bulletin

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS
JOINT FACULTY OF INTENSIVE CARE MEDICINE FACULTY OF PAIN MEDICINE

MARCH
06

- ***The Role of ANZCA in the Development of Quality and Safety in Australia: Four Landmarks***
- ***Principles Underpinning the Evolution of the College's Education Strategy***
- ***Fellows Profiles – Experiences in France and Samoa***

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Contents

Editorial

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

Committee

Dr Rod Westhorpe, Editor
Professor Michael Cousins
Dr Kerry Brandis
Professor Garry Phillips

The Bulletin

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President's Message

Death of ANZCA's First CEO

Council and Fellows were saddened by the news of the death of ANZCA's first CEO, Joan Sheales, FANZCA (Hon. awarded 11th Nov 2005).

Fellows have previously received an email from me notifying them of Joan's death. I subsequently placed a brief summary of Joan's service to ANZCA on the College website. Elsewhere in this Bulletin there is an obituary with a detailed account of Joan's life and her extraordinary length and range of service to ANZCA.

On Friday 3rd February 2006 a requiem mass and memorial service was held at Our Lady of Victories' Basilica in Camberwell, Melbourne. ANZCA was strongly represented at the service, with past Presidents, Deans, current Councillors and a large number of ANZCA Fellows. Presidents and senior members of other Colleges also attended, together with a wide cross section of Joan's friends. The service was truly a celebration of an extraordinary individual who had lived a very full and productive life. The eulogy delivered by Professor Garry Phillips AM, paid a most moving tribute to Joan, which is incorporated into the Obituary on page (21) of this Bulletin. Of particular note, was the comment by Garry Phillips that ANZCA had been the most rapidly developing Medical College during the time of Joan's tenure of the position of CEO. A mark of the high esteem that Joan enjoyed amongst her friends and ANZCA Fellows was the attendance of some 600 people at the Basilica.

After the church service and burial at Springvale Lawn Cemetery, Joan's family and friends, ANZCA Fellows and Staff returned to Ulimaroa and ANZCA House to share reminiscences of Joan. The buildings that Joan had worked so hard to develop and the gardens looked magnificent in the afternoon sun. The ANZCA staff excelled themselves in every detail to mark the occasion in a manner that would have been thoroughly approved by Joan. Joan's husband Noel, son Simon and daughter Sarah have asked me to thank the many Fellows who have sent thoughtful messages and expressed their appreciation of Joan's wonderful service to the College. Many of the CEOs from other colleges and national organisations such as the Australian Medical Council, overseas colleges and international organisations expressed their deep appreciation of the excellent relationship that had been developed with them by Joan and the many occasions on which she had rendered assistance to them.

The very high level of safety of anaesthesia in Australia has been confirmed by the latest Report.

I am conscious that I have been the last President to have the privilege of working very closely with Joan. I am sure I am no different to previous Presidents who came to regard Joan as a close and wise friend whose advice on all matters to do with ANZCA was indispensable. Even when ill, her dedication to our College was extraordinary. She insisted on returning to work and devoting what turned out to be a substantial amount of her remaining life, to ANZCA. I know all Fellows and ANZCA Staff will join me in offering our deepest sympathy and support to Noel, Simon and Sarah.

New ANZCA Taskforce

I previously made Fellows aware that the Federal Government and Federal Health Department are taking wide ranging steps to prepare Australia for disasters of various types including terrorist attacks, natural disasters and global medical emergencies such as influenza pandemics. I have been attending meetings of a senior medical advisory group and this has confirmed in my mind that ANZCA needed to examine the role that it could play. I therefore decided to create the 10th Taskforce during my term as President, which is named Taskforce on Disaster Response. The Taskforce is Chaired by Dr George Merridew and Deputy Chair, Dr David Scott. The full composition of the Taskforce and consultative group, together with the Terms of Reference of the Taskforce are provided on page (8) of this Bulletin. As with all other Taskforces, the Recommendations will be circulated to Regional/National Committees and to the ASA for comments before finalising ANZCA Council's implementation of the Recommendations.

I would like to thank all members of this Taskforce for the broad range of expertise that they have brought to the work of the Taskforce and their willingness to work very hard over a short timeframe to achieve an excellent Report. This report was considered at February 06 Council

ANZCA Administrative Structure

Our new CEO, Dr Mike Richards has been working with a team of consultants on a new administrative structure for ANZCA, to best meet the challenges that currently face the College. The first step has been a careful analysis of the current activities and the role of existing staff. This has been followed by discussions with staff about how the tasks that are required can be performed in a more efficient manner, and also what new tasks need to be performed and how to address these. This process is now almost complete with recommendations for consideration for March Council.

ANZCA Relations with Media, Community and Politicians

The CEO, DPA, Past President Dr Rod Westhorpe and I have been working with a public relations company, Wrights Australia, to develop new materials and strategies and this will form the basis for developing a new relationship between ANZCA and the media, general community and politicians. Some of this

material will be of relevance to the launch of the ANZCA Foundation. This process has been valuable for focusing our attention on the key messages that we want to project and how best to get these messages across. Through his significant media and political connections, our CEO is also working to identify key individuals who could become candidates for a full time position within ANZCA to work in this area on a fulltime basis. This resource will be utilised not only at headquarters in Melbourne, but also at a regional level in Australia and in New Zealand.

DPA's

Council has agreed that ANZCA needs an understudy for our highly experienced DPA Prof. Garry Phillips, to take on this role when Garry retires. It is agreed that prior experience at a high level on Council is needed, together with broad ranging experience in dealing with other Colleges, Government bodies etc. The process of identifying suitable candidates is underway.

Mortality Report

The data from State Anaesthesia Mortality Committees has now been analysed to provide national data. Particular thanks are due to the Chairman of each State Committee and to Neville Gibbs, Chris Borton and Pat Mackay for their role in bringing the data together for the National Report for the years 2000-2002. The Report is currently in the final stages of preparation prior to its release. A significant aspect of this Report is the availability of more reliable data on the number of anaesthetics administered and this is expected to be further improved in the next Report. The very high level of safety of anaesthesia in Australia has been confirmed by the latest Report.

Michael J. Cousins, AM
President

Education Report

Principles Underpinning the Evolution of the College's Education Strategy

Russell W. Jones
Director of Education, ANZCA

Successful as the current educational programs of our College may be, periodically it is worthwhile to review the overall education strategy which guides these programs. This is important to ensure that the strategy evolves with the changing medical education landscape and meets current, imminent and long-term educational needs. Such a review should include the following considerations.

Education is a continuum, and the strategy should cover educational activities within the College from when a trainee first joins the College throughout their training, graduation to Fellowship, continuing professional development and, indeed, all anaesthesia related education until their retirement. Thus the educational strategy should encompass training and Continuing Medical Education / Continuing Professional Development.

Most College related education occurs within the clinical environment (eg, hospitals), via distance education, or at some form of meeting (eg, the Annual Scientific Meeting, regional conferences, examination preparation courses, etc.). The strategy should incorporate education within all of these locations.

Although the quality of medical education is improving, there remains considerable variation in the educational, teaching and instructional abilities across the more than 170 hospitals where much of ANZCA training occurs. It is important that the education strategy seeks to maintain an acceptable minimal level of education across all hospitals and to provide those responsible for training with appropriate support. Hence the strategy must include a mechanism to increase the educational, teaching and instructional abilities of Supervisors of Training, Module Supervisors, other Fellows and senior Trainees who are and will continue to be responsible for training in clinical situations.

Anaesthetists within ANZCA are primarily distributed across six time zones and five countries (Australia, New Zealand, Hong Kong, Malaysia and Singapore) with some Fellows and Trainees even further afield as part of sabbatical, study leave or provisional fellowship. Therefore the strategy should contain a significant distance education component which will allow anaesthetists to use educational resources at a time and place of convenience to them.

The College already provides and/or supports numerous valuable educational activities (eg, the apprenticeship model within the clinical environment, Effective Management of Anaesthetic Crises course, and the Clinical Teaching Course). Therefore, wherever possible, the strategy should incorporate current successful education activities, although it may be necessary to develop additional educational activities.

Anaesthetists tend to be extremely busy people and demands on their time are likely to continue to increase. Therefore the strategy should seek to minimise additional impositions upon Fellows. The aim should be to support Fellows wherever possible, without adding to their considerable workloads.

Any education strategy should be implemented for the long-term with a view to periodic review and must be sustainable. This sustainability must include not only the provision of education, including ongoing training for facilitators and instructors, but also the regular revision of educational content.

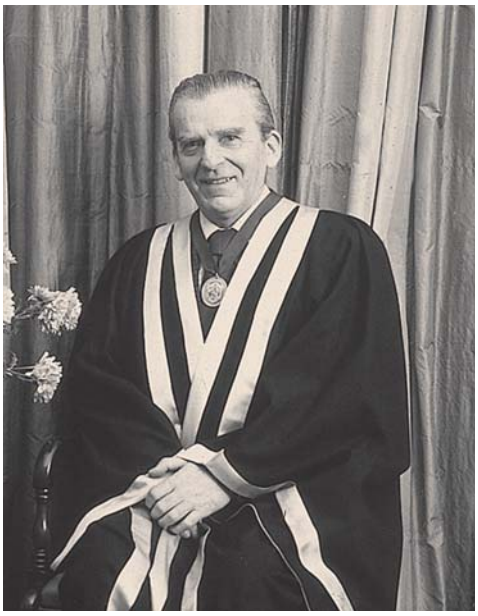
The strategy should ensure that all content directed towards Trainees covers content specified in the FANZCA Curriculum Modules and that all content directed towards Fellows covers content pertinent to Continuing Professional Development and Quality Assurance.

Other important issues for an educational strategy include funding, intellectual property and copyright. And, finally there must be in place mechanisms for ensuring that those who deliver of educational activities are adequately resourced and fully supported. The strategy should also facilitate the provision of educational support materials to those responsible for the provision of training.

The considerations described above should complement an approach to education that: is supportive of practising anaesthetists and matches the needs of Trainees and Fellows; ensures well defined and described outcomes or objectives are readily available to all Trainees and Fellows; fosters the development of skills for, and a philosophy of, life-long learning; is provided in a variety of ways to match the different learning styles inherent within such a large population of Trainees and Fellows; uses appropriate technology to aid learning and instruction; is facilitated by administrative structures and communicative mechanisms that aid the efficiency and effectiveness of the educational processes; encourages continuing professional and personal development; and is responsive to an ever changing medical education curriculum and the evolving needs of the broad health community and society as a whole.

Series on Past Deans and Presidents

Dr Kevin McCaul



Dr Kevin McCaul was the ninth Dean of the Faculty of Anaesthetists Royal Australasian College of Surgeons, holding the position for two years from 1970-1972. He followed Dr Noel Cass and was succeeded by Dr Tess Brophy.

Kevin McCaul was born on 16th January 1914 in Carrickmacross, Co. Monaghan Ireland. He was the son of an Irish general practitioner in fact a fifth generation medical practitioner. He was educated at St Patricks National School at Carrickmacross and then St Vincent's College, Castleknock. He completed his clinical years in his medical course at the London Hospital, graduating in 1937 with the Conjoint Diploma of the Royal College of Physicians and the Royal College of Surgeons in Ireland, and the Licentiate in Midwifery, returning to England for his house officer posts in 1938-1939.

During the Second World War he served with the rank of Major in the Royal Army Corps, serving with the 12th Indian Casualty Clearing Station, the 14th Indian Field Ambulance, the 12th Indian Mobile Surgical Unit and the 12th Indian General Hospital.

By way of explanation "the arrangement of Hospitals in the war zone was almost identical to that in World War 1. Once again the wounded were evacuated to advanced and main dressing stations where a minimum of essential surgical treatment was given. Major casualties were then evacuated by motor ambulance to casualty clearing stations many miles behind the front. They were equipped to perform all urgent surgery. As soon as the soldier's condition permitted, they were transferred by road or rail to the General Hospital up to 400 miles behind the front…. However due to the speed of warfare sometimes these hospitals found themselves caught up in the movement of the front line and so became casualty clearing stations."[1]

In 1944 he was captured when the Japanese encircled the seventh Division. His courage in escaping and bringing wounded prisoners to safety was recognised by the award of the MBE(Military Division). Kevin McCaul served with the Royal Australian Army Medical Corps from 1954-1972 as consultant anaesthetist with the rank of Colonel and was awarded the Efficiency Decoration(ED) in 1972.

He took a great personal interest in the professional welfare of young service doctors. During his tenure as Dean and Vice Dean, the ANZUK Hospital in Singapore, the Army Hospital at Vung Tau, Vietnam, and the School of Underwater Medicine at HMAS Penguin were approved for limited training for Faculty examinations. This ensured that military personnel could commence training for postgraduate qualifications while fulfilling their commitments to the armed services.

In 1951, Kevin McCaul was appointed as Director of Anaesthesia at the Royal Women's Hospital in Melbourne. This appointment ushered in an era of change with the introduction of epidural anaesthesia for labour, making the RWH the first in the world to abandon general anaesthesia in labour. Epidural anaesthesia was extended into analgesia for gynaecological surgery for cancer. He also introduced the position of anaesthetic registrar to the Hospital appointing Drs Noel Cass and Pat Scrivenor to the role in 1952. Ironically he would follow Noel Cass as Dean of the Faculty. One of the main stays of anaesthetic registrar training in Melbourne for many years was the third year rotation between the Royal Children's Hospital and the Royal Women's Hospital that provided specialist Obstetric and Paediatric experience. This rotation was formed by Kevin McCaul and Dr Greta McClelland who was Director at the RCH and continues to this day.

Kevin McCaul obtained the Diploma of Anaesthetics in 1945 and was admitted to the Fellowship of the Faculty of Anaesthetists, Royal College of Surgeons(FFARCS) in 1953. This was followed by admission to Fellowship of the Australian Faculty in 1954 and in 1956 he became an examiner for the final examination for the FFARACS continuing until 1973 serving as Chairman of the Court of Examiners from 1965-1969. He was elected to the Board of Faculty in 1964 becoming Vice Dean 1968-1970 and then as Dean 1972-1974 continuing in a supportive role to the subsequent Dean.

Honours were afforded to Kevin McCaul in his life time, being awarded the Robert Orton Medal by the Faculty, its highest honour for a practising Fellow. In 1978 he was elected a Fellow of the Royal College of Obstetricians and Gynaecologists and in 1989 the Royal Australian College of Obstetricians elected him to its Honorary Fellowship recognising outstanding service to Obstetric and Gynaecological anaesthesia. The New Zealand Society of Anaesthetists admitted him to Honorary Membership in 1954. He was already a member of the Australian society of Anaesthetists. In 1971 he was admitted to Honorary Fellowship of the Faculty of Anaesthetists Royal College of Surgeons Ireland-the first Australian so honoured. He was appointed a Professorial Associate in the Department of Obstetrics and Gynaecology, University of Melbourne 1974.

The last word will be from Mrs John Leckie, President of the Board of the Royal Women's Hospital, Melbourne at the retirement of Kevin McCaul in 1979. "He has done more for women in Australia than any other person I can think of" Kevin McCaul passed away on 16th June1998 survived by his wife, a brother and a sister, three children and two grandchildren.

I would like to acknowledge the Obituary written by Prof T Crammond(Brophy) as the source for the majority of the information contained in this essay.

Reference

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Report

The Role of ANZCA in the Development of Quality and Safety in Australia: Four Landmarks

Landmark 1

This was the regular systematic reporting following review of anaesthesia-related mortality, beginning early in the 1960s. Indeed Australia led the world by the introduction in 1960 of an *anaesthesia mortality committee* sponsored by the New South Wales (NSW) Government. Between 1969 and 1978, all other states followed this lead. Two sentinel articles by Holland on Anaesthesia Mortality in NSW [1,2] attracted worldwide interest, preceding publications or reports by each of the state mortality committees. The mortality committee in Victoria (VCCAMM) was established in 1976; it was the single state council to include anaesthesia-related morbidity in its terms of reference and to provide feedback to practitioners by web based information and "alerts".

State to state anaesthesia mortality was pooled in 1990 as a national report, compiled first by the National Health and Medical Research Council (NH&MRC) incorporating years 1985-90, and after1995 by the Australian and New Zealand College of Anaesthetists (ANZCA) which has published reports for years 1990-2001. These reports have been somewhat limited by (a) non-uniformity of state legislation, (b) reliance on voluntary reporting and (c) a lack of accurate information on numerator (incidence of deaths) and denominator (population at risk). Nevertheless there has been substantial reduction over 40 years in the incidence of anaesthesia-related mortality despite extension of anaesthesia to high-risk individuals and increasing participation in reporting by anaesthetists.

Landmark 2

This was the development from 1981, by the then Australasian Faculty of Anaesthetists (now ANZCA), of professionally constructed documents containing comprehensive guidelines for safe practice under many conditions, and specifying technical aspects, professional standards, training and educational requirements. The Australian Society of Anaesthetists also has contributed. This College was among the very first to issue specific guidelines on Quality Assurance, and further guidelines are maintained and updated regularly according to changing circumstances. These are not so much clinical practice guidelines but rather material for use by governments and health institutions for the purposes of education and accreditation of facilities.

Landmark 3

This was the development in 1988 of a national anaesthesia incident monitoring system (AIMS) to implement effective procedures for analysis of critical incidents and development of crisis management. A symposium was published in 1993[3] with analysis of the first 2000 incidents reported voluntarily Australia-wide, followed by numerous publications of findings, although direct feedback has lapsed recently. Use of this information, together with the support of ANZCA, indicates that AIMS accelerated the introduction of mandatory monitoring standards, so reducing deaths from hypoxia and respiratory failure; the ensuing crisis management algorithms that are widely used by trainees and specialists. The development of simulation centres since 1997 has also beneficially influenced education for crisis management.

The result of these initiative, Landmarks 1-3, is the widely recognized level of safety of anaesthesia in Australia. In the Quality in Australian Healthcare Study in 1995[4] that scrutinised safety aspects of healthcare, the contribution of anaesthesia to adverse events was significantly lower than that of most other specialities.

Landmark 4

This was the adoption of the basic principles of Evidence Based Medicine (EBM). Clinical anaesthesia is essentially the practice of acute medicine and EBM has not yet reached the same applicability as it has for therapeutic medicine. However, as the perimeters of anaesthetic practice expand to include perioperative medicine and pain control, an evidence base becomes increasingly relevant. Notably .there have been developed large randomised clinical trials supported by ANZCA and NH&MRC, of which three have been completed since 2000.The MASTER trial[5] established the value of post-operative epidural pain relief, particularly in severe respiratory illness. The B-aware trial[6] evaluated use of the bispectral index monitoring to detect awareness during anaesthesia and results have significantly influenced the wider adoption of monitors of depth of anaesthesia. The ENIGMA trial (unpublished) has assessed morbidity associated with the use of nitrous oxide in anaesthesia of duration greater than two hours. The success of these trials has prompted ANZCA to create a Clinical Trials Group which will collaborate with other specialties to design trials of mutual interest. Moreover there is an outstanding publication by ANZCA entitled "Acute Pain Management-Scientific Evidence[7] that contains guidelines on the "best evidence" currently available. Finally a recent initiative by the Victorian Quality Council, in response to concerns of VCCAMM on the number of adverse events related to acute pain management, has resulted in the award of a contract to St. Vincent's Hospital, Melbourne, to develop an acute pain toolkit enabling standardization of methods statewide for assessment and recording of acute pain. This supplements current trends to introduce measurable and therefore comparable best practice guidelines for effective yet safe management of acute pain.

In conclusion the above procedures over some 30 years would have resulted in significant cost saving, and the many achievements in quality and safety provide a solid platform for the expanding role of anaesthetists in peri-operative medicine. The specialty of anaesthesia will increasingly foster interaction with other specialties, promulgate undergraduate and postgraduate training in quality assurance and safety issues and seek closer involvement of private and rural practitioners. The still unmet needs include: acquisition of centralized data with qualitative evaluation of adverse events along with interactive web based communication, prompt publication of "alerts", provision for education of the entire community, and development of clinical practice guidelines incorporating a "best evidence base".

Dr Patricia Mackay, FANZCA

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Research Report

Trials Group

Ornella Clavisi
Research Coordinator, ANZCA Trials Group

Survey research

In an attempt to help those already involved or contemplating survey research, the Trials Group has co-authored a review on survey research in anaesthesia which is due to be published in the 2006 April edition of *Anaesthesia and Intensive Care*. Generally speaking the time and effort required to conduct survey research is often underestimated and although it may seem to be an easier option compared to other methodologies, it requires substantial planning and can be resource intensive on all fronts. The review covers many of the methodological and logistical problems inherent to survey research. It includes considerations for developing a survey instrument, deciding on an optimal method of data collection and strategies for increasing survey response rates. The Trials Group is also the supervising body for surveys targeting College Fellows and trainees. One of the research resources of the College is a database containing contact and general demographic details of all College members. Use of these details is open to all Fellows and trainees, however access is based on a review of the proposed research and approval by the Trials Group Executive. Once approved, the Trials Group organises the initial and follow up mail outs and act as a central point for returned surveys (particularly email surveys) in order to maintain confidentiality. Anyone wishing to utilise this data should contact the Trials Group for further information or just send in your research protocol stating your interest in using the College database.

Broadening the research base

Overall the Trials Group executive is keen to support College Fellows in developing their research questions, and providing infrastructure support for the development of any subsequent research studies and publications. In its endeavours, the Trials Group has written to each Special Interest Group (SIG) Chair inviting them to use the Trials Group resources to develop their research questions into multicenter trials and ultimately publish in high impact journals.

Furthermore, in order to broaden the ANZCA research community well beyond "the usual suspects", the Trials Group is also keen to support the SIGs to develop networks of interested Fellows to facilitate the development of trials that are of particular interest to them. The response received so far has been encouraging particularly from the Cardiothoracic, Vascular and Perfusion Group and the Diving and Hyperbaric Medicine Group.

Systematic reviews

The Trials Group has also been involved in the development of a Cochrane Protocol for a systematic review of Target Controlled Infusion (TCI) versus Manually Controlled Infusion (MCI) of Propofol. The protocol is due to be published in *The Cochrane Library* 2, 2006 edition, which will be released in April 2006. The Trials Group is also happy to announce that the title of its review on Tranoesophageal Echocardiography has been accepted for registration by the Cochrane Anaesthesia Review Group (CARG). A protocol for this review is currently being developed. For those unfamiliar with the Cochrane process, the development of a Cochrane Systematic Review consists of multiple stages. Initially authors are required to register the title of their review with a Cochrane Review Group (CRG) from which an editorial team is sourced. In the case of the TCI review, this was registered with the Cochrane Anaesthesia Review Group, however there are many other CRGs such as the Heart Group, Pain Palliative and Support Care Group and the Pregnancy and Child Birth Group. Once your title has been approved you are then required to prepare a protocol (i.e. a plan of how the review will be carried out) which is peer reviewed and published. Only when the protocol is accepted for publication can the authors start the hard work of developing their review. If you are interested in developing a systematic review, but are unsure how to get started, please feel free to contact us.

A quick update on some of the projects that the Trials Group is currently working on

The Aspirin and Tranexamic Acid in Cardiac Surgery (ATACAS) trial is finally set to start. At this stage, the procedures manual and data collection forms for the trial have been finalised, issues surrounding drug availability have been resolved and patient recruitment has commenced. It is anticipated that the trial will be up and running by late February 2006.

The Obstetrics and General Anaesthesia Survey for caesarean section is currently underway with 18 sites currently recruited and data collected on approximately 630 patients. This study is looking to quantify the incidence of difficult and failed intubation. We are keen to get more sites on board, so if there is anyone wishing to be involved in the study please feel free to contact the Trials Group.

Finally the Trials Group wishes to remind all Fellows of our Pilot Grant Scheme. It is open to all Fellows of ANZCA, JFICM and FPM and is aimed at providing start up funding for those interested in either developing pilot phase testing of trials, collecting baseline data using surveys or establishing a network of investigators. The Grant scheme is for $5000 with the addition of infrastructure support from the Trials Group Research Coordinator.

All enquiries regarding the Trials Group can be directed to Ornella Clavisi (Trials Group Coordinator) on: +61 3 8517 5326 or oclavisi@anzca.edu.au.

Report

Highlights from February Council

HONOURS, APPOINTMENTS AND HIGHER DEGREES

- Dr Jeanne Margaret Collison (NSW) - Officer of the Order of Australia (AO)
- Prof Teik E Oh (WA) - Emeritus Professor, University of Western Australia, and Honorary Fellowship, Hong Kong College of Anaesthesiologists
- Prof Barry Baker (NSW) - Emeritus Professor, University of Sydney

ELECTION OF NEXT PRESIDENT

Dr Walter Thompson (WA) was elected President-elect, and will take Office following the Annual General Meeting in May.

JOINT FACULTY OF INTENSIVE CARE MEDICINE

A delegations document, clarifying a number of issues regarding the Joint Faculty's relationship with ANZCA, was accepted by Council.

EDUCATION AND TRAINING

Training in the Private Sector

Through the Education and Training Committee, consideration is being given to the training that can be undertaken in alternative settings. In addition, development of a policy on Supervisors of Training for such institutions was considered appropriate.

CONTINUING EDUCATION AND QUALITY ASSURANCE

New Fellows' Conference 2006

Dr Lindy Roberts was appointed Councillor in Residence to the 2006 New Fellows' Conference, which this year will be held at Victor Harbour, SA.

Clinical Indicators

As part of the ACHS Clinical Indicator Review Process, consideration is being given via the CE&QA Committee to re-forming the Clinical Indicators Working Party.

INTERNAL AFFAIRS

Regulation 23 - Advice Regarding Recognition as a Specialist in Anaesthesia. This Regulation was reviewed, and the OTS documentation will be updated accordingly to ensure consistency is maintained.

Taskforces

The Taskforce reports have now been considered in detail by Council. An action sheet is being developed to assign priority to each recommendation, and will include a costing related to implementation, the status of activity, and completion date.

Formation of a Quality and Safety Committee

Following the report from the Q&S Taskforce, the establishment of a Quality and Safety Committee was supported. Early identification of an appropriate data vehicle is to be a priority for the Committee, and input from the ASA and NZSA will be sought.

Professor Alan Merry was appointed Chairman, and confirmation of the membership of the Committee is anticipated in April.

OTS Committee

An update to the documentation on the Area of Need Assessment Process was accepted by Council.

Finance, Audit and Risk Management (FARM) Committee

Council supported the recommendation of the FARM Committee that the College Audit should be put out to tender, and an appropriate recommendation made at the AGM in May.

College Involvement in South East Asia

There was general consensus about the College's continued involvement in South East Asia, the aim being to maintain close links with ANZCA Fellows, colleagues and sister anaesthesia organisations in the region.

Council considered local Government support for its training program in Hong Kong, Singapore and Malaysia a necessary condition for maintaining that training program in those countries.

Council recommended that other modes of co-operation with the anaesthesia training bodies in Hong Kong, Singapore and Malaysia be explored, by convening a forum formed by HKCA, University of Singapore, University of Malaysia, UKM (National University of Malaysia) and ANZCA. This forum will be convened by Dr Walter Thompson.

PROFESSIONAL DOCUMENTS

The following documents were approved by Council:

- T1 - Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations
- T3 - Safety Requirements for Anaesthesia Machines for Clinical Practice (this new document will undergo an interim review in 12 months)
- PS18 - Recommendations on Monitoring During Anaesthesia
- TE2 - Policy on Vocational Training Modules and Module Supervision (Interim Review following review of Regulations 14 and 15). This document will undergo the normal process at its next scheduled review in 2008.

Following acceptance of the updated T1, Professional Document T2 - Recommendations on Minimum Facilities for Safe Anaesthesia Practice Outside Operating Suites, was withdrawn.

ANZCA COUNCIL CITATIONS

Dr Kenneth McLeod, Qld was awarded a Council Citation for his contributions to rural anaesthesia, especially in the education and training of both ANZCA trainees and GP anaesthetists.

A posthumous Council Citation was awarded to Dr Campbell Barrett, NZ for his contributions to Anaesthesia, and especially Intensive Care over many years in New Zealand.

Geoffrey Kaye Museum of Anaesthetic History

Into the Future

Ms Elizabeth Triarico
Museum Manager

Since its foundation in 1935, the Museum has continued to develop due to the hard work and dedication of a number of interested individuals and in particular Honorary Curators and Assistant Curators including Dr G. Kaye (1947-1995), Dr H.P. Penn (1958-1981), Dr G. Westmore (1980-1981), Dr A. Ross (1982), Dr R. Westhorpe (1986-) and Dr C. Ball (1989-). In 2003, the first professionally trained Museum Curator was employed to work closely with the current Honorary Museum Curators to build on past achievements and manage the Museum to best practice standards.

Over the past three years a great deal of work has been undertaken to improve the management of the Museum and ensure that it is efficient, relevant and interesting. This has involved the implementation of basic infrastructure including the development of: The first Museum Committee; a Museum office, workroom and display area; a draft collection management policy; the first Museum 3 Year Strategic Plan and the successful completion of the *Museum Storage Upgrade and Collection Inventory Project,* in December 2005. Some of the key achievements so far include:

- Greatly improved storage and object handling systems.
- Over 5,000 Collection objects inventoried.
- Greatly improved access to objects and documentation.
- Tours of the Museum display are available five days a week and include:
  - Tours for Fellows and Trainees on request.
  - Tours for Trainees during VRC Courses.
  - A highly successful *Talk and Tour* program for community groups such as Rotary Clubs, Probus Groups and, educational and heritage organizations.
- Assisting the promotion of ANZCA and its activities through the *Talk and Tour* Program which promotes the work of anaesthetists within the wider community.
- Improved response to research inquiries.
- Improved working conditions and security for objects.
- Increased use of the Collection:
  - Objects and information used by Trainees and Fellows in research, conference papers, and various publications.
  - On site and off site displays.
- Introduction of a permanent Museum Display Area on Level 5 of ANZCA House.
- First display held at a hospital – St Vincent's Hospital Display July 2005.
- Development of successful on-going working partnerships.

The main focus for 2006 will be introduction of a collection management database and cataloguing program and the upgrade of the Museum Display Area. The upgrade is a major project that includes the redesign of the display area and the development and implementation of a relevant and engaging changing display program.

The first ANZCA ASM Museum display will be held this year in Adelaide. The focus of the display is based on the ASM theme of, *All in a Days Work*. The display will feature a wide variety of interesting objects and stories that illustrate the working life of anaesthetists from the 1880s to the 1950s. This exciting new initiative has been made possible due to the improved access to the Museum Collection and demonstrates a long-term commitment to relevant and interesting Museum activities.

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 etriarico@anzca.edu.au

Museum Display
Level 5, ANZCA House
To be upgraded in 2006.

Museum Work Area
Ms E Triarico, Museum Manager
Level 5, ANZCA House

Community Group Talks
Dr Rod Westhorpe (Honorary Curator) and the Combined Probus Club of Monash Central,, Douglas Joseph Room, Ulimaroa, 28 April, 2005.

Community Group Museum Tours
Dr Christine Ball (Honorary Assistant Curator) and the Syndal Ladies Probus, 12 December, 2005.

Deaths

Council noted with regret the death of the following Fellows:

Dr James Patrick Dalton Keaney (ACT)

FFARACS 1977, FANZCA 1992

Dr Charles Ashur Sara (NSW)

FFARACS 1952, FANZCA 1992

Dr Kanapathipillai Inbasegaran (Malaysia)

FFARACS 1979, FANZCA 1992

Mrs Joan Margaret Sheales (VIC)

FANZCA (Hon) 2005

Dr Edward Ward Te Kanawa Douglas (NZ)

FANZCA 1998

Obituary

James Patrick Dalton Keaney (Jim) – ACT

14th September 1932 – 16th November 2005

FFARACS - 18th March 1977, FANZCA - 30th June 1992
FFARACS IC - 1st June 1982, FFICANZCA - 4th November 1993

(As printed in the Canberra Times, 14th December 2005)

James Patrick Dalton Keaney (Jim) was a pioneer of critical care in the Australian Capital Territory.

He was born in Silverwater in Western Sydney on the 14th of September 1932, the youngest of eight children of Irish immigrants Patrick (a merchant sea-man) and Norah. He entered Springwood Seminary at 14, receiving a grounding in philosophy, theology and classics which was to affect all his later life and work. He left the Seminary before taking orders, but on good terms. For the next six years he roamed the outback, working, inter alia, as a shearer, storman and construction labourer. He then settled on Medicine, still working part-time and qualifying from the University of Sydney in 1964. He married a fellow student, Margaret Mary O'Flynn, the same year.

The next six years were spent in anaesthesia and intensive care at the Royal College of Surgeons in Edinburgh and the Royal Derbyshire Infirmary and Derbyshire Children's Hospital. He obtained his post-graduate degree as a Fellow of the Faculty of Anaesthetists of the Royal College of Surgeons in London. Back in Australia, he obtained Fellowship of the Australian and New Zealand College of Anaesthetists and (Foundation Fellow) of the Faculty of Intensive Care of the Australian and New Zealand College of Anaesthetics and the Royal Australasian College of Physicians.

After a spell of private anaesthetic practice in Penrith, Jim took the job of Director of Intensive Care in Canberra (later Royal Canberra) Hospital in 1974. The Keaney family came to live at Cottage 2, Canberra Hospital, which quickly became a modest but greatly loved family home on the Acton Peninsula (now 'Limestone House' at the National Museum of Australia). In 1988 Jim took the position of inaugural Director of Neonatal Intensive Care at Woden Valley Hospital. He had also been a Consultant at the Calvary Hospital since 1984 and became the inaugural Director of its Intensive Care in 1995.

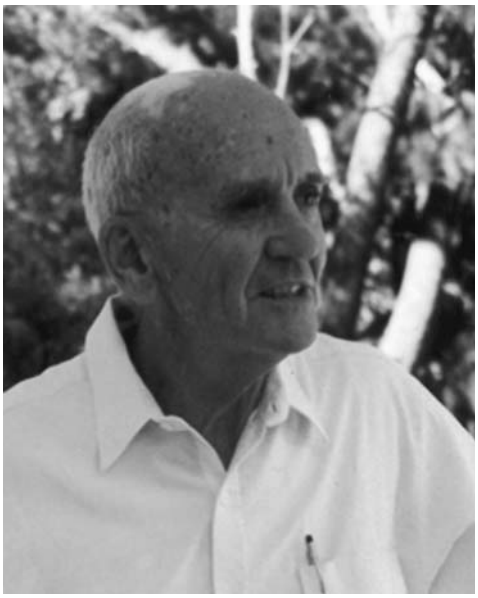
What made Jim's contribution extraordinary is the sustained intensity of his commitment to the critically ill - not only in the ICU, but throughout the hospital, including Casualty - 24 hours a day, all year round, accumulating enormous leave and not taking it until forced to do so. For many years, he would be there first at all cardiac arrests and emergencies, at any time of day or night. He was loved by generations of nursing staff.

Also extraordinary was the modest, almost self-effacing way in which he conducted all professional transactions. This often led to lesser players receiving greater credit for the clinical outcomes and to Jim being underestimated by some. He never sought to redress those injustices. Similarly, he never criticised his colleagues in a personal, ad hominem, manner: he defined the medical issues and allowed the facts to speak for themselves.

He never sought private practice or higher remuneration for his long and lonely work - this despite helping support a large family. We cannot, in fact, recall him complaining of anything: his entire attention was on what should be done, and how. Canberra medical scene was rather embattled in mid-1970s, perhaps more bitterly than elsewhere in the Commonwealth. He stayed above it throughout.

A deeply religious man, he maintained a lifelong interest in philosophy and, particularly, ethics. Yet, he never preached, pontificated or invoked higher causes to explain his actions: he talked simply and directly with confidence of a true Christian. With dying patients and their families he addressed the issues in plain, simple, secular terms - one would never guess how much he knew. One could not wish for a better physician in those moments: a man of sure judgement and unimpeachable integrity.

His hobbies included horse racing - he became the official course physician at the ACT Racing Club in 1991 - and photography, especially of



vitrage in country churches.

Many people thought that Jim should somehow be recognised and honoured - far as it must have been from his own mind. Few people deserved public honours more - but in his case we can say that what is best in all Medicine was honoured in the acknowledgement of his true virtue and extraordinary efforts. He was made a Member of the Order of Australia in June 2002, the year after both he and his wife Margaret retired. Margaret had been Director of the Emergency Medicine at Calvary Hospital for over 20 years. Jim continued his passion for medicine and teaching as a tutor with the newly established ANU Medical School.

Jim died unexpectedly of a heart attack on 16th November. He is survived by his wife Margaret and their six children: Gerald, Catherine, Thomas, Magdalene, Benedict and Mary and their families. He led an exemplary life and its greatest reward was his family. Those of us who worked with him will continue to hear his voice of compassion and reason, as long as we work in critical care, and beyond.

IMOGEN MITCHELL, Director, ICU, TCH
GEORGE NIKOLIC, Senior Specialist, ICU, TCH
The Canberra Hospital, 23rd November, 2005

Obituary

Charles Ashur Sara – NSW

5th October 1915 – 28th December 2005

FFARACS - 25th August 1952, FANZCA - 24th February 1992

Charles Sara was one of a family of three sons and one daughter, born to Charles John Edwin Aubrey (known as Aubrey) and Ruby Sara. Aubrey Sarah had emigrated from Hakaru, New Zealand where he was a pharmacist's assistant. (On entry to Australia at Sydney Customs, he dropped the "h".) He married Ruby Hart, who was descended from Ashur Hart of the long-standing and famous Hart family. Aubrey became a famous identity and shark fisherman at Bondi and a respected office-bearer at the Bondi Surf Life Saving Club.

Charles was educated at Sydney Grammar School and the University of Sydney, graduating M.B., B.S. in 1940. He spent his residency years, 1940 to 1942, at Royal South Sydney Hospital.

He saw active service in the Second World War, first in the Citizens' Military Forces, then as Captain in the Australian Imperial Force from July 1942 to May 1946, serving overseas for a considerable part of that time. He received the Pacific Star, the War Medal, the Defence Medal and the Australian Service Medal 1939 - 1945.

After discharge from the army he entered general medical practice, serving as an Honorary Medical Officer at the Royal South Sydney Hospital and joining the Royal Alexandra Hospital for Children as Honorary Anaesthetist in 1948, a position he held for the next thirty years.

In 1948 Charles married Melbourne girl Barbara Falla, a nurse whom he had met at Royal South Sydney in his residency years.

In 1949 he gained his Diploma of Anaesthesia of the University of Sydney and subsequently was appointed Honorary Anaesthetist to the Royal Prince Alfred Hospital, retiring in 1983. He was given Consultant Anaesthetist status to both the Children's Hospital and Royal Prince Alfred Hospital on his retirement.

Charles also practised in Honorary, then Visiting Anaesthetist positions at Concord Repatriation Hospital and the United Dental Hospital, Sydney. From 1966 to 1975 he was Lecturer in Anaesthesia for Dental Surgery, Faculty of Dentistry at the University of Sydney. Charles was highly respected in his pioneering work in dental anaesthesia, contributing important papers to the literature and being awarded, in 1975, the Belisario Award of the Australian Society for the Advancement of Anaesthesia and Sedation in Dentistry, for "outstanding contribution in the field of Dental Anaesthesia and Sedation" over a period of some 25 years.

During his time at the Dental Hospital, Charles established a position for young postgraduates in anaesthesia returning from overseas. This Honorary Assistant Anaesthetist position carried with it the Title of Clinical Lecturer in Anaesthesia at the University of Sydney, a prestigious start to a career which was appreciated by Charles' younger colleagues who were fortunate to be appointed.

Charles enthusiastically served both Faculty and Society. In the Australian Society of Anaesthetists he held positions of Treasurer, then Secretary, from 1954 to 1959, and Chairman of the New South Wales Section 1960 - 1961. In 1952 he was a Foundation Member of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons, being awarded his Fellowship of the Faculty (FFARACS) at that time. He was a member of the Faculty's Court of Examiners, then Vice Chairman of the Court, from 1961 to 1970. As a member of the Board of Faculty from 1967 to 1974, Charles contributed enormously to the establishment of the Faculty's training program in anaesthesia. On his retirement from the Board, he was fittingly awarded the Robert Orton Medal for meritorious service to Anaesthesia, the highest honour of the Faculty.

He represented the Faculty on the Standards Association of Australia and was consultant to the Coronial Investigation Unit for Anaesthetic and Drug Related Mortality.

Charles Sara had a scientific approach to anaesthesia practice, seeking to elucidate the reasons for his observations of the effects of anaesthetic drugs, and conducting experiments to reproduce these observations in the laboratory, publishing many papers at a time when few of his colleagues seemed interested in this aspect of furthering knowledge of the science of anaesthesia. His many published works portray his wide-ranging interests. His first paper co-authored with Tony Balthazar, described the relaxant decamethonium in anaesthesia,then its successor, succinylcholine, while others ranged through mechanical respiratory support (with Bruce Clifton), a series of papers on heat and humidity during endotracheal intubation (with Colin Shanks in the early 1970s), nebulization, epithelial changes in the trachea and bronchi, rebreathing with the circle absorber at low fresh gas flows, and neonatal resuscitation. Charles wrote a comprehensive review on intravenous sedation, published in the Australian Dental Journal in 1974, and wrote on peripheral pulse monitoring, all this quite early in the recognition of the importance of these concepts.He also frequently contributed to journal correspondence and book reviews.

In fact, Charles was a great proponent of publication. In particular he was most supportive of the establishment of the Society's Journal "Anaesthesia and Intensive Care" from its initial concept in the early 1950s when there was much heated debate within the Society as to whether it would succeed, and indeed up to and after the Journal was established by Ben Barry in 1972.

John Lowenthal, Professor of Surgery at the University of Sydney, and with whom Charles worked in the operating theatre at Royal Prince Alfred Hospital, wrote of Charles in 1959, describing his "excellence as an anaesthetist… combining the nonchalance of the experienced with the freshness and vigour of one who is constantly thinking about his art and craft". Charles always endeavoured to provide the best possible operating conditions for his surgeons, minimizing blood loss and thereby avoiding the

necessity for transfusion. He was highly respected by all the surgeons he worked with.

On a more personal level, Charles had a strong interest in surfing, being a member of the Bondi Surf Club team that won the Australian Junior Surf Board Championship in 1932 and 1933, and participated in the Black Sunday rescue at Bondi when around one hundred and fifty people were swept out to sea. He was pleased to be invited back to the club for a 50-year member function some years ago. Photography, reading, bird watching, amateur radio and film making were among his many interests, while he also enjoyed some medicolegal casework in his retirement years. It was unfortunate that he was increasingly handicapped in later years, following complications that ensued after neurosurgery for excision of a meningioma.

Charles was not only a skilful, thoughtful and helpful colleague, but also a genial and happy personality. He will be remembered as an encouraging mentor, with an outgoing nature, confident and inspiring confidence, and always with a quick and hearty laugh.

He is survived by his wife Barbara, son Antony, a doctor now practising full-time as Director of Clinical Information Systems, daughter Angela, a landscape architect, and six grandchildren.

Jeanette Thirlwell-Jones.

Dato' Dr K Inbasegaran

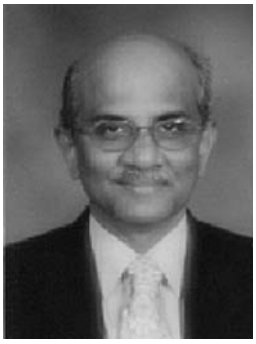
26th May 1947 – 8th November 2005

FFARACS - 28th July 1979, FANZCA - 14th March 1992

On the 8th of November, 2005, the Malaysian anaesthetic and medical community mourned the loss of a great friend and true leader.

Dato Dr Inba was Head of the Department of Anaesthesia and Intensive care in Hospital Kuala Lumpur and chief anaesthesiologist in the country from 1992 till his retirement in 2002. He was also President of the Malaysian Society of Anaesthesiologists and served an unprecedented two terms during which he was also actively involved with the World Federation of Societies of Anaestheisology (WFSA).

Dato Inba contributed significantly to the development of anaesthesia in this country, and was instrumental in bringing about several important changes to the landscape of anaesthesia in the country. He was always very conscious of safety in the provision of anaesthesia, and was instrumental in drawing up the consensus document on Monitoring Standards for Anaesthesia in Malaysia, the implementation of the review of maternal deaths in Malaysia, and the setting up of the Perioperative Mortality review (POMR) committee in the Ministry of Health. Due to his efforts, the equipment for anaesthesia and intensive care in public hospitals was systematically upgraded and modernized, with an emphasis on safety. He was also responsible for the streamlining of credentialing and accreditation of anaesthesia and intensive care services in hospitals in the country.



Dato Dr Inbasegaran contributed to the field of anaesthesia in a way that few can equal; his work has resulted in a greatly improved image of the anaesthesiologist as a professional who is a key member of the perioperative team and the medical fraternity. He will be sorely missed.

Dr M Cardosa, Prof YK Chan, Dr SH Ng

Obituary

Joan Margaret Sheales

3rd November 1942 – 29th January 2006

FANZCA (Hon) - 11th November 2005

The death of Joan Sheales on the 29th January, 2006 marks a watershed in ANZCA's history.

As our first CEO, Joan served this College and its forerunner, the Faculty of Anaesthetists, RACS, for over 25 years and was totally dedicated to enhancing the status, financial security, facilities and programs of the College. Joan was appointed Administrative Officer in 1987 (the top management position of the time). She established a strong network with CEOs of other Colleges, with Government and other bodies. No other College CEO was more respected than Joan Sheales: she was pivotal in enhancing ANZCA's high standing in Australia, New Zealand and around the world.

Joan Sheales was born in Melbourne on the 3rd of November 1942, the elder daughter of James Michael and Kathleen Elsie Canny. She was the elder sister of Annette.

Her family lived in Spring Street, then King Street, then Elwood and then Rathdowne Street, so Joan knew Melbourne well. She walked and travelled by tram or bus to school, spending holiday time at Radio 3XY, at theatres, and working casually at Myer. She had a great sense of adventure, a trait that stayed with her all her life.

Joan was educated at St. John's in Clifton Hill, and at the Catholic Ladies College East Melbourne.

Following Business College, she spent a number of years first at Legal and General Assurance in Melbourne, then as a legal secretary and law clerk in firms in both Melbourne and Sydney. By this time she had developed her communication skills and confidence for the future.

Joan met Noel Sheales in 1962 before she went to Sydney, and they married when she returned to Melbourne in 1968. Their two children, Simon and Sarah attended first the Baptist kindergarten at Hawthorn, and then Our Lady of Victories School, which was when Joan joined the Faculty of Anaesthetists, Royal Australasian College of Surgeons in Spring Street as a part time general duties assistant, under the watchful eye of Nancy O'Donnell, who was in charge of Faculty administration. The part time arrangement allowed her to be at home until the children went to school, and at home when they returned.

Joan quickly demonstrated her qualities of enthusiasm, willingness to take on any task, conscientiousness, perseverance and careful attention to detail which saw her take over preparation of agendas, minutes, hospital surveys and inspections, examinations, registers, and every other aspect of Faculty activity, until she became Administrative Officer when Nancy retired, then Registrar and then Chief Executive Officer of the newly formed Australian and New Zealand College of Anaesthetists in 1993.

A staff profile published in 1989 simply stated that "she ensured that the Faculty office coped most admirably with the rapid expansion of activity which occurred with her appointment." It then went on to say that "when not devoting her life to the Faculty, Mrs. Sheales supports her most tolerant husband and teenage children. Her recreational interests include walking, gardening, cooking and entertaining."

In her twelve years as CEO of the College, Joan became responsible for the most rapidly growing Medical College in Australia and New Zealand, with branches in Hong Kong, Singapore and Malaysia, and influence in Papua New Guinea and South Pacific Island countries.

Her staff grew and developed - in Melbourne, in regional offices and in New Zealand. She was CEO when Ulimaroa was purchased and refurbished, and was effectively foreman-in-chief for the construction and furnishing of ANZCA House, another example of her efforts to enhance the image of the College to which she devoted herself, and which she enjoyed. Joan was an innovator in coordination of inter-college activities in Australian and New Zealand, and internationally, and did much to enhance the College's interactions with Government agencies.

But Joan seen from the College viewpoint was by no means the only Joan.

She guided her mother and sister after her father died. Annette recalls that "Joan always knew what to do", whatever the problem.

She was a proud and loving mother of her children, and delighted in her family.

She had many, many friends, including Noela Russell from her Legal and General days, Ray Connell from the MCC, Barry Hynes from the Melbourne Cup, Fay Gilbert from theatre events, Fellows of the College, her Deans and Presidents, Michael and Christine Gorton, and Colleen Meldrum, to name but a few, and a large circle of professional and personal friends.

Joan participated in Church activities, and in sporting activities - from the local football team in earlier years to the VRC and the MCC in later years.

She loved the end of year luncheons and functions around the Melbourne Cup, Christmas and New Year. She enjoyed dinners, concerts and musicals, and the shopping and preparation for these.

She was at ease at the College Annual Meetings and social events, whether they were in Australia, New Zealand or Hong Kong, and was in

regular contact with people from all over the world met at these meetings, remembering names, children, and events, long after at least some of her Deans and Presidents had forgotten.

In fact, hospitality was one of Joan's fortés, and enjoying the pleasure of the people around her.

She was equally at ease with people from all walks of life, and could keep her peace, or create order from chaos as the situation required. She seldom confronted, but used her powers of persuasion to stay on course. One story told to me was of her parking at a building site, because she was in a hurry and couldn't find a park. Confronted by the man on watch, who said "Hoy, you can't park there lady", she simply phoned his boss from her mobile and had the offender back down on the spot.

She could and did do well anything she set her mind to, and was seldom outdone; and although she never boasted, she did it her way. Her motto could well have been "Can't I just, just watch me."

Another of Joan's strengths was compassion. She laughed with people who were happy, and cried with those who were sad. Importantly, she could be relied upon to be there for all of her family and friends when they needed her.

Some highlights of Joan Sheales' long career include:

- Facilitating the change from Faculty to College
- Managing important aspects of the purchase of Ulimaroa and its commissioning for ANZCA
- Major efforts in many aspects of the building and commissioning of ANZCA House
- Purchase/Leasing of properties in Brisbane, Wellington, Sydney, Adelaide
- Introduction of the Bulletin
- Major assistance with the introduction of training and examinations in Intensive Care and the formation of the Faculty of Intensive Care and JFICM
- A substantial contribution to the 'fast track' development of the Faculty of Pain Medicine
- Maintaining the high standard of the conduct of our examinations
- Maintaining the high standard of our Formal Ceremony -to produce an outcome unmatched by other Colleges
- Oversight of ASMs from 1987 including arrangements for invited Visitors and arrangements for Medal and Prize winners, and Distinguished Professors
- Strong involvement with the beginnings and early development of Committee of Presidents of Medical Colleges (CPMC)
- Involvement in the development of the New Fellows Conference, SIGs, EMAC, MOPS
- Fostering relationships with Colleges in our Region and world wide.

Joan worked with the following Deans and Presidents:
Maurice Sando 1978-1980
Douglas Joseph 1980-1982
William Crosby 1982-1984
Ross Holland 1984-1986
Robin Smallwood 1986-1987
Barry Baker 1987-1990
Peter Livingstone 1990-1992
Michael Hodgson 1992-1993
Michael Davies 1993-1995
Neville Davis 1995 - 1996
Garry Phillips 1996-1998
Richard Walsh 1998-2000
Teik Oh 2000-2002
Richard Willis 2002-2004
Michael Cousins 2004 - 2006

And with the following Deans of Joint Faculty of Intensive Care Medicine:
Geoff Clarke 1993-1997
Alan Duncan 1997-1999
Felicity Hawker 1999-2002
Neil Mathews 2002-2004
Jack Havill 2004- 2006

And with the following Deans of Faculty of Pain Medicine:
Michael Cousins 1999-2002
Leigh Atkinson 2002-2004
Milton Cohen 2004 - 2006

Joan was a 'hands on' CEO - that was her style. In many, many areas of College activities she knew the details of how things should be done. She would worry about these details, check that they were addressed - and when they were not, she would fix the problem - often herself.

Joan always had fierce loyalty to our College. She tried very hard to take every opportunity to project ANZCA well to external bodies. Joan also kept a very close eye on the credibility and consistency of our internal processes. Her knowledge of precedent was encyclopaedic and prevented unwise decisions by Council over many years. Fortunately this 'case law' is well documented and available for our ongoing work.

Despite Joan's insistence on following established procedures, she was prepared to embrace change. This was underlined by her strong involvement and interest in recent Strategic Planning, in our Administrative Structural Development and in the appointment of our new CEO. Joan's warmth, vivacity and interest in people resulted in many of the staff and Fellows becoming lifelong friends.

From discussions with Former Presidents and Deans. a verbal mosaic picture of Joan emerged and some literature quotations illustrate these qualities:

A Strong Sense of Duty:
"Let us have faith that right makes might, and in

that faith, let us to the end, dare to do our duty as we understand it"

Abraham Lincoln, Speech 27th Feb 1860

Proud Loyalty:
None of our Fellows or people outside of ANZCA would have had the temerity to sully the name of ANZCA in front of Joan

Steadfast, Reliable, always to be counted upon:
Joan always insisted upon meticulous attention to the details that determine a high quality outcome - whether it be our examinations, our formal Ceremony, the furnishing and decorating of Ulimaroa or the building and equipping of ANZCA House. In many respects this is exactly how a good anaesthetist works in the Operating Theatre.

"Bright star would I were steadfast as thou art"

John Keats 1795 - 1821

Discernment:
Joan gave wise advice to many Presidents, based upon her knowledge, judgement and acumen. She was also happy to mull over a problem while having a scotch with the President at the end of the day.

Visionary Thinking:
Joan had the ability to see the big picture and to put the energy and time into priority areas of great future importance to ANZCA

Friendship and laughter:
" There's nothing worth the wear of winning, but laughter and the love of friends "

HilaireBelloc 1870 - 1953

Warmth:

" And life is colour and warmth and light and a striving evermore for these "

Julian Grenfell 1888 - 1915

Mothering Attributes:
Joan showed extraordinary kindness and help to staff in times of need. Similar generosity was extended to Councillors and Fellows; Joan was really the 'Mother of ANZCA', from gestation to adulthood.

Joan also had style and elegance in her work and particularly in her social persona. She knew how to organise a good party and she was invariably superbly 'turned out' on such occasions (the result of very skilful shopping). Our parties at ASMs have an unmatched reputation. When needed Joan also had 'Grand Prix' driving skills.

Fellows are aware that a special dinner was held for Joan at ANZCA House on Friday 11th November, 2005. Many Past Deans and Presidents attended together with current Councillors and staff. Joan was honoured at the dinner with the award of FANZCA (Hon). Sadly Joan did not survive long after this dinner and died at the end of January. On the 3rd February, 2006 a Requiem Mass and Memorial Service was attended by close to 600 people including Past Presidents and Deans, ANZCA Councillors and Fellows, Staff and friends. A memorable gathering was held at ANZCA House after the service to share reminiscences of Joan. Representatives of many other organizations paid their respects to Joan.

Many messages have been received from ANZCA Fellows and staff expressing their appreciation for what Joan did for them and the friendship that she extended to them Similar communications have come from other bodies in Australia and overseas. This friendship will be an enduring part of ANZCA

MICHAEL J. COUSINS
President

GARRY D. PHILLIPS
Director of Professional Affairs

College Library

New Addition to the ANZCA Library Collection

Historical Moments in British Anaesthesia

In the early 1980s, Professor Keith Sykes was appointed as the Professor of Anaesthetics in Oxford. One thing he found in the Nuffield Department of Anaesthetics was a collection of films on anaesthesia and resuscitation from the late 1930s and 1940s. Because they were liable to marked deterioration, he arranged transfer of these films onto video. In the 1980s, this meant 3/4 inch Umatic tape. To ensure that these historic records were not lost to future generations of anaesthetists, he gave copies to several people with the idea that they would store them in hospitals across the world. One set was given to Professor John Russell, who took them to Adelaide and stored them in the Department at the Royal Adelaide Hospital.

In the 1990s it was obvious that 3/4 inch Umatic tape was going out of use and all of the videos were transferred onto the popular 1/2 inch VHS video format. About three years ago, it was apparent that like the earlier Umatic format, VHS was also losing popularity. All of the historic tapes were transferred onto DVD and a copy of this DVD is now available for loan from the library at the Australian and New Zealand College of Anaesthetists in Melbourne.

There are seven sequences in the set.

Planes of Anaesthesia made in 1945 looks at the effect on respiration, the pupil and the laryngeal reflex as the level of inhalational anaesthesia is progressively deepened

Artificial Ventilation made in 1938 shows the common respirators of the time. The Drinker and the Both respirators both enclosed the patient and achieved ventilation by a negative pressure. The "patient exclusion" ventilators worked by pulsation (Paul Bragg) Negative pressure on the chest (the Barstall) or on the abdomen (the Biomotor). Other methods such as the use of the rocker were also shown. Finally the positive pressure use of compressed gas is shown with the McKesson and the Oxford ventilators.

Flotation Devices made in 1943. This shows the experiments which were conducted to determine the correct design of lifejackets for the RAF. Essentially this required an unconscious patient in the water and Pask was the volunteer to be anaesthetised. The commentator is Professor Macintosh. The section is followed by demonstrations of artificial ventilation by the Sylvester method, the Schafer method and the Eve's Rocker.

Alcohol as an Anaesthetic and Morphine as a Total Anaesthetic made in 1938. This is a silent film demonstrating the use of alcohol and the use of morphine as anaesthetics.

A Demonstration of Open Drop Ether made in 1944 as a sound film. This film demonstrates the way to give open drop ether and the don'ts of the technique.

Tracheal Anaesthesia a film made in 1944 with sound. This shows the technique of inducing tracheal intubation. It describes laryngospasm and discusses the tube selection and the use of gags as well as inhalational techniques.

Wheels of Fortune is a film taken by the BBC of the life of William Morris who later became Lord Nuffield. It describes his early days developing Morris Motors and then his later fame both as a manufacturer during the war of essential materials and as a donor of equipment and resources to Medicine. His great achievement in creating the Chair of Anaesthetics at Oxford is also described.

Professor W. John Russell

UNDERGRADUATE PRIZE IN ANAESTHESIA

The recipient of the 2005 ANZCA Prize within the School of Medicine, Flinders University was Dr Amanda Diaz.

Dr Diaz's award was presented to her at the Flinders University BMBS Annual Qualifying Ceremony held on
Thursday, 15th December 2005.

French Experience

Dr Jane Torrie, specialist anaesthetist at Auckland City Hospital, recently returned from a year working in Toulouse, France.

Having had our children relatively late, our youngest was still in nappies when we settled on France as the perfect country for an imminent mid-life crisis. We were absolutely resolute, and this is what sustained us, two non-EU passport holders with very modest French, through the 18 months required to organise it. If you are looking for this sort of enriching experience our path-finding will ease things for you, but bear in mind that in France, laws and regulations are considered only guidelines. Another interpretation may close (or open) another route.

Toulouse has a population of a million people and a large aeronautical manufacturing industry, an employment opportunity for my engineer husband. My cold e-mailing to the university hospital struck lucky, as it reached Professor Samii, the coordinator of anaesthesia services, the editor of the major French text on anaesthesia and intensive care, and very importantly, keen to bring outside ideas to a provincial department. Yes of course I could work there, under a sort of work-experience postgraduate study scheme. My specialist status would not be recognised and the pay was lousy, but here was my chance to infiltrate the French health system, justify my leave of absence and enjoy the better-known advantages of living in the south of France. The seductive lifestyle endures there - our children were soon heard to complain "Not another five-hour lunch!" whenever we received invitations to dine.

Some bureaucratic aeons and a basic French language examination later, we were in Toulouse and way out of our comfort zone. At first the difficulties were with language, but as this improved I became aware that we were dealing with some astonishing cultural differences. Taking our three children to France unfortunately curtailed the extensive sight-seeing that we had previously enjoyed, but it did expose us to a cornerstone of French culture - their education system. Schools reflect and shape their communities and it seemed to us a miracle that French flair occurs at all given the full-time stifling environment provided free for children from the age of 2-3 years. Furthermore, the lack of transparency and responsiveness was galling to us - parents require an appointment before entering school grounds and we never saw the inside of our sons' classrooms.

Perhaps I should devote some words now to the health system where the above comments also have some pertinence.

The well-resourced and well-trained French healthcare providers deliver comprehensive and inclusive health care mostly funded by compulsory contributions. Many deserving groups are exempt from any charges and top-up private insurance is held by most. To the envy of the British, and indeed Kiwis, there are no waiting lists and 70% of all surgery is done in private clinics. Patients were extremely well-followed and worked-up fully; since 1994 all patients must by law consult an anaesthetist at least 48 hours before the procedure unless the condition is life-threatening, and they must be seen again the day of surgery.

Similarly, pregnant women must see an obstetrician eight times prenatally as well as having an anaesthetic consultation in the third trimester. Compliance is achieved by making parental benefits conditional on this schedule. I found it difficult to imagine Australasian women meekly accepting this arrangement, and Auckland parents would be difficult to persuade that their healthy child needed a separate visit for pre-anaesthetic assessment. The pressures which drive us to provide one-stop clinic visits, day-stay and day of surgery admission, fast-track recovery, streamlined investigations and effective oral post-operative analgesia, are very much less in France. Hardly surprising perhaps that a country which retains those wonderful villages, markets, traditions etc which enchant us, will also exhibit a degree of inertia in its systems which can take an Antipodean's breath away.

I worked first in the paediatric bloc operatoire and later the bloc obstetrique despite having practised in neither area for ten years. I am eternally grateful to the hospital staff who welcomed me despite my clumsy communication and eccentric Anglo-Saxon ways. They dealt gracefully with me, the student from hell - not junior, nor from a developing former French colony, opinionated, unaware of tradition or hierarchy and constantly probing "why?"

Why, for example, was parental presence unheard-of at induction and very rare in the

recovery room? Why was prolonged pre-operative fasting required and oral intake forbidden for an hour post-operatively? Why was local wound infiltration rare? Why was a coagulation screen required before a caudal?

Obstetrics proved to be even more fascinating, and by this stage I was minimally supervised. The Level 3 unit had a 90% epidural rate and these were administered early. LSCS rate was 23%, regarded as very high in France - the French have always known that obstetricians cause caesareans, not epidurals. Discord between midwife and doctor was almost unknown.

During the year I also visited two private hospitals, a pre-eminent paediatric hospital in Paris, a peripheral public hospital, and attended three national conferences (and saw our general practitioner several times). Drugs, equipment and techniques were much the same as in any developed country, but the organisation and delivery continually surprised me. France suffers a shortage of anaesthetists in part due to their numerous major roles: pre-operative assessment, post-operative care on the wards, medical and surgical intensive care, pre-hospital care (the infamous 'stay-and-play' approach), emergency hospital services and pain services. Doctors work long hours, satisfying the EU 35-hour/week directive by taking nine weeks leave annually. Specialists are resident on call yet this close supervision did not necessarily create confident juniors. Nurse anaesthetists often deprived them of hands-on time. I missed our assertive registrars with their constant questions that keep me up to date.

We're glad to be back now at the end of the world. We have had a myriad of rich and sometimes difficult experiences, the children speak French, but most importantly that mid-life crisis feeling has been thoroughly buried - for the moment.

Queries from readers are welcome. (jtorrie@adhb.govt.nz).

Hong Kong Society of Anaesthetists Golden Jubilee

Fellows of the College who have been involved in the development of anaesthesia in Hong Kong will be interested to read of the Golden Jubilee of their Society held in August 2005.

Our College and its former Faculty assisted in the recognition of anaesthesia in that region by establishing examinations and providing tutors for courses. Many will remember the involvement and encouragement of the late Professor Tan Sri G. B. Ong (Professor of Surgery, University of Hong Kong,) and Zoltan Lett (better known as Lefty) who pioneered our specialty in the colony over many years. Lefty was G.B. Ong's anaesthetist for many years, and was unremitting in his efforts to further the development of our specialty. Although now retired and living in England, he attended the Jubilee and was honored for his role.

Dr Noel Cass, FANZCA

The Council Members of the Society of Anaesthetist of Hong Kong and Past Presidents: (Back Row L-R) - Gigi Wong, Libby Lee, Vivian Ng, Joseph Lui, CW Cheung, SK Ng, CF Fung, Joe Kwok, Steven Wong, Tommy Suen; (Front Row L-R) - YF Chow, Ronald Lo, ML Yeung, Zoltan Lett, CT Hung and CK Chan

Anaesthesia Island Style: Samoan Working Holiday

This is the story of my experiences in Samoa during October 2005. The opportunity arose one Friday when a request was made for a senior registrar to accompany a VMO anaesthetist to Samoa. The VMO was Dr Sandy Gillies and the trip was to provide cover for local doctors to attend a conference. I was very keen and was fortunate to be the lucky applicant.

The Samoan islands lie in the middle of the South Pacific island chain around 1000km northeast of Fiji. The people are Polynesian and Samoa is divided into two parts based on 20th century colonial expansion. It was divided into German and American parts in 1899 and the German section was seized by New Zealand in the First World War. It obtained independence from New Zealand in 1962 as Western Samoa and changed its name to the Independent State of Samoa in 1997.

Vavau Beach

My destination was Tupua Tamasese Meaole Hospital in Apia, Independent Samoa. This is the national hospital and serves a population of around 180,000 people. The hospital is staffed by 30 Samoan and 10 expatriate (Indian and Chinese) consultants and at the time of our arrival they were 3 weeks into a doctor's strike. The strike involved the Samoan doctors and was for better wages and conditions but they were still doing emergencies (unpaid) while on strike. The expatriate staff was exhausted and the strike continued for the duration of our stay.

The anaesthetic equipment was old but serviceable, and during my time there I was able to appreciate the advantages of some of this equipment in a humid environment with an erratic electrical and gas supply. The old Boyles machine only needed an oxygen supply to work and its stainless steel construction is very robust. Its twin attached backup oxygen cylinders were very useful as we had temporary wall oxygen supply failure around twice a week. It did not have an anti-hypoxic flowmeter device. There was an electric bag in bottle type ventilator, a circle circuit and a range of T piece circuits using valves on the bag. I made an open bag T-piece circuit with scissors, assorted spare tubing and connectors which proved very useful later in the trip. There was a range of laryngoscopes of varying brightness and a selection of new and recycled endotracheal tubes. There was no gas monitoring (CO_2, N_2O, O_2, or agent) and electronic monitoring was limited to portable Welsh Allyn units for ECG, NIBP and SpO_2. Clinical monitoring assumed a critical role. Colour, chest movement, a finger on the pulse and auscultation play a far more prominent role when you don't have the array of safety equipment that modern systems have. Endotracheal tube placement could only be confirmed with auscultation and a finger on the pulse substituted for invasive arterial monitoring. There were shortages of some important items with only 22 gauge Quincke (cutting tip) needles available for spinal anaesthetics.

Dr Andrew Mitchell with a Paediatric Case

Drugs were predominantly generic and manufactured in India or South East Asia. There were good supplies of most drugs with the exception of vasopressors and relaxants. There were only 8 ampoules of ephedrine (but heaps of adrenaline) and 19 ampoules of atracurium (but heaps of sux). These drugs had been on order for some time but did not arrive during my stay. Many drugs we take for granted, such as metaraminol and propofol were not stocked. Halothane is the only volatile agent, and I came away with the feeling that it is currently the ideal agent for the job. Its gives a fast smooth gas induction, while awakening is quick enough when combined with nitrous oxide, and it is very affordable. White sticking plaster was one of the most versatile items in the theatre. It was ripped into a variety of widths and was used for securing everything from endotracheal tubes, IV lines and errant equipment, as well as bandages.

A usual day began with a family breakfast of tropical fruit, toast and fresh doughnuts. Then a short walk to the hospital where the day's list would be planned with pre-operative assessments in the corridor. These were usually via a relative interpreting, so we kept to the essentials. In addition to the expected appendectomies, fractures and diabetic amputations there were a number of notable cases.

An early one was a 15 day old neonate with a massive 15cm by 8cm anterior neck abscess. It

occupied 2/3 of the circumference of the neck and surprisingly, there were no signs of airway obstruction. All emergency drugs were prepared, IV access was secured, and then a gas induction was commenced. When the baby was deeply anaesthetized, Sandy did a laryngoscopy to confirm what appeared to be an easy airway. We then carried on with a spontaneous breathing anesthetic with the knowledge that the airway could be secured if we had any trouble. Sandy introduced me to the praecordial stethoscope for this case (a stethoscope attached to the chest with sticking plaster) which is an outstanding monitor of heart rate, breathing and airway patency.

Dr Sandy Gillies and Theatre Staff

When the day was done we alternated nights on call and some of the best cases were at night. It would start with a phone call, then an ambulance would arrive to take you to the hospital as marauding dogs were a danger at night. On my first night we had a scary case of a 7 year old boy who had been hit by a bus and had a pelvic fracture with frank haematuria. He was booked for an exploratory laparotomy and I did the case with Dr Yuan, a Chinese anaesthetist. It was a bit "touch and go" as the surgeons ran into about one hour of intractable bleeding, where we measured the loss of over half his estimated blood volume. I feared that the development of a dilutional coagulopathy would be a terminal event, so I took blood myself from his cousin (who shared the same blood group) in a side room. After quickly crossmatching, we transfused the whole blood while it was still warm. He survived but developed what appeared to be a vesico-peritoneal fistula.

I did my first obstetric cord prolapse one night where the midwife had been holding back the cord for over an hour. The woman was prepared for induction in the head down kneeling position on the trolley. When everything was ready we rolled her onto the theatre table and followed with thiopentone and suxamethonium. The baby was out shortly after the ET tube was secured followed by an unexpected second baby…twins! When the case was finished, I walked home as the day was dawning with an intense feeling of personal satisfaction.

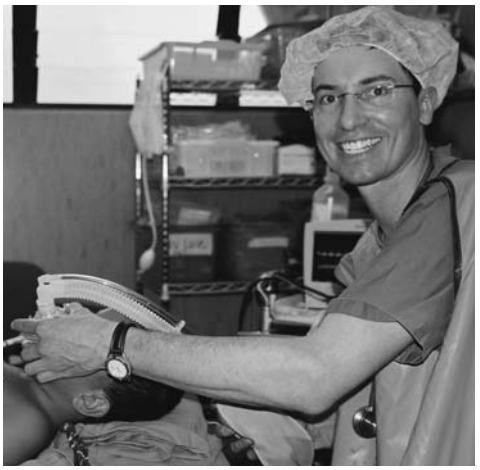
One of the most memorable aspects to the trip was the people. They are very friendly and welcoming. It was humbling to see the trust they would give to a foreign doctor. The capacity of the sick children to bounce back was incredible. One child who presented with a one week history of bowel obstruction (from a remote village) was one of the most unwell children I have ever seen. Following aggressive rehydration and a laparotomy for an incarcerated hernia he was smiling and asking for breakfast the next morning.

The pace of work was relaxed most of the time and I took a few days holiday at the end to stay with my family on a remote white sandy beach. Overhanging rainforest provided welcome shade and a crystal clear lagoon was great for swimming. Ice cold local beer with delicious local food made for a memorable end to a very satisfying working holiday.

Acknowledgements

I would like to thank Dr Sandy Gillies for arranging this trip. I would also like to thank the staff of the Tupua Tamasese Meaole Hospital for making me very welcome and Professor Paul Myles for arranging the special educational leave that allowed me to go. Finally I would like to thank my partner Deidre for looking after our three preschoolers in a single hotel room while I had fun at work.

Author **Dr Andrew Mitchell**



Dr Andrew Mitchell with a Paediatric Case

Dr Andrew M Mitchell
BSc MB ChB DCH Dip Obs (FANZCA from Feb 06)
Trainee no. 16435
Currently Anaesthetic Fellow, The Alfred Hospital, Melbourne till Feb 5 2006

Will Be Staff Specialist , Royal Darwin Hospital from May 2006

A Local Church

Special Interest

Joan Sheales' Retirement Dinner

A farewell dinner for Joan Sheales was held at ANZCA House last November, shortly after her retirement. Guests included many of her Presidents and Deans (pictured), and a large number of friends, including Fellows and staff.

President, Professor Michael Cousins AM, spoke of Joan's achievements, followed by impromptu anecdotes from Barry Baker and Garry Phillips.

Joan responded, and spoke of the support she had received from staff and Fellows, and her vision for ANZCA. She received a pearl bracelet as a gift from the College.

Joan's farewell after 25 years of dedicated service to the College was held, appropriately, in the setting of ANZCA House.

Report

9th Annual Registrars Meeting

On Saturday 29th October the 9th Annual Registrars Meeting was held at 50 Water Street Spring Hill. The 15 presentations included 14 from in Queensland and one from New Zealand. In total, 45 people were in attendance on the day and it was a great success.

Adjudicators this year were, Dr Genevieve Goulding, Dr Michael Fanshawe, Dr Martin Wakefield and Dr Tim O'Brien. These doctors were representative of our 3 major tertiary hospitals, Royal Brisbane and Womens' Hospital, the Princess Alexandra Hospital and the Mater Public Hospital, as well as Dr Michael Fanshawe who is in private practice. Dr Diana Webster generously donated her time as Time Keeper and did a great job of ensuring the day ran to time.

All presentations were of high quality and the winner of the "Tess Cramond Award" was Dr Frank Phillips, with his presentation titled "Syringe Injection of Blood and Haemolysis of Red Blood Cells".

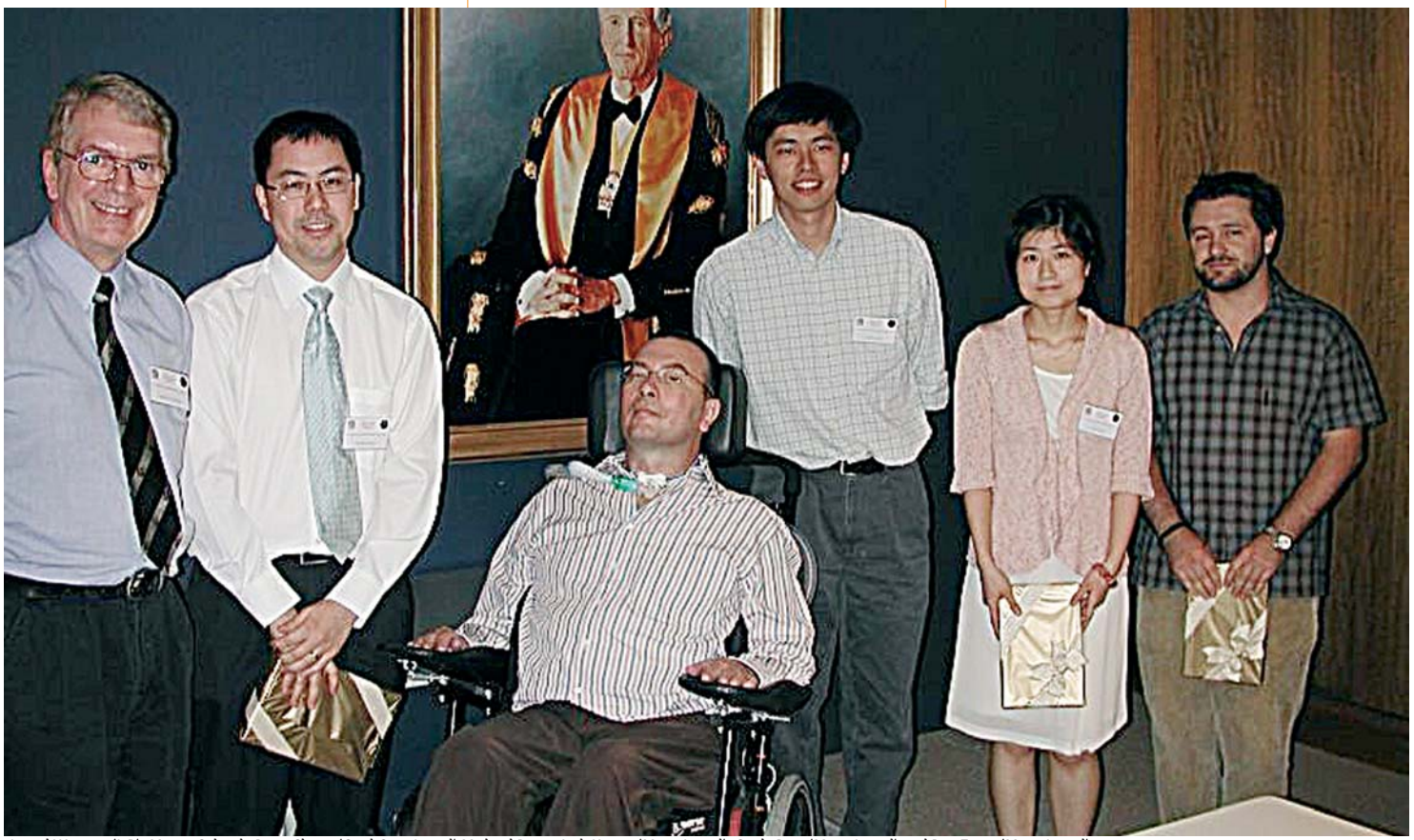
Axxon Health generously sponsored the second place award and named it in honour of Dr Michael Beem in recognition of his contribution to anaesthesia in Queensland. Michael and his wife Sylvia were able to join us in the afternoon for presentations with Dr Beem presenting his talk on welfare of anaesthetists to the group. The adjudicators agreed the winner to be Dr David Trappet who presented "The Effects of an Epidural Blood Patch on CSF Absorption"

We were delighted that Professor Tess Cramond, Dr Michael Beem and Dr Chris Beem Chairman of Axxon Health, were able to attend to present the awards for first and second place and thanked them for their continued support of Anaesthesia Education in Queensland

The day was opened by the Queensland ASA Chairman, Dr Martin Culwick and closed by our Queensland Regional Committee Formal Projects Officer Dr Pal Sivalingam.

On behalf of everyone I would again like to thank Ms Anne Strasburg & Ms Sharon Miethke for their organisation and administrative assistance.

Dr Pal Sivalingam
Formal Projects Officer (Qld)
Queensland Regional Committee



Award Winners (L-R) -Martin Culwick, Peter Chong (Cecil Gray Award) Michael Beem, Jack Huang (Merit Award), Cindy Ding (Merit Award) and Ben Zugai (Merit Award)

Candidates - David Belavy, Mark Robinson, Matthew Howes, Peter Chong, Tony Ringuet, Trevor Ghidella, Frank Phillips, Isabelle Ha, Peta Lorroway, Pal Sivalingam, Marsha Golikou, Kirsty Bennett, David Trappett, Kasia Charbucinska, David Rowe and Heidi Walker

Axxon Health Prize Winner Dr David Trappett (centre) with Drs Chris Beem (left) and Michael Beem (right)

Winner of the "Tess Cramond Award" Dr Frank Phillips, with Professor Cramond

2005 Adjudicators (L-R) - Pal Sivalingam, Martin Wakefield, Tim O'Brien, Michael Fanshawe, Genevieve Goulding

Organisers of the 9th Annual Registrars Meeting (L-R), Ms Anne Strasburg, Dr Genevieve Goulding and Ms Sharon Miethke

ANZCA New Zealand Adminstrative Officer Retires after 27 Years

In November 2005, Lorna Berwick retired as Administrative Officer at the ANZCA New Zealand Office. Lorna had given loyal service to the Faculty and College of Anaesthetists for over 27 years, and this was recognized by the awarding of an ANZCA Council Citation.

To mark the occasion, the New Zealand Committee held a dinner in Lorna's honour. It was a real measure of the esteem that past committee Chairs have for Lorna that twelve of them, spanning the 27 years, were able to come to Wellington to attend.

This evening was a special occasion as the photos bear witness. Professor Alan Merry (ANZCA Council member - New Zealand), Dr Vaughan Laurenson (current New Zealand National Committee Chair) and Dr Basil Hutchinson (NZNC Chair, 1975 - 78) spoke of Lorna's time with the Faculty and College and the ANZCA Council Citation was presented.

In the early years Lorna also worked for the RACS. There are many surgical and anaesthesia trainees and specialists who have benefited from Lorna's caring and enthusiastic commitment to the welfare of the Colleges and Faculty.

Lorna has asked me to include a message from her: *To all the many people I've been in touch with over the years by email, phone, correspondence etc - goodbye! It's been a real pleasure working with all of you and I will find it very quiet at first in my retirement. Many thanks for all your help. Lorna Berwick*

Heather Ann Moodie. Executive Officer, ANZCA New Zealand Office

Seated (L to R) - Dr Leona Wilson (1992-1994), Prof Alan Merry (1996-1999), Lorna Berwick, Dr Ron Trubuhovich (FIC, 1994-1998), Dr Malcolm Futter (1999-2001)
Standing (L to R) - Drs Vaughan Laurenson (2005 -), Dr Basil Hutchinson (1975-1978), Dr Hugh Clarkson (1984-1986), Dr Peter Cooke (2003-2005), Dr Mack Holmes (1978-1981), Dr Tony Newson (1986-1988), Dr Jack Havill (1994-1996) and Prof John Gibbs (1981-1984)

Presentation of Council Citation - Dr Vaughan Laurenson, Chair, ANZCA NZNC and Lorna Berwick

Guests (Current NZNC members and staff, Past NZNC Chairs and accompanying guests)

Joint Faculty of Intensive Care Medicine

Dean's Message

Kia Ora (Greetings),

I trust you all had a good break over the summer holidays. Faculty life continues apace and there are a number of developments and changes.

Most will be aware that Joan Sheales the previous CEO of ANZCA passed away recently. I wish to pay tribute to her and the way she supported the Faculty at various stages of its history. Joan contributed a mixture of emotional support and rigorous procedure over many years and that has left the Faculty with an excellent basis for the future. In her case, her enormous contributions will live on for a long time.

Dean Elect

At the February Board meeting, Dr Richard Lee was elected Dean Elect. Most of you will know him as an excellent person as he has contributed extensively in a number of portfolios, particularly as Censor and Chairman of the Examination Committee. The Board is very pleased that Richard has agreed to take the position. He will take office in June.

"The Joint Faculty of Intensive Care Medicine, is continuing to develop into an identifiable, viable, independent body responsible for standards and training in intensive care medicine, including teaching and research".

New Fellow or Trainee Representation on Board?

The Board has been considering representation of a trainee on the Board for some time. This is consistent with other Colleges and the wishes of other jurisdictions. After discussion with our Trainee Committee and with New Fellows at their conference, we have decided to appoint a New Fellow (less than five years post Fellowship) to the Board for a maximum of three years. This position will have full voting rights and an election will occur as per the usual Board processes. It is considered that this will allow representation of the trainee voice with the perspective of having just experienced the whole process.

Journal of Critical Care and Resuscitation

Excellent news was received regarding the Journal in late 2005. It has now been indexed and this will be backdated to the first issue. Congratulations to "Tub" Worthley and Vernon van Heerden for the excellent work done and thank you to the many contributors who have supported the Journal to date.

What is the Future of the Joint Faculty?

At the Board Planning Meeting in October 2005, wide discussions were held including looking at the future. A Vision Statement was agreed:

"The Joint Faculty of Intensive Care Medicine, is continuing to develop into an identifiable, viable, independent body responsible for standards and training in intensive care medicine, including teaching and research".

The aims of this vision are to allow for:

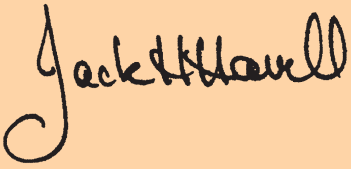
1. External recognition as an authoritative body, and
2. Independence in matters of governance, decision-making and finance.

This vision's development and timeframe needs to allow for:

1. The opinion of JFICM Fellows,
2. Maintenance of collaborative relationships with ANZCA, RACP, ANZICS, ACEM and other bodies,
3. Financial viability, and
4. Workload demands of the Executive Office and the Board.

Though this will be the Joint Faculty's goal for the future, more ground work is required to investigate key areas such as the financial viability of such a project, the opinions of the Fellows, and the sustainability of becoming an independent College.

The above discussion was underpinned by the desire to maintain and enhance the relationships with parent colleges.



Jack Havill
February 2006

Report

Report of the February 2006 Board Meeting

Education and Training

The Education Committee has been asked to consider the issue of supporting or endorsing various courses that may be available to trainees or Fellows. This follows consideration of the BASIC Course, which has been run in New Zealand and also in Queensland.

The role of Supervisors of Training again came into focus and the issue of seniority versus experience and enthusiasm was debated.

Award of the JFICM Medal

The Board have decided to award the JFICM Medal (established in 2005) to Dr L.I.G. Worthley, for his contributions to intensive care medicine in Australia and New Zealand.

PROFESSIONAL AFFAIRS

The Board reviewed and approved Policy Document IC-7 "Administrative Services to Intensive Care Units". A copy of the new document is available on the Joint Faculty Website.

Critical Care and Resuscitation

The Board was delighted to note that the Journal is now indexed with the National Library of Medicine, and will be backdated to its first issue.

ANZCA ASM 2006, Adelaide

Dr Geoff Shaw, Christchurch, is the Joint Faculty's Foundation Visitor for 2006. He will be attending the ANZCA ASM in Adelaide and his talk will be entitled *"Think smart or drive blind: sensors and models in critical illness"*. Dr Shaw will be travelling to New South Wales following the ASM for further visits. Thanks go to Dr Mark Finnis for putting together a two day program, which touches on prehospital care and trauma, an update on CTG activities, Haematology and Ventilation.

RACP ASM 2006, Cairns

The Joint Faculty is providing a morning session to this meeting, which will be an intensive care for Physicians update. This covers progress with sepsis management, changes in the ICU in the last decade and Tropical Disease.

JFICM ASM 2006 Melbourne

The Board noted the proposed program for this meeting, which will follow the tradition of the single themed meeting, with *'Sepsis - Surviving the Guidelines'* as its focus. A range of international and local speakers will examine the problems, the guidelines and focus on various therapies in a pro/con debate format. Following on from the success in 2005, the Conference Dinner will be held on Friday night and will host the presentation of Graduands as well as awards.

New Fellows Conference, 2006

Drs Nikki Blackwell, Qld, and Roger Harris, NSW were endorsed as further JFICM representatives to the New Fellows Conference in 2006.

Board Constitution

Dr Neil Matthews, SA, will be retiring from the Board in June following 12 years of service to the Faculty of Intensive Care, ANZCA, and the JFICM, which included his period as Dean. One vacancy will therefore exist and a call for nominations has been circulated.

The Board elected Dr Richard Lee (current Vice-Dean, Censor, and Chairman of the OTS Committee) as Dean to take office from June, when Dr Jack Havill will complete his two year tenure.

Professor Napier Thomson will assume office as the President of the RACP in May. He will remain on the Board of Faculty as the Council representative, which the Board greatly appreciates.

Following input from both the Trainee Committee and the intensive care representatives at the New Fellows Conference, the Board has resolved to increase the membership of the Board by one to include a New Fellow Representative (a Fellow within five years of admission). It is intended that the position will be elected with full voting rights and will have a maximum tenure of three years.

Vale

The Board expressed its regret at the passing of Mrs Joan Sheales, former CEO, ANZCA. Joan's contributions to the Faculty of Intensive Care, ANZCA, and also the Joint Faculty were acknowledged.

Expressions of Interest

DISASTER PREPAREDNESS

The Joint Faculty is seeking expressions of interest from Fellows wishing to be involved in encouraging disaster education and to help promote a cohesive group to consider disaster preparedness. Please contact the Executive Officer in the first instance on jficm@anzca.edu.au or on (03) 9530 2861.

HONOUR - DR GEORGE NIKOLIC

Dr George Nikolic was awarded an Order of Australia Medal for services to medicine, particularly in critical care in the ACT.

Dr Nikolic immigrated from the Kingdom of Yugoslavia at the age of nineteen and some six years later, he successfully graduated from the University of Sydney Medical School. Having gained his Fellowship with the Royal Australasian College of Physicians he moved to Canberra to continue his interest in cardiology but found he increasingly spent more time in the intensive care unit at Woden Valley Hospital. To strengthen further his cardiological experience, he spent two years in the United States as a Cardiology Fellow.

Upon his return to Australia in 1982, he took up the directorship of Woden Valley Hospital Intensive Care Unit where he virtually single handedly ran the Unit for ten years. During this time, he worked tirelessly without complaint always striving for the best for his patients. Since this time, he has continued as a Senior Staff Specialist in The Canberra Hospital's Intensive Care Unit.

Dr Nikolic's clinical expertise is widely regarded and his opinion frequently sought both for medical and non-medical matters. His knowledge of ECGs is world class and he must have one of the world's largest collections of ECGs. He is extensively published in this area and often helps registrars out with scanty publication lists!

Dr Nikolic is married to Annette, with two children (both grown up) and currently resides in Canberra.

Report

Intensive Care Foundation

The Intensive Care Foundation has raised over $3.2 million and awarded over $1 million in research grants since the Appeal was launched in 2000. Although the Foundation was established by ANZICS, we are an independent body and our primary aim of supporting high quality research in intensive care is shared by all organizations within the intensive care community. This is reflected in our recent re-branding as simply 'The Intensive Care Foundation' rather than ANZICF and ANZIC Foundation.

In this spirit, I met with the Faculty Board last year with the aim of exploring a more formal partnership between the two bodies. I am pleased to report that, although our discussion was general in nature, it was very positive, and I hope we can develop some more specific initiatives in the near future.

Our major public fundraising campaign, the Intensive Care Appeal, will run from 2 - 16 April. I ask all Fellows to reflect on how they might assist us, whether through the sale of our new wristbands, the promotion of good news stories through the media (our colleagues can assist) or the setting up of displays in hospitals and waiting rooms. It all helps. I ask you also to consider adding the Foundation to the list of charities to which you and your family regularly donate. If we don't support our own research foundation, why should anyone else?

George Skowronski
Chairman, Intensive Care Foundation
For further information visit www.intensivecareappeal.com or phone +61 (03) 9340 3444

Joint Faculty of Intensive Care Medicine

Policy Documents

IC-1	(2003)	Minimum Standards for Intensive Care Units
IC-2	(2005)	Intensive Care Specialist Practice in Hospitals Accredited for Training in Intensive Care Medicine
IC-3	(2003)	Guidelines for Intensive Care Units seeking Accreditation for Training in Intensive Care Medicine
IC-4	(2000)	The Supervision of Vocational Trainees in Intensive Care
IC-5	(1995)	Withdrawn
IC-6	(2002)	The Role of Supervisors of Training in Intensive Care Medicine
IC-7	(2006)	Administrative Services to Intensive Care Units
IC-8	(2000)	Quality Assurance
IC-9	(2002)	Statement on the Ethical Practice of Intensive Care Medicine
IC-10	(2003)	Minimum Standards for Transport of the Critically Ill
IC-11	(2003)	Guidelines for the In-Training Assessment of Trainees in Intensive Care Medicine
IC-12	(2001)	Examination Candidates Suffering from Illness, Accident or Disability
IC-13	(2002)	Recommendations on Standards for High Dependency Units Seeking Accreditation for Training in Intensive Care Medicine
IC-14	(2004)	Statement on Withholding and Withdrawing Treatment
IC-15	(2004)	Recommendations of Practice Re-entry for an Intensive Care Specialist
PS38	(2004)	Statement Relating to the Relief of Pain and Suffering and End of Life Decisions
PS39	(2003)	Minimum Standards for Intrahospital Transport of Critically Ill Patients
PS40	(2000)	Guidelines for the Relationship Between Fellows and the Healthcare Industry
PS45	(2001)	Statement of Patient's Rights to Pain Management
PS48	(2003)	Statement on Clinical Principles for Procedural Sedation
PS49	(2003)	Guidelines on the Health of Specialists and Trainees

All Current Policy Documents are available at www.jficm.anzca.edu.au/publications/policy/index.htm

March 2006

ADMISSION TO FELLOWSHIP BY EXAMINATION *LIST OF 17th FEBRUARY 2006*

		EXAMINATION	TRAINING COMPLETED
Wei-Ping CHAN	NSW	May 2005	January 2006
Leonarddus Johannes NUNNINK	QLD	September 2005	January 2006
Sing Tao Thomas LI	HK	May 2005	January 2006
Anthony David HOLLEY	QLD	September 2005	January 2006
Hayden Thomas Wesley WHITE	QLD	May 2004	January 2006
Yukiko GOTO	WA	May 2005	January 2006
Roger David HARRIS	NSW	September 2005	January 2006

The Members of the Fellowship Admissions Committee (the Censor, the Chairman of the Fellowship Examinations and I), have reviewed the documentation and move that the above be admitted to Fellowship of the Joint Faculty of Intensive Care Medicine, Australian and New Zealand College of Anaesthetists and Royal Australasian College of Physicians, by examination.

JACK H. HAVILL (Dr), Dean

Faculty of Pain Medicine

Dean's Message

Such glad and sad tidings, so closely juxtaposed. We were all saddened to learn of the passing of Mrs Joan Sheales, ANZCA's first CEO. The tribute to Joan occurs elsewhere in this Bulletin. The Faculty has been fortunate that Joan was at the helm when it was launched and her navigational skills were signal in setting the course that has served us so well so far. As we farewell Joan, so we bid welcome to Dr Mike Richards as our new CEO and we look forward to the chart- and engine-room activity that will be generated.

"Glad" is of course an understatement to greet the news that our discipline, Pain Medicine, has been granted specialty status in Australia. The exercise that the Faculty went through in developing its submission and in responding to complex issues, some of which were apparently far removed from our daily brief as pain physicians, not only reinforced our "mission" but also reflected the changing relationship between the broader medical profession and government. I believe that the imprimatur which we have been given must accelerate the impetus towards establishing an integral role for Pain Medicine in the medical lives in our region.

I would identify three main sets of implications arising out of specialty recognition. For our Patients - and perhaps many others who, for readily recognisable reasons, have not had access to pain physicians - this development helps to legitimise their plight and to inform them that there is a body of expertise which can be marshalled to improve the quality of their lives, without stigma, shame or avoidable suffering. Patients can feel justified in asserting their rights to pain relief and, especially in developed countries such as Australia and New Zealand, in asking questions of institutions and jurisdictions when that is not forthcoming.

The second set applies to Practitioners - not only ourselves (who, after all, are the "converted") but to all those who are studying and practising modern medicine. The desirability of knowing about "pain", the challenge of teaching about it and the rewards available from the successful management of it can no longer be ignored by medical schools, post-graduate medical committee and (other) colleges. One would not countenance awarding a medical degree to someone who could not diagnose and know how to treat cardiac failure or pneumonia or bowel obstruction or depression: ignorance of the biology and principles of management of acute, persistent and cancer-associated pain should attract the same sanction. Extension to post-graduate competency and performance must follow. Who could argue against not achieving proficiency in this most transcendent of human complaints?

The third set of implications refers to Public Policy. The arguments through which we achieved recognition are on the public record and can be used - by Patients and Practitioners - to advocate for provision of pain services where there are none, to provide training opportunities where there are painfully few and overall to promote a philosophy that inadequate attention to clinical pain is incompatible with modern society. We are fortunate in our countries that we have access to basic and sophisticated tools to address pain: yet there are many communities at home and in our region if not further afield where that is not so. The common theme here is pain relief as a human right - what better justification could there be for recognition of pain medicine as a specialty?

The degree and pace at which these implications of recognition - and no doubt others - will evolve will depend, I suspect, on our success as pain physicians in being advocates as well clinicians. As the Faculty is growing exponentially, so may the influence of our recognised discipline.

The next move in this direction will be our Refresher Day and Annual Scientific Meeting in Adelaide in May. We have two outstanding visitors, Dr Bill Macrae from Dundee and (our own) Dr Suellen Walker from London, and other distinguished faculty. The program is broad and attractive, themes include acute pain, developmental neurobiology and taking pain medicine "to the streets". Plus many good social reasons for coming together and celebrating.

This is my last message as Dean. It has been an exciting two years for the Faculty and our specialty and it has been a privilege for me to have played this role. The baton passes to Dr Roger Goucke of Perth, who can look forward to the support and enthusiasm of our Fellowship that I have been fortunate to enjoy.

Milton Cohen
Dean

Report

Highlights of the November 2005 Board Meeting

Dr Mike Richards, ANZCA's new CEO was introduced to the Board. Dr Richards outlined his background in political science and his experience working in government, academia, journalism and consultancy.

Honours and Appointments

The following awards were noted:
Mrs Joan Sheales - Awarded Honorary Fellowship of ANZCA
Prof Garry Phillips - Awarded the ANZCA Orton Medal
Dr Pam Macintyre - Awarded the ANZCA Orton Medal

Fellowship

Three Fellows (one FAFRM RACP, one FRACS and one FRCA) were admitted to Fellowship by training and examination and one FRCA by Alternate Pathway. Professor David A Scott FANZCA, Victoria and Dr Roelof van Wijk FANZCA, SA were admitted to Fellowship by election.

Finance

Subscriptions

ANZCA Council has resolved to offer a 50% subscription concession to Fellows who hold Fellowship of ANZCA and JFICM or FPM and whose practice is 100% intensive care medicine or pain medicine and who do not practice anaesthesia.

The Faculty Subscription for 2006 was increased by 5%.

Fees

Faculty Training and Examination Fees were increased to remain in parity with ANZCA's.

Education and Training

FPM Training Program

The Board discussed the process of retrospective approval of prior experience. It was emphasised that retrospective accreditation is not automatic and the need for prospective trainees to document their pain medicine experience as they go through was highlighted.

Examination

2005 Examination

19 out of 24 candidates were successful in the 2005 Faculty Examination. Dr Mark Rockett FRCA, New Zealand was the Barbara Walker Prize Winner and Dr Martine Casserly, FANZCA, a Merit Award recipient.

Case Reports

A Marking Guide for assessment of Case Reports, including detailed instructions for candidates and Sots, is in development.

It was resolved that an Annual Training Fee will apply until the Case Report requirement is complete.

Hospital Accreditation

PM1 Guidelines for Trainees and Departments seeking Faculty approval of Posts for Training in Pain Medicine and Hospital Accreditation Questionnaire documents are under review to bring them in line with the new PM2 Professional Document.

Research

In a proposal to move activities of the Research Committee forward, four main streams were outlined as Knowledge, Infrastructure, Mentorship and Funds and the need to access information on how to set up a database and how to go about accessing grants was highlighted.

A document outlining strategies can be viewed on the Website:
http://www.fpm.anzca.edu.au/documents/profdocs/FPMResearch.pdf

2007 ASM, Melbourne - 5 - 9 May

A Regional Organising Committee has been formed and potential Foundation Visitors were considered.

Report

Highlights of the February 2006 Board Meeting

Dean Elect

Dr Roger Goucke, FANZCA was elected Dean-elect and will take office following the Annual General Meeting in May.

Honours and Appointments

It was noted that Mrs Barbara Walker had been honoured with an AO in the Australia Day Honours.

Fellowship

Five Fellows were admitted to Fellowship by training and examination and Dr Anne Siu-King Kwan, FANZCA, Hong Kong was admitted to Fellowship by election.

Training Requirements for Fellows of other Colleges/Faculties/Chapters

Further to the Board's resolution with respect to the eligibility of Fellows of the RACGP, RNZCGP and Faculties and Chapters of the five participating bodies to enter pain medicine training, it was resolved that such trainees will be required to undertake a three year pain medicine training program, of which two years must occur in a prospectively approved Faculty accredited pain medicine unit.

Retrospective Accreditation of Prior Experience

The Board resolved that, effective immediately, applications for recognition of prior experience will attract the current Annual Training Fee on a pro-rata basis for the period of time retrospectively approved.

Finance

The accounts for the 12 months ended 31 December 2005 were accepted.

Election to Fellowship Fees

The Board resolved that the fee for Election to Fellowship increase in alignment with the Examination Entrance Fee.

Education and Training

Patient Education Pamphlets

The Board is in favour of pursuing the development of Patient Education Pamphlets with the aim of providing better information to patients which could also be used to fulfil part of the informed consent process.

Potential topics include Epidural Stimulators, Non-invasive Procedures, Cognitive Behaviour Therapy and Invasive Treatments.

Fellows are invited to express their interest in contributing to the development of these documents.

Exit Questionnaire

A revised Exit Questionnaire for trainees was accepted for inclusion in the Supervisor of Training Support Kit and the Trainee Support Kit.

Support for Supervisors of Training

A half day Supervisor of Training Workshop will be held during the Adelaide ASM on Monday 15 May.

A schedule of ANZCA Clinical Teaching Course Workshops for 2006 is available from the Website: http://www.anzca.edu.au/edutraining/courses/ctc06.htm

Examination

The 2006 FPM Examination will be held at the Sir Charles Gairdner Hospital, 29 November - 1 December.

The views of recent graduates and Supervisors of Training is being sought with respect to the timing of future examinations.

Hospital Accreditation

Liverpool Hospital was accredited for training for one year. Nepean Hospital, Royal Adelaide Hospital were re-accredited for a period of five years. Concord Repatriation Hospital was accredited for a further three years.

Administrative Instructions Revision

The Faculty's Administrative Instructions have been revised and will go to ANZCA Council for ratification.

Intercollegiate Relationships

The RACS ASC in Sydney will include a pain section on Thursday 18 May 2006 including sessions on Acute Pain, Chronic Pain and Cancer Pain. Professor Peter Teddy will be the guest lecturer.

The Board will pursue other opportunities for a pain medicine program in participating Colleges annual meetings.

Continuing Education

2006 ASM, Adelaide

The scientific program has been finalised and can be viewed at http://www.sapmea.asn.au/conventions/anzca/index.html

2006 Refresher Course Day

Registration brochures have been circulated and can be downloaded from the website: http://www.fpm.anzca.edu.au/meetings/FPMBrochure.pdf

2007 ASM, Melbourne - 5 - 9 May

The Faculty's Foundation Visitor for 2007 was confirmed as Professor Martin Koltzenburg, UK.

Board Election

As six nominations have been received for five positions, a ballot will proceed. Fellows are encouraged to vote.

Launch of Guidelines

Launch of the Guidelines for the Management of Procedure-related Pain in Children by the Paediatrics and Child Health Division of the Royal Australasian College of Physicians

Monday, October 17, 2005

It was my pleasure to attend, on behalf of A/Prof Cohen and the Faculty, the launch of the Guidelines for the Management of Procedure-related Pain in Children on Monday, October 17, 2005 at the RACP Offices, Macquarie St, Sydney. This was a most appropriate day for the launch as it was the IASP's Global Day Against Pain and the theme for 2005 was Pain in Children. In fact, it marked the start of a year dedicated to highlighting the issues of pain and its management in children.

The publication of Australasian Guidelines recognizes the importance of addressing pain management in children at a local level. The guidelines aim to raise awareness that treatment of pain in children is a very high priority, bridge gaps between research and clinical practice, provide recommendations relevant to clinical practice in Australia and New Zealand at both individual and institutional levels and challenge health care professionals who deal with children to reflect on their attitudes, beliefs and practices.

The Guidelines are the product of an enormous amount of work by a RACP Working Party chaired by Dr Angela Mackenzie over a two year period. They are divided into two documents, one addressing procedure-related pain in children and adolescents and the second addressing procedure-related pain in neonates. Both are comprehensive documents with evidence-based recommendations for the vast majority of common procedures performed in children and neonates ranging from simple procedures such as blood sampling to the more complex such as radiological investigations, fracture manipulation and burns dressings to name a few. Issues of the resources required, the role of parents, pre-procedure preparation, communication and behaviour problems are all addressed. Pharmacological and bio-behavioural techniques are described. However, the Guidelines are not a recipe book. The recommendations provide flexible options so that a pain management technique can be chosen that is tailored to the needs of the individual child. The Guidelines end with an extensive reference list for those who wish to explore individual pain management techniques or other issues in greater detail.

The Guidelines can be found on the RACP website in the public access section at www.racp.edu.au/public/publications.htm under Policy Documents, paediatric policy. Alternatively, the guidelines will be published next month as a supplement in the Australian Journal of Paediatrics and Child Health. I recommend these Guidelines as essential reading for all who treat children.

Meredith Craigie
Chair, Paediatric Pain Working Party

Faculty of Pain Medicine

Professional Documents

P = Professional PS = Professional Standards

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

College Professional Documents Adopted by the Faculty:

PS4	(2000)	Recommendations for the Post-Anaesthesia Recovery Room (Adopted February 2001)
PS7	(2003)	Recommendations on the Pre-Anaesthesia Consultation (Adopted November 2003)
PS8	(2003)	Guidelines on the Assistant for the Anaesthetist (Adopted November 2003)
PS9	(2005)	Guidelines on Conscious Sedation for Diagnostic, Interventional Medical and Surgical Procedures (May 2002)
PS10	(2004)	The Handover of Responsibility During an Anaesthetic (Adopted February 2001)
PS15	(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)
PS18	(2005)	Recommendations on Monitoring During Anaesthesia
PS20	(2001)	Recommendations for Responsibilities of the Anaesthetist in the Post-Operative Period (Adopted February 2001)
PS31	(2003)	Recommendations on Checking Anaesthesia Delivery Systems (Adopted July 2003)

All Current Professional Documents are available at www.fpm.anzca.edu.au/documents/profdocs/index.htm

March 2006