anaesthetist from overseas to be appointed to the full time staff of the Auckland Hospital Board. He arrived during a period of renaissance in the Auckland hospitals. In anaesthesia much of the equipment was all American (being post war) and not suitable for use on children. The new Superintendent-in-Chief, the Board Chairman and the new Director of Anaesthetics were receptive to any improvement. So gradually new anaesthetic machines were obtained from England where they were in vogue. Brendan played a key role in this change.

Before Brendan came to New Zealand, friends of his mother suggested that he look up their niece Kay Hogg. Kay was nursing at the Greenlane Hospital in the cardiac ward in the early days of heart surgery and thoracoplasty. Brendan worked there too. He recalls that not long after he arrived he went along and saw her and that was that!! They were married at St. Patrick's Cathedral in January 1952 by Bishop Sneddon. They have six children, Anne, Clare, Brendan, Mary, Margaret and Adrian.

He became a Member of the Faculty of Anaesthetists, Royal Australasian College of Surgeons towards the end of 1954, a Fellow in 1956 and in 1992 a foundation Fellow of the Australian and New Zealand College of Anaesthetists

Brendan spent his first eight years working in one or other of the 4 hospitals of the Auckland Hospital Board, namely Auckland, Greenlane, Middlemore and Cornwall Women's (the original National Women's). As his seniority increased he worked just at Auckland and Middlemore. Towards the end of the 1950s he commenced

*'Brendan was the first specialist anaesthetist in private practice in Auckland. Until this time private anaesthesia was the domain of the GP who usually referred the patient to the surgeon.'*

part-time private anaesthesia practice alongside his public work. This necessitated very long hours and Kay carried the home.

Brendan was the first specialist anaesthetist in private practice in Auckland. Until this time private anaesthesia was the domain of the GP who usually referred the patient to the surgeon. As Brendan had developed a close working relationship with some surgeons in the public hospitals he was able to continue this high standard of care and professionalism in private. He was involved in a lot of plastic surgery and in particular with Sir William Manchester and his work with cleft palate and lip surgery. Brendan found this challenging but very satisfying.

In December 1964 a group of seven anaesthetists (both specialist and GP) banded together to form the Remuera Anaesthetic Bureau. The purpose was 'to provide a more efficient means of practice management and more importantly, by their mutual co-operation, providing a better anaesthetic service to the private patients of Auckland'. Brendan as the first Chairman guided this new service professionally. This group continues today, following the high ideals of the founding members of 1964, albeit with a name change and 41 specialist anaesthetist members. Brendan retired from anaesthetic practice in 1988. He was highly regarded by all of his colleagues.

There were three facets to Brendan's life, his Faith, his Family and his Profession.

He had a deep and sincere faith with strong Christian values which were incorporated into all aspects of his life. It was this faith that was his guide and gave him strong spiritual strength to the end. Since the early 1970's 'Our Lady of Fatima' church and its community were important to Brendan and his family. Their house moves were centred to staying close to his church and during his daily long walks he always managed to visit his church. Brendan was not content to just have passive role but took an active part in church life. He served on the local Parish Pastoral Council as well as the Diocesan Pastoral Council. It was through his work with the St Vincent de Paul Society, of which he was chairman for many years, that he was able help people who were disadvantaged or marginalised in our society.

He was very much the family man. He was devoted to his wife Kay and they recently celebrated 54 years of marriage. Kay was always there to support him and together they created a wonderful home for their six children, then their families and their twelve adored grandchildren. Besides his busy professional life he gave them, together with Kay, a happy secure childhood so that no matter what life was to throw at them they

could always draw strength from those happy memories. He even became a self-appointed part time movie director to record precious family moments on film long before video was thought about. Although he had emigrated to New Zealand, a piece of him always remained in Ireland. He never relinquished his Irish passport and he made 3-4 trips to his homeland to visit family and relish walking around the countryside and sailing on Bantry Bay. He enjoyed walking; the pleasure and the exercise were a great benefit to him. Brendan loved dinner parties. He made a wonderful host (along with Kay, a wonderful hostess). There was the finest food from her kitchen, the best crystal and china, good wine and the family to wait on you. Meetings of the Journal Club at Brendan's home were always a well attended educational and social event. When he was involved with the British Medical Association and they held their Annual Conference in Auckland (1969), Brendan was on the organising committee, in charge of transport. He helped organised the ferry trip to Motuihe Island which turned out to be a wonderful social outing, including perfect weather.

Brendan decided to specialise in anaesthesia because he was passionate about relieving people from their pain. When he commenced his training the speciality was in its infancy and undergoing development following World War 2. This provided him with great intellectual, academic and career opportunities which he found both stimulating and personally satisfying. He was totally dedicated to his patients with a caring and compassionate bedside manner. Not only was he highly respected by his peers but was held in high regard by the young doctors. They were not scared to call him at any time and appreciated that he would go back to the hospital in the middle of the night if they needed his support.

When Brendan retired his colleagues gave him a silver tray which was inscribed:-

'To Brendan Lyne in recognition of his contribution to anaesthesia over a period of 42 years as a teacher, a humane practitioner, advisor and as our colleague'.

To Kay and to her family we extend our deepest sympathy and recall a sincere friend and colleague who gave his all to his faith, to his family and to his profession and patients.

Cedric Hoskins

## Peter Lloyd, MBChB, FANZCA 1961-2006

**Thou wert the morning-star among the living, Ere thy fair light had fled, Now, having died, thou art as Hesperus, giving New splendour to the dead!** (Shelley's translation, From Adonais, by Shelley)

● Peter Lloyd collapsed and died while riding his bicycle to work on the morning of September 18th, 2006. Born in Wales on February 26th 1961, Peter emigrated to Auckland with his family in 1974, where he acquired his secondary and medical education. He spent his house-surgeon years in Wanganui, marrying Merryn shortly before he departed for Wales and general practice. He completed a Diploma of Anaesthesia in 1989 and, having been exposed to the 'sacred art', returned to Auckland to undertake formal training in what was to become his beloved speciality. He joined the Hawke's Bay Anaesthetic Department in 1993 and was granted Fellowship of the College in 1995.

Throughout his career, Peter was larger than life, and is fondly remembered by many as the 'ballad-reading Welshman'. Peter used his oratorical talents to great effect to tame fear-ridden children in theatre by enchanting and entrancing them with a story or poem before induction, or to explain, to those of us with lesser intellect, the finer points of anaesthesia.

In his own practice, Peter was always looking for improvement. Every anaesthetic he performed was a work of art as he strove for perfection. This led to a constantly evolving style. Some of his innovations, (like measuring blood pressure in kilopascals), frustrated his colleagues, but we all appreciated his advocacy of change when evidence challenged existing empiric practice - such as when he championed a conservative blood transfusion strategy.

Peter contributed greatly to the craft of anaesthesia. His work advancing strong ion analysis and developing a strong ion calculator gained international recognition. His commitment to local registrar teaching, including a time as Supervisor of Training and as an invited speaker on courses, benefited many registrars. Coupled with his extensive knowledge, his infectious enthusiasm for otherwise dry subjects was inspiring.

Whether it was cycling, golf, four-wheel driving or Macintosh computers, Peter was passionate about everything he was involved in. He would fervently articulate these passions, the most recent, and consuming, of which was the rapid deterioration of our environment. This global issue had recently become Peter's major focus, and he fought to change our collective behaviour to protect our future. Peter's accumulated knowledge, from his extensive research of the subject, together with his ability to captivate audiences, made him a sought-after speaker. He lived as he taught and, having sold his beloved but fossil fuel-guzzling Landrover for a more efficient car, Peter maximised the energy efficiency of his house, including generating solar-powered electricity for the National Grid.

His children, Gwilym, Elin and Carys, survive Peter.

He will be sorely missed, and the world is a poorer place with his passing.

Ross Freebairn  
Murray Harty  
Hawke's Bay Hospital  
Hastings, New Zealand

## Benedict John Barry

1936 -2006

**Ben Barry was a giant in Australian Anaesthesia. A tall but shy man, he came from a small country farm at Moonbah, 'out the back of Jindabyne' in the Snowy Mountains District of Southern New South Wales. From such beginnings, he came to graduate in Medicine from the University of Sydney, become President of the Australian Society of Anaesthetists (ASA) and Foundation Editor of the Society's journal 'Anaesthesia and Intensive Care' one of the world's great medical journals. He also became a Member of the Board of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons. He received many honours. They included the Gilbert Brown Medal(1975) and Life Membership of the Australian Society of Anaesthetists (1988). In 1987 the Faculty of Anaesthetists of the Royal College of Surgeons of England elected him to Fellowship and in 1994 the Australian and New Zealand College of Anaesthetists awarded him its Robert Orton Medal the highest honour the College can bestow.**

● Ben Barry was proud of his origins. At an Australia Day ceremony in 1998 he was asked as a member of a pioneering family to address the people of the Snowy River Shire. He describes how in 1823 'in the City of Cork, Ireland, Margaret Bourke was sentenced to be transported to the Colony of New South Wales for seven years penal servitude. Her offence was 'having on her person articles suspected of being stolen'. William Barry, her future husband, rose in the court room objecting to the severity of the sentence and abused the magistrate. For his demonstration he too was sentenced to be transported for seven years'. That is how Ben, six generations later became an Australian.

The original Barrys eventually obtained their 'tickets of leave', became free settlers and generally prospered in the Moonbah District near Jindabyne.

Ben was born on 9th February 1936 the third of five children of Alex and Margaret and grew up living an isolated relatively primitive life in a simple home on their small property at Moonbah. There were no conveniences, no electricity, radio or refrigeration. Kerosene lamp and candles at night, no running water, the only hot water was that heated on the open fire. Life revolved around family, attending to the sheep and cattle, battling the rabbit plague, school and church. Jyndabyne was ten miles away and the school, Moonbah Public School was three miles away and he walked it each day. The family lived off the property raising their own sheep and vegetables supplemented by supplies periodically from Jyndabyne.

Ben was ten years old when tragedy struck. His mother died unexpectedly and it was decided that Ben should go to Sydney to be cared for by the nuns at St. Johns College at Campbelltown. Here he boarded for two years with occasional visits home and to his aunts in Lane Cove. He then was sent to Christian Brothers College at Waverley where he boarded for six years. Though lonely at first he adapted well, made good friends completed his schooling and proceeded on to Sydney University in the faculty of Medicine and became a resident of St. Johns College. He did well at sport, played Rugby and rowed in the University eight. After his early years and life as a boarder at school, Ben could not believe the freedom of University life. He enjoyed the company, the sport, the social life and study did not intrude too much. While at St. Johns, Ben, in 1960 now in his final year in Medicine, met his wife to be, Colleen McGuinness. She, a young teacher from New Zealand was visiting St. Johns. They were to marry in St. Johns chapel two years later.

Ben graduated in 1961 and became resident Medical Officer for the next two years at St. Vincent's Hospital Sydney. Encouraged by Dr. Brian Dwyer, head of Department, he became a Registrar in Anaesthesia at St. Vincent's Hospital from 1963 to 1965 as he undertook his specialist training. He was also for a time at the Royal Alexandra Hospital for Children. It was during these years that he really found his mark. He became intensely interested in this relatively new and rapidly evolving specialty. He achieved his Specialty qualification as a Fellow of the Faculty of

Anaesthetists of the Royal Australasian College of Surgeons in 1965. As the most successful candidate he was awarded the Cecil Gray prize.

Ben had arrived on the threshold of his career. Having completed his training years he was invited in 1966 to join the prestigious anaesthetic practice at Elizabeth Bay Sydney known as General Anaesthetic Services (sometimes referred to as 'the Gas Company'). He became an honorary anaesthetist at Liverpool, Balmain and Prince of Wales Hospitals and in 1967 at St. Vincent's Hospital Sydney and the Repatriation General Hospital Concord. Ben was now very busy in his private practice and concentrated on St. Vincent's and Prince of Wales Hospitals both teaching hospitals of the University of New South Wales. At these hospitals he taught and influenced numerous registrars to be specialists in Anaesthesia. His practice in later years was conducted from St. Vincent's Clinic as a member of 'Vinaes' a leading private practice group.

At St. Vincent's General Hospital Ben became very active in the organization of the anaesthetic department and when an executive structure was developed he became the inaugural Chairman. With boundless energy, the young Dr. Barry became interested in contributing to his Specialty in broader and broader terms. This extended beyond teaching to the organization and academic structure of Anaesthesia. His talents attracted the interests of the ASA and in 1969 he became Honorary Federal Secretary a post he held for four years.



During this time Ben embarked on a task that was to lead to probably his greatest achievement. Anaesthesia had become a rapidly growing specialty with an enormous expansion in its science and in its clinical development. In addition growing numbers were entering the specialty and it was attracting many of the cream of medical graduates (it is today the third largest of all medical specialties). Australian anaesthetists were at the forefront of the explosion of new knowledge and needed a vehicle to publish their work. Ben saw this and convinced the ASA and the Faculty of Anaesthetists, (the academic and examining body for Anaesthetists) to support the project in the face of some firm opposition from some who believed it would not succeed. Ben was appointed first editor and in June 1972 produced the first edition of 'Anaesthesia and Intensive Care'. It was a resounding success and has been so ever since. It has published papers from Australia and elsewhere for many years which have greatly advanced the science of Anaesthesia and of many other medical fields. In 1975 Ben was awarded the Society's Gilbert Brown Award in recognition of outstanding services to the Society and Anaesthesia in Australia.

*'With boundless energy, the young Dr Barry became interested in contributing to his Specialty in broader and broader terms.'*

The Australian and New Zealand College of Anaesthetists in 1995 awarded Ben Barry the Robert Orton Medal (its highest honour) in recognition of his contributions to the College and to Australian Anaesthesia. In the citation to mark this award, delivered by Dr. Brian Horan the second editor of the Journal, he quoted Professor Joseph (Professor of Anaesthetics Sydney University) 'the foundation and continuity of this journal have

been due almost entirely to the dedication and efforts of its first editor'. It was Professor Prys-Roberts (of Oxford) on the occasion of Dr. Barry being elected to Fellowship of the Faculty of Anaesthetists of the Royal College of Surgeons (England) in 1987 who stated 'more than anyone else Ben Barry established the journal which we now recognize as one of the leading English language journals in the world'.

In 2006 the journal is the official scientific publication for all anesthetists in Australia and New Zealand, has six editions per year and receives articles from all over the world. For this and his other contributions Ben was made an Honorary Life Member of the Australian Society of Anaesthetists in 1988. In 1995 the Society approved an occasional award to be known as 'The Ben Barry Award' to be given to individuals who have contributed in an outstanding way to the affairs of the Journal.

Ben's labours for Anaesthesia did not stop with the Society. He was very active in the Faculty of Anaesthetists of the Royal Australasian College of Surgeons. He was an examiner for the Final Fellowship Examination from 1972 to 1984 and a member of the Board of Faculty from 1976 to 1981 and during that time filled the offices of General Scientific Meeting Officer and Continuing Medical Education Officer.

Through Ben's high profile in the ASA he became involved in the World Federation of Societies of Anaesthetists and was Vice President for four years from 1984. When the 11th World Congress of Anaesthesiologists was held in Sydney in 1996 Ben was its Honorary President.

Ben Barry has had an enormous influence on Anaesthesia in this country and its practitioners. His Presidential address given at the ASA Annual General Meeting in 1988 strongly advocated the formation of an Australian College of Anaesthetists separate from the Royal Australasian College of Surgeons. It was only a matter of a few years before this concept was accepted as others embraced his ideas. The Australian and New Zealand College of Anaesthetists became a reality in 1992.

*'Ben's labours for Anaesthesia did not stop with the Society. He was very active in the Faculty of Anaesthetists of the Royal Australasian College of Surgeons'*

Ben Barry was gifted with altruism, foresight, clarity of mind, integrity and great energy. He was a loyal friend to those who knew him. He and Colleen enjoyed a wonderful family life over many years and produced two sons, Jim and Justin, and three daughters Mary-Ellen, Bronwyn and Rachael (deceased). They have 11 grandchildren.

The great love of Ben's life after his family was 'Banyan' his lovely property near Crookwell in the New South Wales Southern Highlands. Here he returned to his roots whenever he could and tended his cross-bred Dorset rams and Merino-Border-Leicester ewes. He even grew a few rows of grapes from which he made some of his own wines with mixed success but great fun.

Ben was a wonderful person to know. He left this place better than he found it. He died after a long illness on 6th September, 2006.

Dr Don Maxwell  
Past President, Australian Society  
of Anaesthetists  
Bronte NSW

# PRIMARY EXAMINATION

July/September 2006

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

The viva examination was held at College Headquarters, Melbourne and the Academy of Medicine, Hong Kong.

## SUCCESSFUL CANDIDATES

The following candidates successfully completed the Primary Fellowship Examination at this sitting.

Jeremy Duncan Trenorden Abbott	QLD	Paul Egan	NSW	Adam Romney Nettleton	VIC
Daniel John Aras	TAS	David Geoffrey Fahey	QLD	She Yin Ng	NSW
Trevor Robert Arnold	NSW	Nasim Fahimian	WA	Mau-Hing Ann Ngui	WA
Simon Antony Astegno	VIC	Fan Chun Yin	HKG	Nhi Quynh Nguyen	NSW
Kartik Ramchandra Atre	NSW	Jeremy Ranil Fernando	NZ	Tu Quyen Therese Nguyen	VIC
Anthony John Barnard	SA	Morne Vernon Fortuin	VIC	Virgilius Viorel Niculescu	SA
Jayne Elizabeth Berryman	QLD	Samuel Patrick Frost	VIC	Nik Ahmad Mazani Nik Mohamad	NZ
Linda Julie Bingham	VIC	Kim Lisa Fuller	QLD	Melanie Louise Olsen	SA
Deas Macdonald Brouwer	VIC	Andrew Tasman Game	NSW	Marilyn May-Ming Ong	WA
Matthew Bryant	QLD	Veronica Christina Gin	NZ	Osman Ozturk	VIC
Allannah Maree Burke	NZ	Benjamin Hallett	VIC	Girish Suhas Palnitkar	TAS
Peter Carlin	SA	Angelique Halliday	WA	Louise Serena Parker	VIC
Chan Lai Mei	HKG	Navid David Hashemina	WA	Ajinth Pathmanathan	NSW
Chan On Yi	HKG	Adam Francis Hastings	NSW	Ross Graham Peake	ACT
Isaac Wai Hon Cheung	VIC	Dean Rowan Haydon	QLD	Sabine Pecher	NZ
Sue Cheng Chew	VIC	Geoffrey Healy	NSW	Adam David Perczuk	NSW
Chiang Chi Sum James	HKG	Sandy Ling Hui Huang	NSW	Katherine Joy Perry	NZ
Jing-Chen Jason Chou	WA	Ip Ka Ho	HKG	Vivi Pham	NSW
Choy Chung Ming Eric	HKG	David Frederick Isaac	NSW	Phoo Wai Heng	SGP
Adriano Gino Cocciant	VIC	Joeng Kin Ying Alice	HKG	Alexander John Psirides	NZ
Richard Antony Connell	VIC	Andrew David Jones	VIC	Quek Sui-Yi Alina	SGP
John Michael Davis	QLD	Alan Stephen Kakos	VIC	Mohammad Ali Rahmati	VIC
Michael Jeremy Dick	NZ	Darshana Hewa Kandamby	HKG	Arvind Raju Ganga Raju	NSW
Mark Dilda	QLD	Sarah Hadi Khatib	NSW	Vaughan Raleigh	VIC
Jennifer Claire Dixon	NSW	Simon Koh	NSW	Bradley David Sartori	QLD
James Michael McGregor Dowling	SA	Fong Chee Koh	NSW	Timothy Theodore Scholz	QLD
Kate Elizabeth Drummond	SA	Juliana Nai Jia Kok	QLD	Caroline Shadbolt	NSW
Christopher Bruce D'Souza	NZ	Dimitrios Konidaris	SA	Vikramjit Singh	NZ
Rohone D'Souza	NSW	Antigoni Koutantos	NSW	Vincent Ching So	NSW
Carl Edward D'Souza	NSW	James Michael Koziol	VIC	Margaret Brigida Soroka	QLD
Bridget Kate Effeny	QLD	Kushlani Shiromala Kumarasinghe	VIC	Geneva Simone Sportsman	NSW
Peter James Effeny	VIC	Sally Lacey	VIC	Arpit Srivastava	NSW
		David Lam	VIC	Janice Eithne Stafford	QLD
		Lau King Yin	HKG	Angela Ruth Stephen	NZ
		Corinne Jacqueline Law	NZ	Karl Peter Sturm	NZ
		Diem Le	SA	Tam Tak King Dhuugal	HKG
		Long Ha Le	NSW	Tan Yin Kiat Glenn	SGP
		Lee Wai Ping	HKG	Tan Leng Zoo	SGP
		Lee Shu Ying	SGP	Selene Tang Wei Lien	VIC
		Loh May-Han	SGP	Michael James Thomas	TAS
		Kenny Wei-Tsen Loh	SGP	Damon Nicholas Simon Thompson	NZ
		Malini Magesan	NSW	Clifton Edwin Timmins	QLD
		Nicholas Webster Marks	NZ	Minh The Tran	NSW
		Rodney Alexander Martin	NSW	Jennifer Elizabeth Upton	NSW
		Michael John McCartney	NSW	Damien Robert Wallman	WA
		Paul Crossman McCallum	VIC	Andy Yi-Yang Wang	NSW
		Denise Helen McCool	QLD	Camie Wang	NSW
		James Patrick McGirr	NSW	Wat Chun Yin	HKG
		Daniel James Michael	NSW	Edith Bodnar Waugh	VIC

Kim Yuh-Kuan Weng	NSW
Emily Claire Wilcox	NSW
Luke Anthony Wilson	VIC
Chun Keat Wong	SA
Wong Tsz Kin	HKG
Christopher Kin-Bonn Wong	NSW
Wong Hoi Kay Tiffany	HKG
David William Wright	QLD
Yeoh Hann Sean Brian	MLY
Beata Brygida Zmudzki	NSW
John Zois	VIC

#### RENTON PRIZE

The Court of Examiners recommended that the Renton Prize for the half year ended 31 December 2006 be awarded to:

Dr. Damien Robert Wallman	WA
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#### MERIT CERTIFICATES

Merit Certificates were awarded to:

Dr. James Michael McGregor Dowling	SA
Dr. James Michael Koziol	VIC
Dr. Andrew David Jones	VIC
Dr. Quek Sui-Yi Alina	SGP
Dr. Chan Lai Mei	HKG
Dr. David Frederick Isaac	NSW
Dr. Wat Chun Yin	HKG
Dr. Jennifer Elizabeth Upton	NSW
Dr. Peter James Effeney	VIC
Dr. Benjamin Hallett	VIC
Dr. Adam Romney Nettleton	VIC
Dr. Katherine Joy Perry	NZ
Dr. Chun Keat Wong	SA
Dr. Nicholas Webster Marks	NZ
Dr. Adriano Gino Cocciant	VIC



Primary Examination July/September 2006 - Court of Examiners

Front Row: Dr. Ross MacPherson, Prof. David Story, Dr. Julia Fleming, Dr. Peter Doran, Dr. Noel Roberts, Prof. Tony Gin, Dr. Andrew Gardner, Dr. John Copland

Stairs: Dr. Tim Short, Dr. Harry Prevedoros, Dr. Craig Noonan (Chairman), Dr. Brad Smith, Dr. Paul Forrest, Dr. Jo Sutherland, Dr. Alex Konstantatos, A/Prof. Geoff Gordon, Dr. Stephen Barratt

Absent: Dr. Drew Heffernan, Dr. Yuri Kontrobarsky

So that  
she may  
grow...



Dr Rob McDougall FANZCA, Deputy Director of Paediatric Anaesthesia, and Dr Luke Nasedra from Fiji, the 2006 ANZCA Pacific Fellow, caring for an eight month old baby with craniosynostosis. She is undergoing a reconstruction of her entire skull, to allow her brain to grow and develop normally.







# FINAL FELLOWSHIP EXAMINATION

## FINAL FELLOWSHIP EXAMINATION (ANAESTHESIA) SEPTEMBER 2006

The written section of the examination was held in all capital cities in Australia, Adelaide, Launceston, Hobart, Newcastle, Auckland, Brisbane, Christchurch, Darwin, Dunedin, Hamilton, Hong Kong, Singapore, Townsville and Wellington.

The viva and medical clinical examinations were held at the Prince of Wales and Sydney Children's Hospitals, Randwick, Sydney.

### SUCCESSFUL CANDIDATES

Name of successful candidates who have not completed training:

Malcolm Gordon Albany	NSW
Assad Hussain	HK
Welarambage Mendis	NZ
David Laurence Anderson	QLD
Christopher Jephcott	NZ
Simon John Mitchell	NZ
Nicole Leanne Anderson	QLD
Penelope Jane Jones	QLD
Timothy Sean Morgan	NSW
Juling Ang	VIC
William Thomas Jordan	QLD
Sagy Jacob Nathan	NSW
Maryanne Balkin	VIC
Shumita Joseph	TAS
Catherine Olweny	VIC
Rebecca Jane Branch	NZ
Kam Hau Chi	HK
Brendan David Powers	NSW
Peter William Brennan	NSW
Michael Edward King	QLD
Frank Raineri	VIC
Katharine Emily Brunette	NZ
Samuel Herbert Koch	NSW
David Jeremy Rowe	QLD
Paula Jane Carter	NZ
Kong Kau Fung Vincent	HK
Tisha Mary Searles	QLD
Lyndon Chee	NSW
Hai Yen Lam	NSW
Karl Hans Smolka	NSW



Benjamin Koon Cheung	QLD
Stephen Peter Lamb	WA
Richard Paul Sullivan	VIC
Angela Ching Lam Chia	VIC
Daniel Paul Lane	ACT
Lionel Kee-Hau Tan	QLD
Kenneth Ngee-Ken Chin	SA
Anna Irene Leavy	NSW
Michael Patrick Thompson	QLD
Clement Chi Hang Chu	NSW
Emily Mary Lee	TAS
Rudolf Van der Westhuizen	QLD
David Nicholas Closey	VIC
Timothy Heung Wah Lee	VIC
Heidi Christian Walker	NZ
Andrew Dubyk	NSW
Ian Keith Letson	VIC
Evan Mathew Weeks	VIC
Tamara Eichel	NSW
Leung Yin Yee	HK
Paul Joseph Whiting	NSW
Kate Elizabeth France	NSW
Kian Lee Clarence Lim	NSW
Charles Harold Willmott	QLD
Maria Masha Golikov	QLD
Andrew David Lo	NSW
Gerald Laurence Wong	NZ
Cameron Scott Graydon	VIC
Paul Michael Martin	QLD

Cheryl Lok See Yeung	HK
Andrew Peter Hehir	NSW
Matthew Roman Matusik	VIC
Mark Graham Young	QLD
Jason Leonard Henwood	NZ
Daniel John McGlone	TAS
Bong Joon Huh	NSW
Daniel John McIntyre	VIC

### CECIL GRAY PRIZE

The Court of Examiners recommended that the Cecil Gray Prize for the half year ended 31 December 2006 be awarded to Dr Heidi Walker, New Zealand.

### MERIT LIST

The following candidates were awarded a Merit Certificate for their performance at the September 2006 Final Examination:

- Benjamin Cheung, QLD
- Kenneth Chin, SA
- Lionel Tan, QLD
- Rudolf van der Westhuizen, QLD



## ANZCA/ASA Gilbert Troup Prize for 2005

The recipient of the 2005 ANZCA/ASA Gilbert Troup Prize was Mr David Graham. David achieved the best overall performance in the anaesthesia module of the Medical School of the University of Western Australia.

# COUNCIL HIGHLIGHTS

Held on 14 October 2006

## DEATH OF FELLOWS

Council noted with regret the death of the following Fellows:

- Dr Herbert John Dudley (Qld) – FFARACS 1982, FANZCA 1992
- Dr Benedict John Barry (NSW) – FFARACS 1966, FANZCA 1992
- Dr Peter Lloyd (NZ) – FANZCA 1995
- Dr Brendan Vincent Lyne (NZ) – FFARACS 1954, FANZCA 1992

## HONOURS, APPOINTMENTS AND HIGHER DEGREES

Council noted the following:

- Dr Walter Thompson (WA) – Conferral of Fellowship, Academy of Medicine of Malaysia.
- Prof Michael Cousins (NSW) – Conferral of DSc, University of Sydney for his dissertation related to pain, analgesia and anaesthesia in the management of acute, chronic and cancer pain.
- A/Prof Jennifer Weller (NZ) – Conferral of MD, University of Auckland for her thesis on the topic of the evaluation of simulation-based education in the management of medical emergencies.

## EDUCATION AND TRAINING

### Training Agreements

Council supported the introduction of Training Agreements for signature by all trainees undertaking the College training program. It is anticipated that the final document will be ratified by Council at its December Meeting.

## FINANCE

### 2007 ANZCA Training Scholarships

The following trainees were awarded Training Scholarships for 2007:

- Dr Anisa Aisha Binti ABU BAKER (Malaysia)  
Dr Yvette Noellynn D'OLIVEIRO (Malaysia)  
Dr Sajidah Ilyas BT MOHAMMAD ILYAS (Malaysia)  
Dr NG Lip Yang (Malaysia)  
Dr Cheng Bee YIP (Malaysia)

## 2007 ANZCA International Scholarship

No application was received for this Scholarship.

## Financial Delegations to Regional/NZ Committees

Council supported this document as a means of clarifying a number of issues previously dealt with through individual queries to the Treasurer.

## Annual Subscription and Fees for 2007

In determining the Annual Subscription and fees for 2007, Council recognised:

- the increased activity within the College that was related to dealing with the various levels of government and other external bodies.
- the importance of maintaining the primacy of ANZCA in the training and education of anaesthetists.
- the need to develop and consolidate the new initiatives that have arisen from the Taskforces and the current strategic planning process.
- the need to improve the communication with, and services to both Fellows and trainees.
- that fees had been held constant from 1998 – 2005, so that in 2006 the ANZCA administration was operating in real terms (relative to CPI) at 6.8% less than in 1998.
- Council supported a 10% increase in subscriptions and fees for 2007 as follows:
- Annual Subscription - A\$1,250 plus GST, due and payable on 1st January 2007.
- Trainee Registration Fee – A\$1,290.
- Annual Training Fees:

Australia	A\$1,260
New Zealand	A\$1,260 (plus NZ GST)
Hong Kong	A\$1,260
Malaysia	MYR 1,260 (converted to AUD)
Singapore	A\$1,260 (converted to AUD)
- Examination Fee - A\$2,530.
- Maintenance of Professional Standards Fee for Non-Fellows - A\$330 plus GST.
- Overseas Trained Specialist Assessment Fee - A\$1,430 plus GST.
- Occupational Training Visa Assessment Fee - A\$110 plus GST.

## CONTINUING EDUCATION AND QUALITY ASSURANCE

### Annual Scientific Meetings

Council supported a new Fellow representative selected from the examination prize winners, carrying the Mace at the College Ceremony.

Each Regional Organising Committee is to provide a report on the progress of the meeting to each CE&QA Meeting.

### 2007 ASM

Dr Tim Flannery has been invited to deliver the Oration at the 2007 College Ceremony.

### 2008 ASM

Prof Steven Shafer has accepted the invitation to attend the 2008 ASM as Foundation Visitor.

### 2009 ASM

This meeting will be held in Cairns. The Regional Organising Committee for the 2009 ASM has been constituted as follows:

- Convenor – Dr Sean McManus
- Scientific Convenor – Dr Allan Palmer
- Deputy Scientific Convenor – Dr Pal Sivalingam
- Treasurer – Dr Rhonda Boyle
- HCI Liaison Representative – Dr Andrea Nowitz
- Social Convenor – Dr McManus will source from his colleagues in Cairns

### College Sponsorship of Speakers

It was agreed that local Fellows invited to speak at one session or workshop only at the ASM will not be required to pay the Registration fee. However if the fee is not paid the speaker is NOT entitled to:

- Entry into the Health Care Industry Exhibition
- Abstract Book and delegate satchel
- Entry into any other session
- Entry into any social function that is included with registration

### Continuing Education for Fellows/Individual CME

Dr Richard Riley has been appointed Editor of Australasian Anaesthesia.

### Maintenance of Professional Standards

Prof Teik Oh is undertaking a review of the current MOPS Program. Council supported the continuation of voluntary participation in the program, and the facilitation of online access.

### INTERNAL AFFAIRS

**ANZCA Foundation** – the Governor of Victoria has agreed to launch the Foundation into the public sphere, and the likely timing will be towards the end of March next year.

### PROFESSIONAL

#### Professional Documents

Following the normal review process, the following documents were approved by Council:

- EX1 – Policy on Examination Candidates Suffering from Illness, Accident or Disability
- PS6 – Recommendations on Minimum Requirements for the Anaesthesia Record

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

Following discussion with RANZCOG and ACRRM, some further modifications are being considered to enable the document to be promulgated by end of year.

### WORKFORCE

#### Workforce Survey to Fellows

Council supported the concept of periodical, rather than annual Workforce Surveys. It was agreed that a survey will not be undertaken in 2007.

The concept of undertaking a joint survey with the ASA, and the sharing of workforce data is to be pursued.

### COLLEGE AWARDS AND ELECTION

#### Admission to Fellowship by Election

Dr Kevin Johnston (Qld) was admitted to Fellowship by election under Regulation 6.3.1(c).

### RESEARCH

#### 2007 Research Awards

Funding for the following projects was accepted by Council:

RESEARCHERS	PROJECT TITLE	FUNDING APPROVED
A/Prof M Chan (HK)	PeriOperative ISchemic Evaluation (POISE) study. How does metoprolol prevent postoperative cardiac complications?	\$26,650.00
A/Prof M Chan (HK)	Visualizing expired air dispersion during common respiratory therapy: a simulator model to assess the risk of nosocomial infection	\$58,652.40
A/Prof K Leslie (VIC)	ENIGMA Trial Long-term follow-up study	\$53,807.40
Prof M J Paech (WA)	The use of skin conductance monitoring to predict severe hypotension after spinal anaesthesia for elective caesarean section	\$15,149.00
Dr A J Davidson (VIC)	an international RCT comparing spinal and general anaesthesia on neurodevelopment outcome and apnoea in neonates	\$44,820.00
Dr A J Davidson (VIC)	Explicit recall during anaesthesia in children	\$14,006.00
A/Prof P J Siddall (NSW)	Activation of brain regions in people with neuropathic pain following spinal cord injury	\$50,943.00
Dr A N Pollock (NZ)	Pharmacological characterisation of malignant hyperthermia	\$20,000.00
Dr P J Peyton (VIC)	Continuous non-invasive measurement of cardiac output in ventilated patients by the pulmonary capnodynamic method	\$40,000.00
A/Prof A W Quail (NSW)	The effects of colatile anaesthetic agents on bronchial dimensions and blood flow	\$40,000.00
Dr D J Sturgess (QLD)	Comparison of BNP, Troponin and Tissue Doppler in the Evaluation of Ventricular Filling and Prognosis in Severe Sepsis	\$22,500.00
A/Prof D J Cooper (VIC)	PROphylaxis for ThromboEmbolism in Critical Care Trial	\$54,280.00
Prof M J Paech (WA)	Transfer of parecoxib into breast milk; a study of post-operative use following caesarean section	\$45,549.00
Dr M J Chapman (QLD)	Effects of glucagon-like peptide-1 on glucose levels and small intestinal transit in critically ill patients	\$35,965.00
Prof P S Myles (VIC)	International Perioperative genetics and safety outcomes study in cardiac surgery (iPEGASUS)	\$21,500.00

## Council highlights continued

Applications 07/035 and 07/017 were supported for funding of the second year of their projects, pending the receipt of a satisfactory progress report. Applications 07/003 and 07/015 were supported for funding of the second year of their projects, pending reapplication.

ID #/APPLICANTS	PROJECT TITLE	FUNDING APPROVED FOR 2008
07/035 Prof P S Myles (VIC)	International Perioperative genetics and safety outcomes study in cardiac surgery (iPEGASUS)	\$21,500.00
07/017 A/Prof A W Quail (NSW)	The effects of colatile anaesthetic agents on bronchial dimensions and blood flow	\$52,662.00
07/003 A/Prof M Chan (HK)	PeriOperative ISchemic Evaluation (POISE) study. How does metoprolol prevent postoperative cardiac complications?	\$29,611.40
07/015 Dr A N Pollock (NZ)	Pharmacological characterisation of malignant hyperthermia	\$33,890.00

**The Harry Daly Research Award** was awarded to Prof Paul Myles for his project 'International Perioperative genetics and safety outcomes study in cardiac surgery (iPEGASUS)'.

**The Organon Research Award** was awarded to Dr Jamie Cooper for his project 'PROphylaxis for ThromboEmbolism in Critical Care Trial'.

### 2006 Academic Enhancement Grant

Council agreed to support the two applications for this grant in the amount of A\$45,000 each:

- Prof J Lipman, Department of Anaesthesia, Royal Brisbane and Women's Hospital
- Prof C A Kam, Department of Anaesthesia, Royal Prince Alfred Hospital, Camperdown

### 2007 Simulation Education Grant

The following project was supported by for the award of the 2007 Simulation/Education Grant:

APPLICANT	PROJECT TITLE	FUNDING APPROVED
Dr R W Frengley (NZ)	An intervention to improve rapid sequence intubation in intensive care teams	\$35,000

### Lennard Travers Professor 2007

The 2007 Lennard Travers Professorship was awarded to Prof Michael Paech for his project 'Regular oral oxycodone compared with intrathecal morphine for pain relief after caesarean delivery: A randomised controlled trial (The SMOOTH Study)'(A\$30,000).

Prof Paech will be the Australasian Visitor to the 2008 ASM in Sydney.

# VRC CHAIRMAN'S NEWSLETTER

December 2006

**2006 has been a year of review and restructure at the College under the new leadership of Dr Mike Richards. He brings to the College extensive governance and corporate experience that is being used in large measure to guide the College in its planning and future direction.**

2006 has also been a year of change for the VRC. After twelve years of dedicated service to the VRC, Dr Peter McCall relinquished his role as Chair. The College and the VRC are indebted to him for his tireless efforts and consistent contribution to the Committee, the Trainee Program and to the anaesthesia profession as a whole. Dr McCall is pursuing his personal research and continues to be involved in specific activities of the College.

In June of 2006 a new VRC Committee was formed as a result of formal Elections. The new Committee members have been drawn from hospitals across Victoria and we look forward to a meaningful and rewarding term of office.

The various CME Evening Meetings run by the VRC were by all accounts very successful and were applauded for their quality and content by Fellows of the College.

The annual Anaesthetic Registrars' Scientific Meeting again this year provided an interesting and informative program of excellent Presentations by Registrars. Our grateful thanks go out to the Convenor, the Prize Judges and Session Chairs who so generously gave of their time and effort which contributed in no small way to the success of the ARSM.

The 27th Annual ASA/ANZCA Combined CME in July was once again well attended. The program was innovative and absorbing and congratulations are extended to the Convenor for his tireless efforts and excellent contribution to a successful meeting.

As the year comes to an end we thank the Directors of Anaesthesia, Supervisors of Training, and participating Lecturers in our Primary and Final Full Time Courses for their unstinting support and cooperation that enable these courses to be offered on a regular basis.

With the advent of the festive season we send best wishes to all Fellows and Trainees, the VRC members and all staff of the College for a prosperous and rewarding New Year.

.....  
**Dr Winifred Burnett**  
.....

# WESTERN AUSTRALIAN REGIONAL COMMITTEE

## Spring Scientific Meeting 06



On Saturday 2 September 2006 the Western Australian Regional Committee hosted the Spring Scientific Meeting at the University Club of WA. The theme of meeting was 'Ultrasound in Anaesthesia'. From all reports it was a great success with 110 people registering for the meeting.

The 2006 Dr Maxwell Sloss Lecturer, Dr Sarah Johnston from the Children's Hospital at Westmead, Sydney, delivered the opening lecture of the meeting, which was a presentation on ultrasound guided regional anaesthesia. This theme was continued with Dr James Rippey describing the use of ultrasound in the Emergency Department setting. On behalf of the Committee I would like to thank both Sarah and James for their contribution to the WA academic programme.

The free papers session followed after morning tea with presentations from Anaesthetic Registrars Dr Rik Kapila, Dr Shannon Matzelle and Dr Kevin Elks who all competed for the Nerida Dilworth Prize for the best registrar presentation. Dr Kirsten Tucker also gave a presentation in this session.

Congratulations go to Dr Rik Kapila who was the eventual winner of the Nerida Dilworth Prize for his presentation on

monitoring of skin conductance to assess postoperative pain intensity. Dr Nerida Dilworth was 'on hand' to present the prize.

The WA ANZCA/ASA Gilbert Troup Prize in Anaesthesia was also presented at the meeting to David Graham for obtaining the highest mark for the assessment in anaesthesia Options 590 in the course for the University of WA degree of Bachelor of Medicine and Bachelor of Surgery for 2005.

Prior to lunch Dr Sarah Johnston gave another interesting presentation on the use of ultrasound for peripheral limb blocks in children.

The afternoon session was made up of workshops and problem based learning discussions (PBLD) providing the opportunity for delegates to choose from a wide variety of topics to suit their own learning needs. The ultrasound workshops, x-ray interpretation and echocardiogram sessions continued the theme of imaging as it applies to our daily work as anaesthetists. The Committee would also like to thank the workshop and PBLD presenters who generously gave their time.

Dr David Wright Convenor



Above left: Sandra Box, Administrative Officer in WA with Dr Sarah Johnston the 2006 Dr Maxwell Sloss lecturer

Above:  
Drs Michael Veltman Chair of WARC and Ralph Longhorn  
Drs Jon Steinberg, Don McKenzie and Nerida Dilworth  
Drs Grant Turner and Richard Clarke  
Free paper presenters: Drs Kirsten Tucker, Kevin Elks,  
Rik Kapila and Shannon Matzelle  
ANZCA President, Dr Wally Thompson  
presenting David Graham with the  
2005 ANZCA/ASA WA Gilbert Troup Prize



# GEOFFREY KAYE MUSEUM OF ANAESTHETIC HISTORY

## Successfully Promoting the Work of Anaesthetists

Museum Talks and Tours for Rotary and Probus Groups are continuing to be very popular. Interest in this important historical collection from the wider community, offers an excellent opportunity to promote current developments in anaesthesia and the work of anaesthetists in general.



Visitors are provided with an informative and interesting talk by the Honorary Museum Curators on the history of anaesthesia, the development of ANZCA and the role of anaesthetists. All visitors are keen to find out what an anaesthetist 'actually does' during an operation.

There are still many misconceptions in the broader community as to the role and work of anaesthetists. One visitor asked: 'Is it true that anaesthetists play golf while a patient is sleep?' The Museum Talks and Tours help to demystify the role of the anaesthetist and at the same time help to gain support for this vital work within the community.

The first formal Museum Talk and Tour was held in September 2004, as a result of the Museum Collection being featured as part of the ABC Catalyst Program. Since that time over 160 members from a variety of Probus and Rotary groups have visited the Museum.

The Talks and Tours are offered free of charge and take approximately two hours including morning tea. Due to the success of past tours there has been no need to



formally publicize the Tours. All tours have been booked as a result of 'word of mouth' promotion which is a great compliment and the best form of free publicity.

Feedback from the visits is consistently and overwhelmingly positive as can be seen from the following comments in the Museum Visitors' Book:

*Thank you - extremely interesting,*  
Pat.Merbt, (Syndal Ladies Probus)  
*Fascinating,* Ethel and Leo Lloyd  
(Syndal, Ladies Probus)  
*An interesting and informative visit –  
all so well presented for us,*  
B. Jennings, (Syndal Ladies Probus)  
*Thank you for a fascinating morning,*  
E. Doey (Lyceum Club Ramblers)

The most recent visit was from the Ladies Probus Club of Hawthorn, on August 10th. In appreciation of the Talk and Tour the Probus Club presented Dr Rod Westhorpe, the Honorary Museum Curator with a donation of \$50.00 to the Museum. This was unexpected and very much appreciated.



Left: Dr Ball Mrs Judith Taylor and Dr Westhorpe with cheque 10 Aug 2006  
Centre: Probus Club of Hawthorn in the Museum Display Area with Dr Westhorpe 10 Aug 2006  
Right: Probus Club of Hawthorn in the DJ Room with Dr Westhorpe 10 Aug 2006

2007 looks as though it will continue to be a busy time for the Museum with a Talk and Tour already booked for the Greenhills Mixed Probus, in March. The Museum is proud to continue to promote and gain support for, the work of anaesthetists and ANZCA within the wider community.

Visits to the Museum are welcome and can be made by arranging an appointment with the Museum Manager. All bookings and enquiries regarding the Museum should be directed to **Ms Elizabeth Triarico** on:

**(61 3) 9510 6299** or **museum@anzca.edu.au**

## DEAN'S MESSAGE



DR RICHARD LEE

**On November 2nd the ownership of the Journal 'Critical Care and Resuscitation' was transferred to JFICM from the Australasian Academy of Critical Care Medicine. Readers will be aware that the Journal started from humble beginnings on the kitchen table of Dr Lindsay (Tub) and Janice Worthley and that it has developed into a valuable, indexed asset. JFICM is proud to be associated with the Journal and has guaranteed to promote and increase the standing of the Journal, publish four editions each year, endeavour to ensure the financial viability of the Journal and maintain the editorial independence of the Journal.**

The transfer followed very amicable and productive negotiations, focused solely on providing an enduring forum for education and research for intensive care specialists in Australia, New Zealand, and Hong Kong and beyond. The acquisition not only marked a point in the development of the Journal, but it also marked a point in the maturing and growth of JFICM and its relationship with the intensive care community, exemplified by the collegial nature of the negotiations.

On another level, acquisition of the Journal meshes with the changing role of JFICM, driven by internal review and external pressures. Two of the major changes in role involve (a) movement to a greater emphasis on teaching, in concert with the existing apprenticeship model of training and (b) establishment of a continuum of learning and assessment beyond award of Fellowship. The Journal will be a great aid in each of these expanding areas:

### **(a) Teaching and Training**

Just as the vehicles we use for getting around are constantly being developed and refined to be safer and more efficient, so must the 'vehicles' we use to train and assess. It is not enough to polish the old models each year, so a major Curriculum Review is being undertaken. The Australian Medical Council (AMC) expects all colleges to increase their teaching activities and use novel assessment tools, with less reliance on subjective standard setting.

To date we have used an apprenticeship model of training and relied heavily on the Fellowship Exam to drive learning, with an implied syllabus. This has worked well in the past and our program has been the envy of the intensive care world, but there are problems with the feasibility of running the Fellowship Exam for 30+ candidates and, as our specialty grows and becomes more diverse, it is inadequate to rely solely on a time-based apprenticeship model.

Therefore ways and means of providing better outcomes (i.e. numbers and quality of Fellows) from our program will be considered. For example, active teaching (courses and workshops), self-directed learning (guided by a comprehensive syllabus) and newer assessments (simulations and web-based tests) will be considered.

For those who fear change or see problems with 'fiddling with perfection', I hope you will be reassured that change will be reasoned, rational and considered long and hard by the Board and Regional Committees. All input to the process will be gratefully received.

### **(b) Continuum of Learning and**

#### **Reflecting on Reflection**

Also, if we accept that 'education and learning are not the acts of filling a bucket but more the acts of lighting a fire, which continues to burn', we will accept that we should develop our practice and be assessed beyond Fellowship. Just as the Fellowship Examiners

*'A specialist on completion of JFICM training should be capable of independent practice and then, not only maintain knowledge, skills and behaviours, but also develop them'*

understand that the candidate is not expected to be a finished product, we should accept a commitment to grow beyond award of Fellowship.

A specialist on completion of JFICM training should be capable of independent practice and then, not only maintain knowledge, skills and behaviours, but also develop them. Therefore the community at large will expect us to reflect and assess our own practice and in the future may expect us to be recertified and recertified, i.e. subject to regular external assessment.

'Reflection' may be seen as the PC term of the moment and some Fellows may anticipate a mirror or reflection facilitation device (RFD) to arrive with their MOPS diary, but reflection is a normal process of continual self-assessment and improvement in a professional practice.

With these principles in mind the colleges and JFICM are developing new Continuous Professional Development (CPD) programs to replace the much-criticised MOPS systems.

As they say at QANTAS, sit back, relax and enjoy your fright. CPD is on its way. ●

# HIGHLIGHTS FROM THE OCTOBER BOARD MEETING

## HONOURS AND APPOINTMENTS

The Board noted the following:

- Dr Elizabeth Rae Segedin, FRACP FJFICM, MNZM, Member of the New Zealand Order of Merit.  
For services to children's health.
- A/Prof Vic Callanan, Qld – Inducted into the ARC Roll of Honour
- A/Professor R.J. Boots, appointed Associate Professor by the University of Queensland
- Professor R. Jones, appointed Foundation ANZCA Professor of Education, Faculty of Medicine, Monash University (Centre for Medical and Health Sciences Education/Dept of Anaesthesia and Perioperative Medicine)
- Professor P.V. van Heerden, appointed Clinical Professor, School of Medicine and Pharmacology, University of Western Australia

## EDUCATION AND TRAINING

### *Intensive Care Primary Examination*

The Primary Examination Committee has been appointed and comprises Dr Gill Bishop as Chair, and Drs Peter Morley, Arthas Flabouris, Michael Cleary, Mark Finnis and Myrene Kilminster. Additional members have been nominated to the Panel of Examiners. Dates for the Examination have been set and are published elsewhere in the Bulletin, along with details regarding the format and structure of the Exam.

### *Examinations Committee*

Following the introduction of separate Committees for the Primary Examination (chaired by Gill Bishop), Paediatric Examination (chaired by Bruce Lister), Fellowship Examination (chaired by Bala Venkatesh), the Examinations Committee was convened by Peter Morley. It is responsible for monitoring recruitment of examiners and ensuring streamlined systems for each examination.

*The G.A. (Don) Harrison Medal Winner, 2006*  
The Board is delighted to announce that Dr Owen Roodenburg has been awarded the G.A. (Don) Harrison Medal for 2006.

### *Exam Course, December 2006*

A further Examination course will be conducted in December 2006 entitled Tailoring Study Techniques to the Exam.

### *Development of the Curriculum*

Work has started in earnest on development of a curriculum for basic and advanced training. It will cover updating the Objectives of Training, syllabuses for the general and paediatric examinations, a trainee portfolio, establishment of new in-training assessment processes specific to each term of training.

### *Formal Project Panel*

Terms of Reference have been developed for this Panel which comprises regional representatives responsible for assessment of the growing number of Formal Projects submitted by Trainees.

### *Accreditation of Overseas Training Units*

The Board resolved that the Intensive Care Units at St James and the Mater Misericordiae University Hospital in Ireland will be accredited for up to one year each for the core intensive care component of training. This might assist an exchange program and is possible as a number of Fellows are located at these Hospitals.

## FINANCE

The Board approved a fee schedule for 2007, which is published elsewhere in this section of the Bulletin.

## PROFESSIONAL

### *ANZICS*

A draft document entitled Role Delineation between ANZICS and the Joint Faculty is still under consideration. It will clarify the roles of each organisation but also assist in identifying joint initiatives.

### *Journal 'Critical Care and Resuscitation'*

The Board is very pleased to announce the signing of an agreement with the Australasian Academy of Critical Care Medicine, transferring the Journal 'Critical Care and Resuscitation' to the Joint Faculty of Intensive Care Medicine.

### *ANZICS/JFICM Conjoint Rural Committee*

Dr Michael Corkeron has been appointed Chair of the Committee.

### *ESICM Liaison*

A report was noted on the recent Examiner's Workshop held by the European Society in which the Joint Faculty participated.

### *DPA*

The Director of Professional Affairs, Dr Felicity Hawker, reported on her involvement in a number of meetings, including the ANZICS Safety and Quality Meeting, ANZCA Council and its strategic workshop and RACP Council.

### *Re-accreditation by the New Zealand Medical Council*

The Board congratulated the New Zealand National Committee on its submission to the Medical Council which resulted in re-accreditation of the Joint Faculty, for a period of six years.

### *MOPS*

The Board is currently reviewing the MOPS program.

## RESEARCH

The Board was pleased to note a number of ANZCA grants awarded to A/Professor Jamie Cooper, Dr M. Chapman, Professor J. Lipman and Dr D Frengley.

## INTERNAL

### *Board appointments*

Dr Allen Beswick, Chair of the Tasmanian Regional Committee, has now been co-opted to the Board. The Board also noted the election of Dr Nicole Blackwell to the Board as its New Fellow Representative.

Dr Peter Morley was appointed Assistant Education Officer, in addition to his portfolio of Chair, Examinations.

### *Amendment to Regulations*

The Board approved amendments to Regulations pertaining to the introduction of the Primary Examination, which are outlined elsewhere in this section of the Bulletin.

### *New staff appointment*

The Board welcomed Dr Daniel Angelico in the new position of Administrative Assistant, Training and Examinations.

## SUPERVISORS OF TRAINING

A Supervisor of Training Day will be held in Wednesday 6th December 2006. Those interested can contact Ms Laura Fernandez on lfernandez@anzca.edu.au or call the JFICM office on 03 9530 3861.

The Board ratified the following appointments:

Dr Anthony Delaney  
Royal North Shore Hospital, NSW

Dr Judith Shen  
Tuen Mun Hospital, Hong Kong

Dr Amjed Aziz  
The Sutherland Hospital, NSW

Dr Khoa Tran  
Logan Hospital, Qld

A Survey has been undertaken of Supervisors to gain feedback on the role.

## AMENDMENT TO REGULATIONS

### Exam Committee Reporting/ Introduction of the Primary Examination

Regulation 3.9.3 which pertains to the Examination Sub-committees was amended to note that they report through the new Examination Committee.

The following Regulations were amended or introduced, following the establishment of the Primary Examination:

7.1.2 Trainees must be registered with the Joint Faculty and have submitted full documentation and have paid the appropriate registration fees before being eligible to present for the Primary or Fellowship Examination. Trainees must be registered with the Joint Faculty before three months of Advanced Training have been completed.

### 7.7 The Primary Examination

7.7.1 Candidates for the JFICM Primary Examination must have completed at least 12 months General Hospital Experience and be registered trainees.

7.7.2 Candidates may present for the Primary Examination prior to commencing Approved Training and at any time during Basic Training.

7.7.3 Candidates for the Primary Examination must have fulfilled requirements for entry to the examination by the date on which the written section of the examination is held.

7.7.3 Primary Examinations will be held at times determined by the Board.

7.7.4 The subject areas for the JFICM Primary Examination are set out in the Syllabus for the Basic Sciences in Intensive Care Medicine.

7.7.5 The examination comprises a written and oral section. The written section may be taken in cities of Australia and New Zealand or other areas at the discretion of the Board. The oral section will be held in a capital city in Australia or New Zealand at the discretion of the Board.

7.7.6 Applications to present for the Primary Examination must be made on the approved form together with all relevant documentation verifying completion of the requirements of Regulation 7.7.1 and the prescribed fee. The completed application must be received by the Executive Officer at least 56 days before the commencement date of the written examination.

### Senior Registrar position

Regulation 7.4.5.2 was amended as follows:

7.4.5.2 A minimum of six months of the core component of intensive care must be undertaken as a 'Senior Registrar' (refer definition under Regulation 7). This Regulation will apply to Trainees commencing Advanced Training from 1st December 2004.

Regulation 7.4.7.7 was amended to read:

7.4.7.7 A minimum of six months of the core component of intensive care training must be undertaken as a 'Senior Registrar' (refer definition under Regulation 7). This Regulation will apply to Trainees commencing Advanced Training from 1st December 2004.



NIKKI BLACKWELL

## NIKKI BLACKWELL - NEW FELLOW REPRESENTATIVE TO THE BOARD OF THE JOINT FACULTY OF INTENSIVE CARE MEDICINE.

In June 2006, the Board of the Joint Faculty of Intensive Care Medicine, ANZCA and RACP established an additional position on the Board to represent the interests of Trainees and New Fellows, to be known as the New Fellow Representative. Fellows were invited to forward nominations of Fellows within five years of admission to Fellowship.

We received 7 nominations and the Board of the Joint Faculty of Intensive Care Medicine congratulates all candidates (listed below).

Nicole Ann Margaret Blackwell  
Peter Dzendrowskyj  
Jonathan Rogers Egan  
Kalpesh Ratanchand Gandhi  
David James Ritchie Morgan  
Neil Ronald Orford  
Stephen Joseph Warrillow

Special congratulations go out to Nikki Blackwell, who was elected to the Board.

### Admission to Fellowship

The Board admitted to Fellowship the following by examination:

Janet Chan, NSW  
Tomas Corcoran, WA  
Jason Fletcher, VIC  
Stephen Lam, SA  
Forbes McGain, VIC  
David Moxon, WA  
Rahul Pandit, NSW  
Rakesh Rai, NSW  
Nandkumar Raut, SA  
Michael Reade, VIC

### Successful Exam Candidates

The following candidates were successful at the recent Fellowship Examinations, held in Melbourne

### Paediatric Fellowship Examination



DR J MARTIN AND DR H RAVINDRANATHAN

### General Fellowship Examination



FROM LEFT: DR R HISLOP, DR S ZALSTEIN, DR V TAM, DR M MAJUMDAR, DR O ROODENBURG, DR N BARRETT, DR G LO, DR I MACKLE, DR W M KWAN, DR A CASAMENTO, DR G DING, DR M VELLAICHAMY, DR R MOSS, DR J BELLAPART (OTS), DR A DEANE, DR T HAYDON, DR C CATTIGAN, DR M SANAP, DR L MCKEAN, DR A HENNESSY (DR P RANGAPPA ABSENT)

Candidates successful in the JFICM Fellowship Examination must also complete all of their prescribed training components before being eligible to apply for admission to Fellowship of the Joint Faculty.

### Panel of Examiners

The Board of the Joint Faculty of Intensive Care Medicine congratulates Dr Peter T Morley on 12 years of service to the JFICM Fellowship Examination. The Board acknowledges his outstanding contributions. Dr Morley continues as Chair of Examinations and Assistant Education Officer.

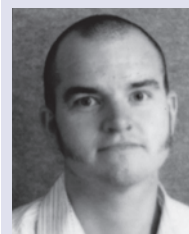


DR PETER MORLEY

### THE G.A. (DON) HARRISON MEDAL 2006

The G A (Don) Harrison Medal was established by the Board of the Faculty of Intensive Care, Australian and New Zealand College of Anaesthetists in 1994, to be awarded annually to the candidate who achieves the highest mark in the Fellowship Examination each year.

Congratulations to Dr Owen Roodenburg, winner of this award for 2006.



DR OWEN ROODENBURG

# MAINTAINING YOUR MOPS

**The second annual MOPS audit has been held this year with 6 Fellows being asked to provide documentation to confirm their participation in activities claimed for MOPS points.**

Five Fellows complied with the requirements and one Fellow did not return his audit data and will thus be required to provide audit documentation again in 2007. For the 5 audits, it was reassuring to see both the wide variety as well as the actual amount of activities undertaken by Fellows. However, it is essential to remember that the documentation provided must match the activities claimed in each MOPS return. Hence it is wise to keep any programmes from conferences or local grand rounds, emails of invitations to speak or review articles or grants and other confirmatory documentation of educational activities attended in order to simplify both calculating your points at the end of the year (yes we all do it!) and if you are audited.

Thank you to all the Fellows who returned their MOPS Survey forms earlier in the year and for the constructive comments included. Nearly 60% of respondents stated that they participated in an alternative programme, with 50% of these also participating in the JFICM MOPS. Reasons for non-participation included that it was too time-consuming (14%), not mandatory (11%), and that it was too complicated (6%), although over two thirds of respondents acknowledged that MOPS was either important or essential. These results will be considered by the Board as we work towards improving the current MOPS structure and developing our facilities for continuing education for Fellows.

Finally, the JFICM MOPS programme has been running in its current form since the formation of the Joint Faculty in 2002 and over 406 Fellows are registered for participation. Increasingly, all medical Colleges are being encouraged to take a more active role in ongoing education beyond training and accreditation, with continuing professional development being a major focus. Both of our parent Colleges, ANZCA and RACP, are currently reviewing their MOPS programmes and ANZCA has recently released to Fellows its new proposed CPD programme for discussion. It is likely that JFICM will also be encouraged to move towards a programme including need-based learning and individually tailored educational activities for all Fellows.

So stay tuned for more details and discussion over the next 12 months and please join the debate, provide feedback and have a say in what will become OUR MOPS programme.

.....  
M.S. Robertson  
MOPS Officer  
.....



## ROYAL AUSTRALASIAN COLLEGE OF PHYSICIANS THE SUPERVISION OF VOCATIONAL TRAINEES IN INTENSIVE CARE MEDICINE

Supervision must be available at all times for vocational trainees in Intensive Care Medicine and this should be performed by a person who possesses the FJFICM, or an equivalent qualification acceptable to the JFICM Board. This supervision should occur in clinical situations, particularly those involving major procedures or sensitive communications with patients or their families, record-keeping, research, audit and quality assurance programs. In addition, appropriate supervision should be available to assist the trainee in relation to their teaching and preparation of scientific material, such as for the Formal Project or for a presentation at a conference. It should encompass the skills, knowledge and attitudes desirable in an intensive care specialist as outlined in the Objectives of Training in Intensive Care Medicine.

### 1. CATEGORIES OF SUPERVISION

During training it is expected there will be a progression of responsibility allowed to the trainee commensurate with their expertise and experience. Four categories have been defined. The category under which each trainee works depends upon individual circumstances, noting that the category of supervision may vary for a given trainee according to the nature of the supervision that is either required or requested.

**Category 1.** A supervisor working directly with one trainee in a clinical situation involving the assessment and/or management of a patient, or in a non-clinical situation as outlined above.

**Category 2.** A supervisor in the same department/unit as a trainee, and available for immediate assistance and consultation.

**Category 3.** A supervisor present elsewhere in the hospital, but immediately available for consultation and assistance.

**Category 4.** A supervisor not in the hospital, but readily contactable and, if necessary, available within reasonable travelling time, who is specifically rostered for the period in question.

### 2. MINIMUM SUPERVISION LEVELS

Supervision must be available at all times, without distinction between ordinary hours and out-of-hours times. Should the supervisor be unavailable for a period of time due to other commitments, it would be appropriate to delegate this role to another suitable specialist to ensure that the trainee always has support readily available.

**2.1** Early in training, a high proportion of supervision must be as in Category 1 or 2.

**2.2** Later in training, supervision may be as in Category 3 or 4 when appropriate, but it is expected that patient review will be held each day with the duty ICU consultant, and that new patient referrals, significant changes in patients' status and unplanned patient discharges will be discussed with this supervisor in a timely manner. Closer supervision and direct help must always be available when sought by the trainee.

### 3. SPECIAL CONDITIONS

- 3.1** The supervisor should direct the trainee to consult with him/her in relevant clinical situations. The requirement to seek consultation may vary with the complexity of the clinical situation and illustrative examples include:
- 3.1.1 Reception of new patients into a unit, and unplanned discharge of patients from a unit.
  - 3.1.2 Unexpected or unexplained changes in a patient's condition.
  - 3.1.3 Performance of complex procedures or requirement for complex therapies on a patient.
  - 3.1.4 Treatment of children in a non-paediatric unit.
  - 3.1.5 Changes to management which have serious ethical implications (e.g. withdrawal of life support, certification of brain death and organ procurement).
  - 3.1.6 Discussion with patients, their families, and referring clinicians on major treatment policies.
  - 3.1.7 Proposed refusal of a request for admission to the unit.
  - 3.1.8 Mobilisation of intensive care resources for inter-hospital transfer.
- 3.2** An intensive care unit should have a written list of guidelines and general policies, in which the requirements of the JFICM for supervision are included.

These guidelines should be interpreted in conjunction with the following Documents of the Joint Faculty of Intensive Care Medicine, Australian and New Zealand College of Anaesthetists and the Royal Australasian College of Physicians:

**IC-3** "Guidelines for Intensive Care Units seeking Accreditation for Training in Intensive Care Medicine"

**IC-6** "The Role of Supervisors of Training in Intensive Care Medicine"

**IC-11** "Guidelines for the In-Training Assessment of Trainees in Intensive Care Medicine"

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

Professional documents are reviewed from time to time, and it is the responsibility of the practitioner to ensure that the practitioner has obtained the current version. Professional documents have been prepared having regard to the information available at the time of their preparation, and the practitioner should therefore have regard to any information, research or material which may have been published or become available subsequently.

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

Promulgated: February 1994

Revised: February 2000

Date of current document: October 2006

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

## JOINT FACULTY OF INTENSIVE CARE MEDICINE POLICY DOCUMENTS

<b>IC-1</b>	(2003)	Minimum Standards for Intensive Care Units	<b>IC-13</b>	(2002)	Recommendations on Standards for High Dependency Units Seeking Accreditation for Training in Intensive Care Medicine
<b>IC-2</b>	(2005)	Intensive Care Specialist Practice in Hospitals Accredited for Training in Intensive Care Medicine	<b>IC-14</b>	(2004)	Statement on Withholding and Withdrawing Treatment
<b>IC-3</b>	(2003)	Guidelines for Intensive Care Units seeking Accreditation for Training in Intensive Care Medicine	<b>IC-15</b>	(2004)	Recommendations of Practice Re-entry for an Intensive Care Specialist
<b>IC-4</b>	(2006)	The Supervision of Vocational Trainees in Intensive Care	<b>PS38</b>	(2004)	Statement Relating to the Relief of Pain and Suffering and End of Life Decisions
<b>IC-6</b>	(2002)	The Role of Supervisors of Training in Intensive Care Medicine	<b>PS39</b>	(2003)	Minimum Standards for Intrahospital Transport of Critically Ill Patients
<b>IC-7</b>	(2006)	Secretarial Services to Intensive Care Units	<b>PS40</b>	(2005)	Guidelines for the Relationship Between Fellows, Trainees, and the Healthcare Industry
<b>IC-8</b>	(2000)	Quality Assurance	<b>PS45</b>	(2001)	Statement of Patient's Rights to Pain Management
<b>IC-9</b>	(2002)	Statement on the Ethical Practice of Intensive Care Medicine	<b>PS48</b>	(2003)	Statement on Clinical Principles for Procedural Sedation
<b>IC-10</b>	(2003)	Minimum Standards for Transport of the Critically Ill	<b>PS49</b>	(2003)	Guidelines on the Health of Specialists and Trainees
<b>IC-11</b>	(2003)	Guidelines for the In-Training Assessment of Trainees in Intensive Care Medicine			
<b>IC-12</b>	(2001)	Examination Candidates Suffering from Illness, Accident or Disability			



## DEAN'S MESSAGE

December 2006



DR ROGER GOUCKE



**There are a wide range of issues that have an impact on Fellows practising Pain Medicine in Australia. Some of these come to the Board of Faculty and increasingly the Board is asked to respond and comment.**

All Fellows will be aware of the significant effort put in by previous Boards in establishing Pain Medicine as a medical specialty, now recognised by the Australian Medical Council and State and Federal Governments.

The treatment of chronic non-cancer pain with opioids has long been a contentious and controversial issue of which State and Federal Governments are well aware. Fellows in their day to day practice will be significantly influenced by requests from General Practitioners, other specialists and state health departments in trying to help manage patients and either condone or restrict access to opioids by patients. The Pharmaceutical Benefits Scheme has also recently adjusted its rules on prescribing increased quantities of opioids. Unfortunately this is one area where the Faculty has not been consulted by government agencies. What do Fellows believe the Faculty's response should be to the changing environment with regard oral opioids and non cancer pain?

*'The Faculty is very pleased to recognise the Victorian Government for the additional funding that it has made available for training registrars in Pain Medicine in Melbourne and Geelong. It is hoped that a formal rotational training program, taking in the Royal Children's Hospital and other approved training centres in Melbourne, will be offered by the middle of 2007.'*

There is increasing evidence in the literature for short term efficacy of opioids however most prescribing in the chronic pain arena is still from personal experience and expert opinion.

As identified in the recent strategic planning meeting, the Board re-emphasised the importance of providing services to Fellows as well as trainees. Some years ago the Board proposed that MOPS/CPD be a mandatory requirement for Fellows. Consequently it was very encouraging to note that the a survey of Fellows during 2005 demonstrated that 97% of Fellows were participating in either the Faculty's MOPS program or through their own specialty's MOPS program. It is essential that we as a Faculty can demonstrate that we have a rigorous Continuing Professional Development program and that our Fellows participate in this program. It is highly likely that the national registration body for medical practitioners proposed by COAG (Council of Australian Governments), to commence in 2008, will enforce CPD as a requirement for continuing registration. The fact that we as a Faculty have such a high uptake is powerful information when negotiating with regulators and legislators.

In the last edition of the Bulletin, the proposed new CPD program was outlined and I would urge Fellows to review that article and

to look out for further information on this new, revised program which is planned to cover all areas of CPD.

Fellows will also be aware that a second scientific meeting of the Faculty is planned, the first of which will be held in September 2007. Close contact is being maintained with both the Australian and New Zealand Pain Societies to avoid any clash with scientific meetings planned by those societies in terms of timing, content and invited speakers.

The Faculty is very pleased to recognise the Victorian Government for the additional funding that it has made available for training registrars in Pain Medicine in Melbourne and Geelong. It is hoped that a formal rotational training program, taking in the Royal Children's Hospital and other approved training centres in Melbourne, will be offered by the middle of 2007.

It is also good news to note the high uptake for the Supervisors of Training Workshop held in Melbourne in November. Supervisors of Training are the keystone in our training program and an essential component of in-training assessment. The Board is very grateful for their input into trainees' education and wishes to support them as much as possible.

Roger Goucke Dean



Geelong **Advertiser**

# Grant to help fight pain

GEELONG Hospital will benefit from a \$560,000 investment to train medical specialists in pain management.

State Health Minister Bronwyn Pike said Victoria urgently needed more specialists in the discipline and the state was funding four trainee posts to help fill the gap.

Barwon Health will receive one of the four funded training positions.

The positions are open to qualified doctors in the final stages of their registrar training in medical specialties.

The other trainee positions are at the Royal Melbourne Hospital, Royal Children's Hospital and St Vincent's Health.

Ms Pike said persistent chronic pain is a hidden epidemic in Australia.

"At present there is only one pain management specialist trainee in Victoria — at the Royal Children's Hospital," Ms Pike said.

The Australian and New Zealand College of Anaesthetists has said that 17.8 million work days are lost around the nation each year because of pain, costing employers \$2.6 billion in lost productivity.

The college said that adverse effects of untreated severe pain include cardiovascular and respiratory problems, and psychological disorders.

Ms Pike said the four positions were being funded as part of a \$12.6 million government initiative announced by the Premier in July to boost specialist training in Victorian public hospitals.

# HIGHLIGHTS AND BOARD MEETINGS

The Board held a Strategic Planning Meeting on 16 July to identify strengths, vulnerabilities, opportunities and threats and met on 17 July and 16 October to transact usual business.

## Strategic Planning Day

A number of important areas highlighted for priority action including:

- The development of pain modules for undergraduate and PGY1 and 2 levels
- Improvement of services to Fellows, including regional based CPD and business meetings
- Development of MoUs with parent Colleges and Pain Societies
- Establishment of links with the RNZCGP
- Representation to MCNZ for Specialty Recognition in New Zealand
- Communication with national registration bodies

The Board is also considering a new structure which will involve four divisions, with a view to raising its services to Fellows and improving liaisons.

## Honours and Appointments

It was noted that Professor Saxby Pridmore had been honoured with an AM.

## Fellowship

The Board agreed to undertake an electronic admission to Fellowship process on occasions when applicants have completed all training and examination requirements at a time remote from a scheduled Board Meeting.

Dr John Balliol Salmon, FFARCS, WA was admitted to Fellowship by election.

## Overseas Trained Doctors

*Qualifications to enter Pain Medicine training and for the award of Fellowship*

Administrative Instruction 3.2 defines the current requirements without which a medical practitioner cannot become registered as a trainee of the Faculty and thus progress towards Fellowship. Overseas Trained Doctors not eligible to enter the Faculty's

Training Program who spend time in a Faculty accredited unit could receive a Certificate from that unit, with no involvement from the Faculty.

Medical Boards have been advised that possession of Fellowship of the Faculty indicates competence in the practice of Pain Medicine and does not imply competence in the practitioner's primary specialty. It is anticipated that OTS holders of FFPMANZCA will be eligible to practice Pain Medicine in Australia, with the appropriate visa, but would not be eligible to practice in their primary specialty unless their primary specialty college accepts their qualification as comparable. Letters have been sent to the participating Colleges highlighting this issue.

## Finance

### *2007 Subscriptions and Fees*

The Board supported a 10% increase in annual subscriptions and fees for 2007 recognising the increased activity within the Faculty and the need to provide adequate resources to meet initiatives arising from committee activity and the strategic planning process.

### *Subscription Concessions*

In line with ANZCA subscription concessions, communication has been made with the Treasurers of the other participating bodies requesting that they consider in principle a reduction in subscriptions for Fellows who practise entirely in Pain Medicine, and who no longer practise in their primary specialty.

## Education and Training

### *Patient Education Pamphlets*

The Board is keen to progress patient information material for Fellows to give to patients and the Education and Training Committee are currently refining a small number of documents for publication in pdf format to be made available on the Faculty Website.

## *CME Needs Analysis*

Following on from the CME Needs Analysis undertaken on behalf of the Faculty, Dr Adam Tucker presented to October Board on the Seeds Program, an interactive, online tutorial program, developed with input from IT and educational specialists. The Board resolved to trial this initiative in 2007 to provide opportunities for Continuing Professional Development for Fellows.

## *In Training Assessment*

A revised ITA form was accepted which incorporates revisions identified by SoTs with the aim of making the forms more meaningful in guiding discussion with trainees. Section two of the revised form now provides an opportunity for SoTs to direct trainees to research interest, awareness of ethical/medico-legal issues and welfare issues. The new forms will be in use from January 2007.

## *Supervisor of Training Support*

A Clinical Teaching Course focusing on Pain Medicine will be held for FPM SoTs at ANZCA House on 9 November 2007. Professor Russell Jones will facilitate.

## *MOPS/CPD*

The Board considered the proposed revisions to the ANZCA/FPM MOPS Program and were supportive of the underlying principles of the revision, including the name change to "Continuing Professional Development" (CPD). The achievement of points will be downplayed in favour of individual programs and learning portfolios. The Board recognised the review process as an opportunity for the Faculty to have some input and ownership and to fine tune the program to provide opportunities for its Fellows.

## *Pain Medicine Journal*

The Board resolved to extend its relationship with the AAPM with respect to the Pain Medicine Journal when the current agreement ends at the end of 2006.

#### *Undergraduate Education/PGY 1 and 2*

Highlighted as a priority at the Faculty's strategic planning day, correspondence had been sent to the Deans of Medical Schools and to the Chair, Confederation of Postgraduate Medical Education Councils (CPMEC) inviting interest and offering support in the teaching of the biology and management of pain in their Medical School Curricula. Responses from the Medical Schools to date had been variable, however the CPMEC had sought feedback on the draft Australian Curriculum Framework for Junior Doctors by 31 October 2006 and the Board had responded with recommendations for required knowledge and skills.

#### *Pain Oriented Physical Examination DVD*

The Board resolved to make the POPE DVD available on the website for download free of charge.

#### **Examination**

Due to the growth in the number of candidates, consideration is being given to separating the written examination up to two weeks before the clinical examination, commencing 2008.

There are 20 candidates for the 2006 Examination being held at the Sir Charles Gairdner Hospital, WA from 29 November to 1 December. The 2007 examination will be held at Westmead Hospital, Sydney.

#### **Training Unit Accreditation**

The Royal Melbourne Hospital Pain Management Services was accredited for Pain Medicine training for two years. St Vincent's Hospital Sydney was accredited for 1 year and the Barbara Walker Centre for Pain Medicine, St Vincent's Hospital, Melbourne was accredited for one year.

This takes the number of accredited units to 21. A further five accreditation reviews are scheduled before the end of the year.

#### **Research**

##### *Pain Medicine Prize*

The Board resolved that an annual Prize consisting of a grant of \$1000.00 for educational or research purposes (together with a Certificate) will be available, to eligible members of the Faculty of Pain Medicine and the five (5) Participating Professional Bodies

Eligibility for the Prize shall be limited to trainees of the Faculty of Pain Medicine (FPM), trainees of the other five participating Professional Bodies and Fellows of the FPM within eight (8) years of having obtained FPPMANZCA, except that Elected Fellows must be within eight (8) years of admission to their original Fellowship

The Prize will be awarded for original work judged to be a significant contribution to Pain Medicine and/or Pain Research. Adjudication of eligible papers (papers whose authors have agreed to participate as applicants for the Deans' Prize) will take place during the FPM ASM and will be awarded at the FPM Annual General Meeting.

#### **Professional**

##### *Professional Documents*

A new Professional Document, PM5 (2006)

*Policy for Supervisors of Training in Pain Medicine*, was accepted for promulgation.

A revision of PM1 (2006) *Policy for Trainees Seeking Faculty Approval of Programs for Training in Multidisciplinary Pain Medicine* was also accepted. The documents were published in full in the October Bulletin and are available on the Faculty Website.

Feedback will be provided to ANZCA Council on PS45 *Statement on Patients' Rights to Pain Medicine* and PS41 *Guidelines on Acute Pain Management*, currently in the final stages of review.

##### *Clinical Diploma in Palliative Medicine*

The Australasian Chapter of Palliative Medicine (RACP) has developed and trialled, with funding from the Department of Health and Ageing, a Clinical Diploma in Palliative Medicine (with input from the Faculty of Pain Medicine, RACGP, RNZCGP, the Faculty of Radiation Oncology (RANZCR), ACRRM and the Australian and New Zealand Society of Palliative Medicine represented on their Diploma Working Party).

This is a 6 month Diploma for GPs or other Doctors who are working in the palliative medicine field but do not have sufficient clinical load or experience to qualify for Fellowship of the AChPM or RACP. The aim is to improve the quality of Palliative Medicine in the primary care setting but doctors in other settings such as tertiary hospitals should also benefit.

The Board agreed to endorse the framework and content of the Diploma and to offer support by way of representation in the Diploma Joint Steering Committee. Council approved the use of the ANZCA Logo.

##### *Intercollegiate Relationships*

Development of Memoranda of Understanding with the participating bodies was highlighted as a priority at the strategic planning day. It is anticipated that this will be progressed by the proposed Faculty Liaison Committee.

The Board was pleased to note progress in having a pain component at the RACS, AFRM and RACP meetings.

##### *Recognition of Pain Medicine as a Specialty – New Zealand*

The Board supported a proposal by New Zealand Fellows to progress an application to the Medical Council of New Zealand for specialty recognition and this will be raised at December Council.

#### **Continuing Education**

##### *ASM 2007, Melbourne*

Programs for the Refresher Course Day and ASM are well developed. The Foundation Visitor, Professor Martin Koltzenburg, will visit NSW following the ASM. The venue for the Refresher Course was confirmed as the Langham Hotel, Melbourne.

##### *ASM 2008, Sydney*

Dr Charles Brooker has accepted the appointment of FPM Convenor.

##### *Stand Alone Meetings*

A stand alone meeting of the Faculty with a medico-legal theme is planned for 20-22 September 2007 at the Sheraton Hotel, Gold Coast.

#### **Communications**

##### *Managing Acute Pain: A Guide for Patients*

A copy of this document was circulated to all Fellows with the September Bulletin. Copies can be downloaded for patient use from the Faculty Website.

##### *Website*

Board members met with ANZCA's Director IT to discuss the Faculty's website. A process is to be put in action to update items regularly. Redevelopment of the website to enhance navigation and content is in progress.



## FACULTY OF PAIN MEDICINE PROFESSIONAL DOCUMENTS

<b>PM1</b>	(2006)	Policy for Trainees Seeking Faculty Approval of Programs for Training in Multidisciplinary Pain Medicine
<b>PM2</b>	(2005)	Guidelines for Units Offering Training in Multidisciplinary Pain Medicine
<b>PM3</b>	(2002)	Lumbar Epidural Administration of Corticosteroids
<b>PM4</b>	(2005)	Guidelines for Patient Assessment and Implantation of Intrathecal Catheters, Ports and Pumps for Intrathecal Therapy
<b>PM5</b>	(2006)	Policy for Supervisors of Training in Pain Medicine
<b>PS3</b>	(2003)	Guidelines for the Management of Major Regional Analgesia
<b>PS38</b>	(2004)	Statement Relating to the Relief of Pain and Suffering and End of Life Decisions
<b>PS40</b>	(2005)	Guidelines for the Relationship Between Fellows and the Healthcare Industry
<b>PS41</b>	(2000)	Guidelines on Acute Pain Management
<b>PS45</b>	(2001)	Statement on Patients' Rights to Pain Management
<b>PS48</b>	(2003)	Statement on Clinical Principles for Procedural Sedation
<b>PS49</b>	(2003)	Guidelines on the Health of Specialists and Trainees

		<b>ANZCA Professional Documents adopted by the Faculty:</b>
<b>PS4</b>	(2000)	Recommendations for the Post-Anaesthesia Recovery Room (Adopted February 2001)
<b>PS7</b>	(2003)	Recommendations on the Pre-Anaesthesia Consultation (Adopted November 2003)
<b>PS8</b>	(2003)	Guidelines on the Assistant for the Anaesthetist (Adopted November 2003)
<b>PS9</b>	(2005)	Guidelines on Conscious Sedation for Diagnostic, Interventional Medical and Surgical Procedures (May 2002)
<b>PS10</b>	(2004)	The Handover of Responsibility During an Anaesthetic (Adopted February 2001)
<b>PS15</b>	(2000)	Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery with amendment to the title to read Recommendations for the Perioperative Care of Patients Selected for Day Care Procedures (Adopted February 2001)
<b>PS18</b>	(2006)	Recommendations on Monitoring During Anaesthesia (Adopted February 2001)
<b>PS20</b>	(2001)	Recommendations for Responsibilities of the Anaesthetist in the Post-Operative Period (Adopted February 2001)
<b>PS31</b>	(2003)	Recommendations on Checking Anaesthesia Delivery Systems (Adopted July 2003)
<b>T1</b>	(2006)	Recommendations on Minimum Facilities for Safe Anaesthesia Practice in Operating Suites (Adopted May 2006)

# AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

ABN 82 055 042 852

## PROFESSIONAL DOCUMENTS

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

<b>TE1</b>	(2005)	Recommendations for Hospitals Seeking College Approval for Vocational Training in Anaesthesia	<b>PS15</b>	(2006)	Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery
<b>TE2</b>	(2006)	Policy on Vocational Training Modules and Module Supervision (interim review)	<b>PS16</b>	(2001)	Statement on the Standards of Practice of a Specialist Anaesthetist
<b>TE3</b>	(2006)	Policy on Supervision of Clinical Experience for Vocational Trainees in Anaesthesia	<b>PS18</b>	(2006)	Recommendations on Monitoring During Anaesthesia
<b>TE4</b>	(2003)	Policy on Duties of Regional Education Officers in Anaesthesia	<b>PS19</b>	(2001)	Recommendations on Monitored Care by an Anaesthetist
<b>TE5</b>	(2003)	Policy for Supervisors of Training in Anaesthesia	<b>PS20</b>	(2001)	Recommendations for Responsibilities of the Anaesthetist in the Post-Operative Period
<b>TE6</b>	(2000)	Guidelines on the Duties of an Anaesthetist	<b>PS21</b>	(2003)	Guidelines on Conscious Sedation for Dental Procedures
<b>TE7</b>	(2005)	Guidelines for Secretarial and Support Services to Departments of Anaesthesia	<b>PS24</b>	(2004)	Guidelines on Sedation for Gastrointestinal Endoscopic Procedures
<b>TE8</b>	(2003)	Guidelines for the Learning Portfolio for Trainees in Anaesthesia	<b>PS26</b>	(2005)	Guidelines on Consent for Anaesthesia or Sedation
<b>TE9</b>	(2005)	Guidelines on Quality Assurance in Anaesthesia	<b>PS27</b>	(2004)	Guidelines for Fellows who Practice Major Extracorporeal Perfusion
<b>TE10</b>	(2003)	Recommendations for Vocational Training Programs	<b>PS28</b>	(2005)	Guidelines on Infection Control in Anaesthesia
<b>TE11</b>	(2003)	Formal Project Guidelines	<b>PS29</b>	(2002)	Statement on Anaesthesia Care of Children in Healthcare Facilities without Dedicated Paediatric Facilities
<b>TE13</b>	(2003)	Guidelines for the Provisional Fellowship Program	<b>PS31</b>	(2003)	Recommendations on Checking Anaesthesia Delivery Systems
<b>TE14</b>	(2001)	Policy for the In-Training Assessment of Trainees in Anaesthesia	<b>PS37</b>	(2004)	Regional Anaesthesia and Allied Health Practitioners
<b>TE17</b>	(2003)	Policy on Advisors of Candidates for Anaesthesia Training	<b>PS38</b>	(2004)	Statement Relating to the Relief of Pain and Suffering and End of Life Decisions
<b>TE18</b>	(2005)	Guidelines for Assisting Trainees with Difficulties	<b>PS39</b>	(2003)	Minimum Standards for Intrahospital Transport of Critically Ill Patients
<b>EX1</b>	(2006)	Policy on Examination Candidates Suffering from Illness, Accident or Disability	<b>PS40</b>	(2005)	Guidelines for the Relationship Between Fellows and the Healthcare Industry
<b>T1</b>	(2006)	Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations	<b>PS41</b>	(2000)	Guidelines on Acute Pain Management
<b>T3</b>	(2006)	Minimum Safety Requirements for Anaesthetic Machines for Clinical Practice	<b>PS42</b>	(2006)	Recommendations for Staffing of Departments of Anaesthesia
<b>PS1</b>	(2002)	Recommendations on Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia	<b>PS43</b>	(2001)	Statement on Fatigue and the Anaesthetist
<b>PS2</b>	(2001)	Statement on Credentialling in Anaesthesia	<b>PS44</b>	(2001)	Guidelines to Fellows Acting on Appointments Committees for Senior Staff in Anaesthesia
<b>PS3</b>	(2003)	Guidelines for the Management of Major Regional Analgesia	<b>PS45</b>	(2001)	Statement on Patients' Rights to Pain Management
<b>PS4</b>	(2006)	Recommendations for the Post-Anaesthesia Recovery Room	<b>PS46</b>	(2004)	Recommendations for Training and Practice of Diagnostic Perioperative Transoesophageal Echocardiography in Adults
<b>PS6</b>	(2006)	The Anaesthesia Record. Recommendations on the Recording of an Episode of Anaesthesia Care	<b>PS47</b>	(2002)	Guidelines for Hospitals Seeking College Approval of Posts for Vocational Training in Diving and Hyperbaric Medicine
<b>PS7</b>	(2003)	Recommendations on the Pre-Anaesthesia Consultation	<b>PS48</b>	(2003)	Statement on Clinical Principles for Procedural Sedation
<b>PS8</b>	(2003)	Guidelines on the Assistant for the Anaesthetist	<b>PS49</b>	(2003)	Guidelines on the Health of Specialists and Trainees
<b>PS9</b>	(2005)	Guidelines on Conscious Sedation for Diagnostic, Interventional Medical and Surgical Procedures	<b>PS50</b>	(2004)	Recommendations on Practice Re-entry for a Specialist Anaesthetist
<b>PS10</b>	(2004)	Handover of Responsibility During an Anaesthetic			
<b>PS12</b>	(2001)	Statement on Smoking as Related to the Perioperative Period			
<b>PS14</b>	(1998)	Guidelines for the Conduct of Major Regional Analgesia in Obstetrics			

# EX1

(2006)

## POLICY ON EXAMINATION CANDIDATES SUFFERING FROM ILLNESS, ACCIDENT OR DISABILITY

### 1. INTRODUCTION

- 1.1 Candidates should not be disadvantaged as a result of events outside their control. Nevertheless, in seeking to redress any disadvantage, no action should be taken which might be held to be unfair to other candidates.
- 1.2 Where a problem arises which is not covered in the Regulations, instructions to examiners, or these guidelines, advice is to be immediately sought from the Chief Executive Officer in discussion with the Chairman of Examinations.

### 2. ACUTE ILLNESS OCCURRING AT THE TIME OF EXAMINATION

- 2.1 If an examiner becomes aware that a candidate is ill, he/she should notify the Chairman of the Court who will:
  - 2.1.1 determine whether, in his/her opinion, the illness is incapacitating.
  - 2.1.2 if appropriate, reschedule the candidate's program within the existing examination or advise the candidate to withdraw.
  - 2.1.3 notify the Chief Executive Officer in writing of his/her action.
- 2.2 No special consideration will be given to a candidate who elects to continue with the examination.
- 2.3 Sudden illness which precludes a candidate from attending all or part of an examination may provide grounds for remission of the examination entry fee.
- 2.4 Application for this consideration must be made by the candidate and supported by a medical certificate.
- 2.5 Further action is at the discretion of the Council on the advice of the Chairman of Examinations.

### 3. ACUTE ILLNESS, ACCIDENT OR DISABILITY WHICH IMMOBILISES, BUT DOES NOT INCAPACITATE THE CANDIDATE

- 3.1 A candidate who is otherwise fit to participate in the written examination may be precluded from attending the venue for the written examination, or require special assistance due to illness, accident or disability.
- 3.2 Under these circumstances, the Chairman of the Court of Examiners and the Chairman of Examinations should consider the possibility that the written examination could be taken at some other appropriate place, and/or special assistance provided at the same time as other candidates in the region. An appropriate invigilator must then be appointed for this purpose.
- 3.3 No such concession is possible for the oral examination, so that if action under 3.2 is contemplated, it must be anticipated that the candidate will be fit to attend the vivas.

### 4. CHRONIC ILLNESS OR DISABILITY

Candidates with a chronic illness or disability will be considered for assistance appropriate to their disability provided that it does not impair the fairness and reliability of the examination. If a candidate believes that extraordinary consideration should be given to particular circumstances, a fully

documented application should be submitted to the Chairman of Examinations at least four (4) calendar months prior to the advised examination closing date. Further action is at the discretion of the Council, on advice from the Chairman of Examinations.

### 5. OTHER CONCESSIONS

- 5.1 A candidate who has been prevented from completing an examination by illness, accident or disability will not be exempt from any part of a future examination.
- 5.2 A candidate who has been prevented from completing an examination by illness, accident or disability will remain eligible for awards and prizes at a future examination.

### COLLEGE PROFESSIONAL DOCUMENTS

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

*This document is intended to apply wherever anaesthesia is administered.*

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

*Professional documents are reviewed from time to time, and it is the responsibility of the practitioner to ensure that the practitioner has obtained the current version. Professional documents have been prepared having regard to the information available at the time of their preparation, and the practitioner should therefore have regard to any information, research or material which may have been published or become available subsequently.*

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

Promulgated: 1984

Reviewed: 1991,1996,2001

Date of current document: Oct 2006

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College Website: <http://www.anzca.edu.au/>

## THE ANAESTHESIA RECORD RECOMMENDATIONS ON THE RECORDING OF AN EPISODE OF ANAESTHESIA CARE

### INTRODUCTION

The anaesthesia record is an essential part of the patient's medical record. The record should allow the anaesthetist to document all aspects of the anaesthesia management, including the pre and post-operative management, that are of relevance to the anaesthesia.

The anaesthesia record provides information that may assist other staff involved in the care of the patient and to any subsequent anaesthetists. It may also be of medico-legal importance and can be used for quality assurance and research purposes. The record must be signed by the anaesthetist/s. The information may be on a single record or may be covered by separate records for the pre-anaesthesia, anaesthesia and post-anaesthesia phases of the patient's care. All components of the anaesthesia record must be readily available throughout a patient's hospital stay, and for all subsequent attendances.

The Anaesthesia Record should include:

#### 1. Basic Information

- 1.1 The name of the patient and the hospital, the hospital record number, the age, gender and weight of the patient.
- 1.2 The dates of the pre-anaesthesia consultation and of the anaesthesia.
- 1.3 The name(s) of the anaesthetist(s).
- 1.4 The name of the surgeon or other proceduralist.
- 1.5 A brief description of the procedure actually performed.

#### 2. Pre-anaesthesia Consultation Information

- 2.1 Documentation of the pre-anaesthesia assessment of the patient. This will normally include:
  - 2.1.1 A summary of general medical status by relevant systems and diseases.
  - 2.1.2 Concurrent therapy and any known drug or other sensitivities.
  - 2.1.3 The history of previous anaesthesia and relevant surgery.
  - 2.1.4 An assessment of the airway, dental condition and risk of gastric reflux, where appropriate.
  - 2.1.5 Results of relevant laboratory data and other investigations.
- 2.2 Any pre-medicant drugs, time given, route of administration and description of any unusual response (if not recorded elsewhere).
- 2.3 An outline of the anaesthesia plan, if appropriate.
- 2.3 Documentation of discussion with the patient or guardian on the anaesthesia plan, possible therapies and possible outcomes and risks (if not recorded elsewhere). See College Professional Document PS26 *Guidelines on Consent for Anaesthesia or Sedation*.

### 3. Anaesthesia Information

- 3.1 Technique: The full details of the anaesthetic technique used, whether general, regional or sedation with monitored anaesthesia care.
- 3.2 Medication: The details of administration of all drugs including any used by the surgeon, and a description of any unusual response.
- 3.3 Airway: The size and type of any artificial airway used, a description of any airway problems encountered and the method of their solution.
- 3.4 Anaesthesia Breathing System: Details of the anaesthesia circuit, gas flows, and controlled ventilation techniques.
- 3.5 Monitoring: The monitoring methods used and regular documentation of relevant information obtained. Information provided as a monitor print-out must have correct patient identification. See College Professional Document PS18 *Recommendations on Monitoring During Anaesthesia*.
- 3.6 Fluid Therapy and Vascular Access:
  - 3.6.1 Intravenous infusion: Details of intravenous solutions including the site, size of cannula and the nature and volume of fluids infused.
  - 3.6.2 Details of central venous and arterial access.
- 3.7 Blood loss: An estimate of blood and fluid loss where appropriate.
- 3.8 Position: The position of the patient during the procedure and, where appropriate, any protective measures employed.
- 3.9 Time: The time of significant anaesthesia and operative events, observations and interventions including administration of drugs.
- 3.10 Complications or problems: A detailed description of any complications or problems encountered.
- 3.11 Other information that the anaesthetist considers is particularly relevant to a particular case should also be recorded.

### 4. Post-Anaesthesia Information (if not recorded elsewhere)

- 4.1 Respiratory, cardio-vascular and neurological status and any other relevant information.
- 4.2 Incidents arising during this period and their management. Refer College Professional Document PS4 *Recommendations for the Post-Anaesthesia Recovery Room*.
- 4.3 Plan for pain management, fluid therapy and oxygen therapy for first 24 hours if appropriate, but certainly for guidance of Recovery Room Staff.
- 4.4 Time and discharge destination on transfer from operating theatre or recovery room.
- 4.5 Space for documentation of the post-anaesthesia visit.
- 4.6 Space for documentation of outcome data, including Clinical Indicators, audit and quality assurance information as decided by the anaesthesia department/anaesthetists



## RELATED ANZCA DOCUMENTS

- PS7 Recommendations on the Pre-Anaesthesia Consultation.
- PS26 Guidelines on Consent for Anaesthesia or Sedation.
- PS18 Recommendations on Monitoring During Anaesthesia.
- PS4 Recommendations for the Post-Anaesthesia Recovery Room.

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Promulgated: 1990

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