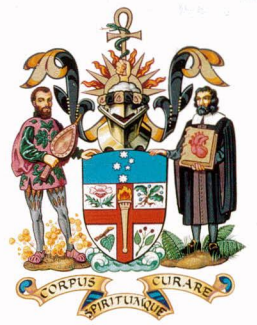


bulletin



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

VOL 14 NO 2

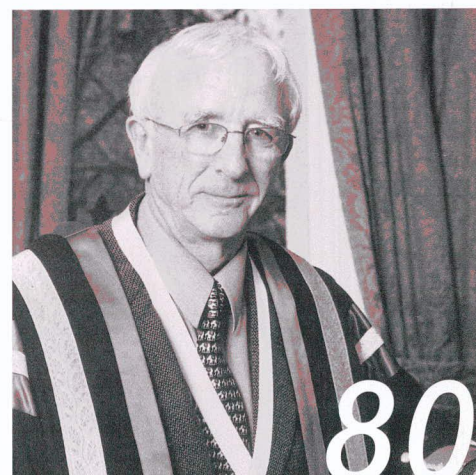
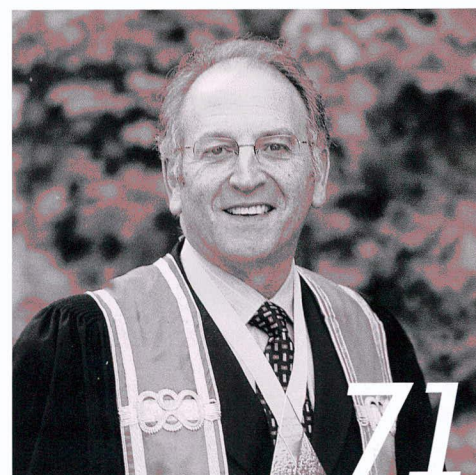
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- *The Anaesthesia Patient Care Team: New Challenges*
- *2005 Annual Scientific Meeting*
- *FPM Annual General Meeting Report*
- *JFICM Regional/National Annual Reports*
- *Letters to the Editor*



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Editorial

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

Committee

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The Bulletin

The Australian and New Zealand College of Anaesthetists' *Bulletin* is published four times per year by the Australian and New Zealand College of Anaesthetists, ABN 82 055 042 852, 630 St Kilda Road, Melbourne, 3004, Victoria

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President's Message

Time for a major effort by all Fellows

ANZCA and other Colleges now face enormous challenges posed by unprecedented actions by both the State and Federal Governments – the latest by the State Government of Queensland.

It is now vital that all Fellows become well informed about the issues and what ANZCA plans to do about them. Also, a large number of Fellows will be needed to participate in that action. A separate article about Nurse Practitioners appears on the following pages, including the current situation in Queensland.

Fellows, you need to become part of the major effort by ANZCA, and its two Faculties to maintain our mission to *serve the community with safety and quality patient care in anaesthesia, intensive care and pain medicine*. Be realistic enough to accept that we must engage in an ongoing dialogue with State and Federal Governments, with universities and with other bodies, including the general public, in order to play a key role in the future of our specialty

“It is now vital that all Fellows become well informed about the issues and what ANZCA plans to do about them. ...a large number of Fellows will be needed to participate...”

– a good example of this is excellent work by ANZCA Fellows in New Zealand with respect to Nurse Practitioners over the past few years.

We have a strong organization and the Fellows who graduate from our training and examination process are second to none. But currently less than 10% of our Fellows are fully informed and strongly involved in the issues I have described – this must change to 100% involvement. The taskforces are the first move in this direction – and the response has been very positive.

Make no mistake, if this increased involvement does not occur, the current unmatched professional milieu and standards of patient care will suffer in a way that may be irreparable. You owe it to your patients not to let this happen.

Some Key Elements of ANZCA's Approach to Current Challenges follow below:

Key elements of ANZCA's approach are:

- 1. Development of brief key messages** for external communication. These were developed for New Zealand and have been recently refined.
- 2. Development of material** for detailed submissions to appropriate bodies. Very substantial and carefully constructed documents were submitted to various bodies in New Zealand by ANZCA and the NZSA. This material is being refined for use in Australia, since the New Zealand documents were undoubtedly part of the effective strategy.

3. Informing Fellows and developing a consistent approach: This is vital to achieving a satisfactory outcome. It was an element in New Zealand and will require some new strategies in communicating more effectively with each individual Fellow.

4. Strategic Planning – ANZCA is engaging professionals to assist the College. Such input will continue for as long as it is needed.

5. Political Dialogue – Professional advice and assistance is also being obtained to allow an ongoing constructive dialogue with State and

Federal Governments and with a substantial number of other bodies such as the AMC, ACCC, Productivity Commission, Health Departments etc.

6. Legal Advice – Legal resources were utilized extensively in New Zealand and were most helpful. We have excellent legal advice via our Honorary Solicitor, Michael Gorton, who is well versed on the strategies used in New Zealand and the different approaches that will be needed in Australia.

7. Informing Politicians and Others – A vital step in our strategy will be to give key Politicians first hand insight into the work of Anaesthetists in the Operating Theatre and other settings, subject to usual Hospital's consents. This will be a big operation that will require very careful management. Fellows will receive "briefing" on this approach.

8. Informative Brochure – Excellent material describing the broad range of work of specialist anaesthetists was developed for the display in the ANZCA Foyer. This is mostly pictorial, accompanied by clear, easily understandable text. Brochures will be developed from this material very shortly.

9. Additional Methods of Communication with Fellows – I will soon announce some new, more personal, rapid and effective methods for a two-way communication between Fellows, ANZCA and the President. This will be an essential ingredient of our strategy.

10. Key Initiatives Resulting from Taskforces – Much vital input from Fellows is being obtained from the nine ANZCA Taskforces involving over 90 additional ANZCA Fellows. This will all be channelled to the October 2005 Council Meeting for action. The Taskforce on Non-Medical Members of the Anaesthesia Care Team will provide an important input, but not the only one that will help to shape the ANZCA Strategy.



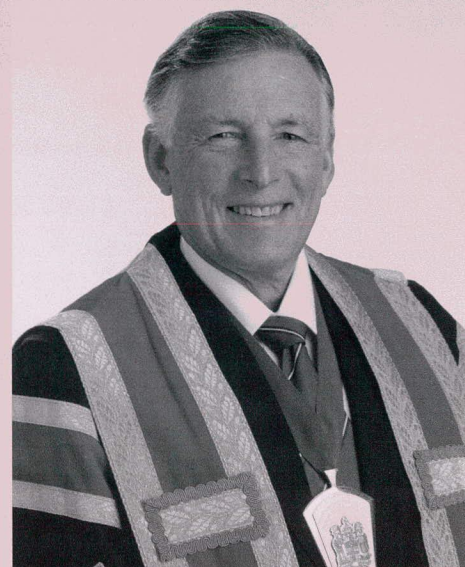
“it is counterproductive to try to pursue such matters through the media...”

Importantly, we have learned from the recent successful campaign in New Zealand that it is counterproductive to try to pursue such matters through the media. To do so will greatly hamper the dialogue that is needed with Governments and other key bodies. This is not going to be a matter of a few exchanges on TV or in the newspapers. What is needed is a carefully planned strategy that is executed over many months in a persistent and credible manner.

A handwritten signature in black ink, appearing to read 'Michael Cousins'.

Michael J. Cousins, AM

President





The Anaesthesia Patient Care Team: Roles and Responsibilities

Queensland's Premier Beattie made a statement on Tuesday 24 May in which he referred to the Bundaberg Hospital Royal Commission and the Forster Review of Queensland Health Services. Included in this statement was an item on Nurse Practitioners, which included: "I am also advised that other countries have trained nurse anaesthetists to undertake some routine procedures. At the moment in Queensland, we have a severe shortage of anaesthetists in the public hospital system which is delaying elective surgery for many patients."... "If nurse practitioner systems can work in Britain and the United States, why not in Queensland."

The Bulletin has included references to nurse practitioners in recent issues:

- *President's Message - Bulletin, June 2004.*
- *New Zealand National Committee Annual Report - Bulletin, June 2004.*
- *President's Message - Bulletin, August 2004.*
- *Highlights from the Council Meeting - Bulletin, October 2004*
- *ANZCA Taskforces - Bulletin, March 2005.*

At the recent June Council meeting, the issue of alternative anaesthesia providers was discussed at length (see President's Message and Highlights from Council in this issue).

At Council, it was agreed that as well as ANZCA making submissions to the Royal Commission, the Review in Queensland and the Productivity Commission, the following background information should be provided to all Fellows:

Nurse Practitioner facilitating legislation has been considered by all States and Territories, first in New South Wales in 1992 (Nurses Amendment (Nurse Practitioner) Bill). The final report of the task force "Victorian Nurse Practitioner Project" was published in July 2000. In it, advanced nursing roles to date are summarised, including the US clinical nurse specialist (CNS), the physician's assistant (PA), and the nurse practitioner (NP), dating back to

the 1960s; the Canadian nurse practitioner in the 1970s; the UK clinical nurse specialist and nurse practitioner in the 1990s; the nurse practitioner and independent nurse practitioner in New Zealand more recently. Nurse practitioners have been considered, and in some cases implemented, in some regions.

The Conduct of Anaesthesia is a Specialised Medical Practice

1. Modern and complex surgery has been made possible and safe for patients by the advances in anaesthesia which over the last 45 years has become a highly specialised area of medical practice.
2. In Australia the specialty of anaesthesia founded on the education and training program of ANZCA, has also initiated and embraced improved patient medical treatment in pre, intra and postoperative care, intensive care and in pain medicine.
3. Specialist anaesthetists are doctors who undergo a total of 13 years training, comprising 6 years of medical school, 2 years as an intern or junior hospital doctor, and then 5 years involving specialist training and rigorous assessment and examination leading to a Fellowship (FANZCA) for successful graduates. It takes this length of time to learn all that a specialist anaesthetist needs to know. (This training provides knowledge in general medicine and surgery plus specialised knowledge and expertise in physiology, pharmacology and anaesthesia related subjects, including the specialised skills that are required.)
4. The training which Australian and New Zealand specialist anaesthetists receive, and their continuing commitment to maintaining their knowledge and skills, has resulted in a standard of care which is equal to the best in the world (the AMC has recently accredited this program with very favourable comments).

5. Having an anaesthetic in 1940 carried a 1:1000 risk of death. In 1960, the risk was 1:5,000. In 1970 the risk was 1:10,000. In 1999, the risk of anaesthesia related death was less than 1:80,000 for all patients, including the very old and the very sick.
6. The people of Australia and New Zealand expect and deserve to continue to receive the best anaesthesia care in the world. Any decision to use less well trained providers would threaten the maintenance of this high standard.
7. Overall manpower figures (eg. AMWAC) indicate a small shortage of Specialist Anaesthetists in Australia and New Zealand, being rapidly made up by increased graduation of ANZCA Fellows via: (1) increased throughput through the ANZCA training program; (2) increased output through the ANZCA OTS assessment process.
8. ANZCA has no restrictions on the number of training positions.
9. The OTS/AON program is in place for areas where a regional maldistribution exists. This program is under revision by Federal/State Governments, with ANZCA's participation.
10. In Australia, a joint program of ANZCA and the Royal Australian College of General Practitioners, trains and supports General Practitioners to provide anaesthesia services in rural and remote areas.

The Role of Non-Medical Health Care Professionals in the Practice of Anaesthesia

11. Nurses are already involved in collaboration with medical specialist anaesthetists: as Assistants to Anaesthetists in Operating Theatres, as Recovery Room Nurses, as Intensive Care Nurses and as nurses in multidisciplinary Pain Management teams. Even in these roles they are in short supply.



Anaesthesia Related Mortality in Australia

12. Australian Surgeons and Anaesthetists have developed a team approach which has resulted in a very high standard of pre, intra and post operative care with the lowest mortality rates in the world.

13. In some countries where nurses or non-medical personnel provide anaesthesia care, they have to be supervised by the surgeon. Australian and New Zealand surgeons are not trained for this role, nor do they wish to have their attention diverted from the increasingly more complex surgery they perform.

14. The training required to provide safer anaesthesia in remote areas without the support of fully qualified specialist anaesthetists is higher than that required in a major metropolitan centre, because of the variety of clinical situations which might arise and because of the lack of help if things go wrong in what was expected to be a straightforward anaesthetic.

15. There are a number of possible solutions to the shortage of anaesthetists in remote areas, and ANZCA is working with State and Federal Governments to address the issue.

Fellows' and trainees' comments about the subject matter of this article are welcome, and will be considered by Council in October, together with the reports of the Taskforce considering this matter.

Michael J. Cousins
President

Until 1991, the most consistent data on anaesthesia related mortality in Australia were provided by the New South Wales Special Committee Investigating Deaths Under Anaesthesia (SCIDUA).

- Deaths reported were those occurring during, within 24 hours of, or resulting from anaesthesia.

- Deaths wholly or partially attributable to anaesthesia were reported to be 1:5,000 in 1960, 1:10,250 in 1970 and 1:20,000 in 1990. The last figure was based on 1503 reports classified between 1984 and 1990, when some 3.5 million anaesthetics were administered.

- In the period 1984-1990 there were 172 deaths wholly or partially attributable to anaesthesia (1:20,000), and 48 of these were wholly attributable to anaesthesia (1:73,000).

Reference: Warden JC, Horan BF. Deaths Attributed to Anaesthesia in New South Wales 1984-1990. *Anesth Intens Care* 1996;24:66-73.

The Victorian Consultative Committee on Anaesthetic Mortality and Morbidity was established in 1976. In its last report:

- Deaths reported were those occurring during, within 24 hours of, or resulting from anaesthesia.

- In the period 1997-1999, 253 deaths were reviewed. Of these, 32 deaths were identified as wholly or partially attributable to anaesthesia (1:90,480). Of the 32, 16 were wholly attributable to anaesthesia.

Reference: Mackay P (Ed) Eighth Report of the Victorian Consultative Committee on Anaesthetic Mortality and Morbidity 1997-1999.

ANZCA has published 3 triennial reports on anaesthesia related mortality. These reports collated and analysed data from the Mortality Committees in New South Wales, Victoria, Queensland, South Australia and Western

Australia. The accuracy of the data has improved with each report.

- The 1991-93 Report established a mortality of 1:68,000, based on 116 deaths partly or wholly due to anaesthesia, with an estimated 7.8 million anaesthetics given. Of the 116 deaths, 45 were definitely attributable to anaesthesia (1:173,333).

- The 1994-1996 Report established a mortality of 1:63,000 based on 135 deaths, with an estimated 8.5 million anaesthetics given. Of the 135, 55 were definitely attributable to anaesthesia (1:154,500).

- The 1997-1999 Report established a mortality of 1:79,500, based on 130 deaths, with an estimated 10.336 million anaesthetics given. Of the 130, 47 were definitely attributable to anaesthesia (1:220,000).

References: Horan BF (Ed) Anaesthesia related mortality in Australia 1991-1993. ANZCA.

Davis NJ (Ed) Anaesthesia related mortality in Australia 1994-1996. ANZCA.

Mackay P (Ed) Safety of Anaesthesia in Australia. A review of anaesthesia-related mortality 1997-1999. ANZCA.



Law Report

Peer Review and Reports



Michael Gorton
AM LLB, BComm FRACS (Hon)
FANZCA (Hon)
College Honorary Solicitor
Partner - Russell Kennedy
Solicitors

Increasingly the Medical Colleges and individual specialists are being asked to carry out peer reviews of the performance of their colleagues.

Hospitals are now more regularly engaging the Colleges and independent medical practitioners to assess the standards and skill of doctors within their particular units. Medical Colleges are being asked by hospitals and health departments to carry out specific purpose assessments of specialists, particularly where performance may be called into question.

“Peer Review” is regarded by many as an important part of self regulation by the profession. The Medical Colleges regard it as part of their public duty to ensure maintenance of standards and to address any performance issues of their own Fellows.

However, prior to undertaking any formal peer review, it is important that the College and medical practitioner are aware of the legal pitfalls that may be encountered.

Indemnity

Where a review or report has been requested by another body (eg hospital, health department, Area Health Network) it is important that the College or the individual assessor obtain a formal legal indemnity before commencing the review.

There is some legal risk in carrying out a review of this nature. The person under review may substantially disagree with the conclusions of the assessor and seek legal redress, particularly where their employment or other rights are affected. There is some risk that the assessor may be personally liable for loss or damages arising, particularly if the assessment is carried out negligently.

It is therefore important that a formal Deed of Indemnity be given to the assessor (and where the assessment is carried out by a College, in favour of the College) to give further protection. The body giving the indemnity should also

maintain appropriate professional liability insurance. It may be necessary to have the indemnity reviewed by a legal adviser.

Natural Justice/Procedural Fairness

Reviews of this nature inevitably affect the employment and other important legal rights of those being assessed. The Courts have recognised the need to ensure that the process by which the doctor is reviewed is in accordance with the legal principles of natural justice/procedural fairness.

Particularly where a review or report will be used in disciplinary procedures, the general principles of natural justice will be required.

These are:

(a) Appropriate Notice

Appropriate notice should be given to the individual being reviewed, setting out in general terms the nature of the review, the substance of any particular allegations being made against the individual, and any particular evidence or factual material to be considered.

The individual will need sufficient time to prepare any response to the material and to address any particular allegations.

If there is information or allegations which are adverse for the doctor, full details of that material must be made available, and the doctor must have adequate opportunity to respond.

(b) Relevance

The reviewers should only focus on material that is strictly necessary for the review process. The reviewers should only take into account information which is relevant to their terms of reference, relevant to performance issues or relevant to the specific allegations made against the doctor.

(c) Bias

The reviewers should be free of bias. The review must be carried out impartially and the reviewers

cannot have a direct or indirect interest in the outcome or relationship with those involved.

Obviously this can be problematic in a peer review situation where those conducting the review are members of the same specialty as those under investigation. It may sometimes be necessary to ensure that the reviewers have no prior relationship with the person under review, or come from a different state, or are otherwise independent.

Reviewers must also come to the task with an “open mind” and must not have prejudged the material, until all of the submissions and all of the evidence is available.

(d) Procedure

The review can be carried out in an informal context, although some formality should be observed in relation to the collection of information and evidence. Statements should be taken from witnesses, preferably in writing, or at least adequately summarised.

It may be, where the review is in relation to a particularly serious allegation, or which may give rise to disciplinary procedures, that an individual be given access to legal representation. Although a legal representative should not necessarily act as an advocate, the individual doctor may wish to access legal advice before and during any interview.

These reviews are not normally bound by formal legal rules of evidence. A reviewer would be entitled to hear material from any relevant source, and determine for themselves what weight to place on the material. Obviously, the reviewers would avoid placing too much weight on information from anonymous parties or information which is second or third hand.

As noted above, any material or evidence should nonetheless be relevant to the issues in dispute or under investigation.



Defamation

There is obviously a risk that reviewers, and witnesses, in attempting to provide a frank and candid assessment of a doctor's performance, will be accused of defamation. Inevitably, negative comments which reflect upon the performance

“Comments about a doctor's personality, personal life or reputation may not necessarily be protected by qualified privilege, unless they are directly relevant to the issues in dispute”

and skills of a doctor may be regarded by the doctor as defamatory.

The law recognises that legal vulnerability could undermine the whole process of peer review, and therefore provides general defence to such claims in the form of “qualified privilege”. Therefore, those involved in such proceedings will not be subject to the ordinary laws relating to defamation. Privilege would also extend to material prepared prior to and for the reviewers' deliberations, such as statements of witnesses.

However, statements made by individuals which go beyond that which is strictly necessary or relevant for the review, may lose protection from defamation, particularly if it is mischievous or malicious.

A review is not generally a process to allow “character assassination” or clearly irrelevant material. Accordingly, reviewers, and those providing material, should avoid comments that extend beyond the strict assessment of the doctor's medical performance or matters relevant to the review. Comments about a doctor's personality, personal life or reputation may not necessarily be protected by qualified privilege, unless they are directly relevant to the issues in dispute.

Statutory Protection

For some peer review processes, particularly

those conducted through hospitals, it may be possible to register the activity as a “quality assurance activity” under relevant State or Federal legislation.

Once an activity is declared under the relevant

legislation, all participants must comply with confidentiality requirements contained in the legislation.

Additionally, for example, registration under the Commonwealth legislation provides two important protections:

- Confidentiality of information that requires individuals or entities;
- Protection from civil proceedings for members of Committees that assess or value the quality of health services provided by others (credentialling activities).

Privacy and Patient Confidentiality

Unless the Privacy Statement of the particular doctor or hospital would ordinarily permit access to a patient's records for this purpose, it may be necessary sometimes to get the consent of the patient. Most hospitals now utilise a general hospital consent form, acknowledged by patients on admission, which permits the use of their hospital records for audit and review purposes. However, this should be confirmed.

In some instances, where the peer review activity can be regarded as research, it may be possible to access patient records without consent, so long as the activity has been approved by the relevant hospital or institutional ethics committee.

Credentialling

Sometimes the review is undertaken for credentialling purposes, either in the institutional or broader network setting. Obviously a review of a practitioner for credentialling can involve the reputation and practising rights of individual doctors.

For these reasons, the review will need to ensure both natural justice and due process.

As noted above, credentialling procedures can be registered as a qualified privilege scheme under relevant Commonwealth legislation (Health Insurance Act 1973).

Some medical colleges have clear processes for credentialling (for example, see The Royal Australasian College of Surgeons - Credentialling Handbook). The Australian Council for Safety and Quality in Healthcare has issued new guidelines for credentialling (Standard for Credentialling and Defining the Scope of Clinical Practice).

Conclusion

Those participating in peer review processes should be aware of the legal issues involved. In particular the need for protection by way of Indemnity and relevant insurance should be confirmed.

Peer review is an important safeguard of the health profession, and should be encouraged. Those involved in peer review should be encouraged to provide honest and accurate reports, without the threat of litigation over their heads.

It is therefore important that these issues are fully considered.

I am grateful for the assistance of Rebecca Kovacs in the preparation of this report.



Series on Past Deans and Presidents

Mary Taylor Burnell (nee Angel)

Mary Burnell was the sixth Dean of the Faculty of Anaesthetists, Royal Australasian College of Surgeons, following Len Shea and succeeded by Ralph Clark. She held the post for twelve months 1966-1967 and was the first woman Dean of the Faculty.

Mary Angel was born on 21 February 1907 in Norwood, South Australia and was educated at St Peter's Collegiate Girls School. She studied science for two years at Adelaide University before switching to Medicine as a career, graduating in 1931. After graduation Mary was a resident medical officer at the Adelaide Children's Hospital in 1932 and 1933. In 1934 she was appointed as assistant honorary anaesthetist

perhaps the only exception being Dr Geoffrey Kaye in Melbourne.

1934 was the year of the establishment of the Australian Society of Anaesthetists, and Mary Burnell became its first female member in 1935 and the secretary of the South Australian section of the ASA. She would become State representative in 1949, succeeding Gilbert Brown in that role and become the Federal President in 1953-1954. In 1970 she would personally fund the Gilbert Brown Award, an award to perpetuate the memory of Gilbert Brown, the inaugural President of the ASA. This is awarded to any individual for outstanding and particularly meritorious service to the Society.

“Mary Burnell also possessed a great love and knowledge of wine and art. She took art classes after she retired from anaesthetic work..”

to the Children's Hospital and in this year married Dr G.H. (Jimmy) Burnell, a surgeon who was one of the tutors in her medical course. At the time it was very uncommon for a doctor to enter full-time anaesthetic practice,

Despite having resigned in 1937, during the war years of 1942-1945 Mary Burnell was reappointed as the sole anaesthetist at the Adelaide Children's Hospital. This required considerable time commitment at a stage when she was raising three children. She would go on to become one of the pioneers in paediatric anaesthesia in Australia along with Dr Greta McClelland in Victoria and Dr Andy Morgan in NSW. Board Minutes from the hospital reveal that the later development of a Department of Anaesthesia was solely due to Mary's persistent representations. She was also the first to read papers on paediatric anaesthesia in Australia at ASA meetings.

The ASA Overseas Visitor Project that is still in existence was conceived and proposed by Mary whilst a state representative on the Society's executive. This commenced in 1953 and has enabled the opportunity for Australian anaesthetists to meet and learn from overseas anaesthetists. In addition to the aforementioned commitments she was also on the organising



Committee of the 3rd Asian Australasian Congress of Anaesthetists held in Canberra in 1970.

In 1955 Mary Burnell was elected to the Board of Faculty and became the first woman Dean of the FARACS. In 1968 Mary Burnell was honoured by being elected as a Fellow of the Faculty of Anaesthetists Royal College of Surgeons. In 1969 she was honoured with Life Membership of the Australian Society, along with Greta McClelland. South Australia recognised Dr Burnell's work with the establishment of the Burnell-Jose Professorship at the University of Adelaide in 1975. In 1976 the RACS elected her to Honorary Fellowship of the College.

Anaesthesia and its organisations were not Dr Burnell's only interests. In 1949 she joined the Central Committee of the Mothers' and Babies' Health Association in South Australia, an organisation responsible for child welfare. Her work for the association, where she was both Secretary and President, extended over 30 years. Mary Burnell also possessed a great love and knowledge of wine and art. She took art classes after she retired from anaesthetic work. Her husband passed away in 1954 and Mary died in 1996. She was survived by two sons, a daughter, grandchildren and great grandchildren.

The details of this essay are gained from Gwen Wilson's book "Fifty Years: the Australian Society of Anaesthetists", and the Obituary written by Gwen Wilson in the ANZCA Bulletin of November 1996.

Terry Loughnan



Education Report

In-Training Assessment (ITA)



Russell W. Jones
Director of Education, ANZCA

In-Training Assessment (ITA) is an invaluable assessment tool that facilitates the ongoing education of Trainees and complements other assessment procedures such as the College's examinations. It is a process of (1) joint goal setting by the Supervisor of Training (SOT) and Trainee, and (2) evaluation by the SOT, other medical specialists and the Trainee. Formal requirements are set out in College Professional Document TE14 (2001) *Policy for the In-Training Assessment of Trainees in Anaesthesia*.

The College objectives for the ITA process are to:

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

The ITA process is described below.

Formal meetings must occur between the SOT and each Trainee at the beginning (the initial interview) and the end (the final interview) of each six month period (or sooner if the attachment is less than six months). For cases where Trainee difficulties are perceived, additional meetings should be arranged as early as possible to allow for those difficulties to be explored and, if possible, corrected during the term. These additional meetings can be requested by either the SOT or the Trainee. Any Trainee experiencing difficulty must be encouraged to bring this difficulty to the attention of the SOT as early as possible. There should also be regular meetings between the SOT, Head of Department and a Department's Trainees en masse.

Prior to the initial interview it is the responsibility of the Trainee to show the SOT their up-to-date Learning Portfolio including copies of all ITA-2 forms (i.e., their Final ITAs) from their previous rotations. These forms should be filed within the Trainee's Learning Portfolio. If forms are missing then the Trainee can obtain copies from either the College or the appropriate previous SOT. At this time the Trainee is also to complete an ITA-1 form for themselves based on their own perception of their performance. The Trainee is to give a copy of

this self-assessment to their SOT at the same time as their Learning Portfolio. The ITA-2 forms, up-to-date Learning Portfolio and completed self-assessment should be given to the SOT prior to the initial meeting allowing sufficient time for the SOT to review the information contained in these documents prior to the interview.

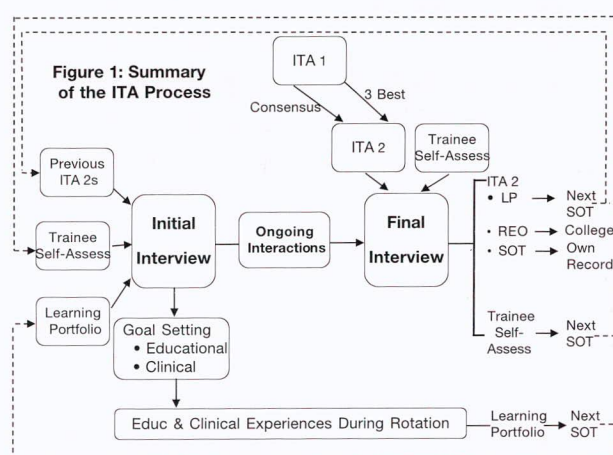
The Learning Portfolio, ITA-2 forms and completed Trainee self-assessment are to be used by the SOT and the Trainee to set appropriate educational and clinical goals for the training term. Both the SOT and Trainee should arrive at the initial interview with

desirable goals for the rotation. These goals are to be realistic and appropriate. Should conflict arise in the goal setting process the SOT is in the best position to decide what is a realistic and appropriate goal because the SOT is most familiar with the particular rotation environment. These documents are to form the basis of a discussion which should take place at the beginning of each term. When the term is in a new hospital or department, the discussion should be part of the orientation process. The SOT is encouraged to contact a Trainee's previous SOTs to seek additional information to assist with their decisions as to the best educational and clinical experiences for a Trainee. A list of SOTs plus their phone, email and postal addresses is available in section 4 of the SOT Support Kit. This Kit has been circulated to all SOTs.

After six months (or upon completion of the rotation for those rotations of less than six months) the SOT should complete an ITA-2 form using information from:

- The three senior staff best placed to provide an assessment, who each complete an ITA-1 form, and/or
- A consensus meeting of the senior staff of the Department in writing using an ITA-1 form.

Selection of the staff to complete the form should be based upon the quantity and quality of their interaction with the Trainee, and their ability to complete documentation in a timely manner.



At the same time the Trainee should complete another ITA-1 form as a self-assessment. These two forms, ITA-2 and ITA-1 (self-assessment), should form the basis of the interview. At the completion of this interview the Trainee should be asked to write any comments he/she wishes on the ITA-2 form. (Comparison of the ITA-2 form with the Trainee's ITA-1 self-assessment form may indicate the degree of insight that a Trainee has into his/her level of performance.)

The original ITA-2 form is to be retained by the Trainee and placed in their Learning Portfolio. The SOT should retain a copy of the ITA-2 form for their own records and also forward a copy to the Regional or National Education Officer. The Education Officer is to review these forms before forwarding them to the College.

The ITA process is summarised in Figure 1. Note how the information generated at the end of any given rotation (i.e., completed ITA-2 form, Trainee self-assessment and updated Learning Portfolio) forms the foundation of the ITA process at the commencement of the subsequent rotation. In this way the ITA process continues as an iterative process throughout the FANZCA training period.



ANZCA Trainee Committee



Annabel Orr
Chair, Trainee Committee

Hopefully many of you will have seen the results of the survey conducted by the Victorian Trainee Committee in 2004 that was published in the March issue of *The Bulletin*. This has given us some valuable information about what is concerning trainees, what they want, and some ideas to feed back to the College to hopefully implement some useful additions and changes. On the back of the success of that questionnaire, we will be sending another questionnaire out very soon which has been formulated with the assistance of the Education Unit at the College, in particular Russell Jones. As with the previous

College, not just Victorian Trainees, and thereby we hope to get an even greater cross-section of trainees to respond.

The members of the trainee committee met again by teleconference in March. A lot of discussion took place regarding the implementation of the revised FANZCA, and accreditation of modules towards training. It appears that there are some teething problems in some areas, and these are being fed back to the appropriate bodies within the College for review.

“This has given us some valuable information about what is concerning trainees, what they want, and some ideas to feed back to the College...”

questionnaire, the results are completely anonymous, and the surveys are not identified in any way. We in the Trainee Committee sincerely hope that you will all find 5 or so minutes to complete it and return it to us, so that we may continue to convey your thoughts and concerns to the College. Unlike last time, this survey will be distributed to all trainees registered with the

Another recent change is that the e-communities sites for the trainee Committees have been amalgamated so we all share the one site. This is because they were not being effectively used, and we hope this will encourage people to jump on every now and then to see what is happening, perhaps ask a question – look for a reference for an exam question etc.

The Victorian Committee will be posting a newsletter there on a monthly basis keeping people up to date with what is going on. Just to remind you how to get there:
<http://online.anzca.edu.au/anzca>

The new Trainee Committee for this year is:

Dr Annabel Orr (Vic) (Chair)
Dr Angela Ralph (Tas)
Dr David Duke (NSW)
Dr Ben Lloyd (Qld)
Dr Corinne Bennett-Law (NZ)
Dr Wanling Leong (Sing)
Dr Assad Hussain (HK)
Dr Alan Millard (WA)
Dr Justin Porter (SA)

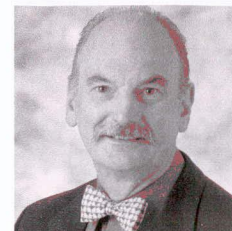
Feel free to contact any of the above people with any queries if you don't wish to use the e-communities, or also if you wish to join your regional Trainee Committee where new members are always welcome.



Letters to the Editor

Your Say!

Here's the chance to have your say! A new innovation in your College Bulletin is the "Letters to the Editor" section. If you have a comment, a complaint, an item of interest, or a burning issue to get off your chest, then this is your column. Of course, I can't guarantee that all letters will be published, but whether you are a Fellow, a Trainee, or anyone who reads the Bulletin, please write to me with your thoughts on College matters.



Rod Westhorpe
Editor

Dear Editor

I am in awe of the excellent publication, the ANZCA Bulletin, that is sent out to your scattered Fellows, even those like me who reside in remote places. But the current issue, for March 05, did something unusual for me: its contents made me want to respond, to have a say, to contribute to the conversation. Yet I found no way to do so anywhere within your usual format. There was no column where letters to the Editor are published. That discovery I found surprising, in the light of the always-interesting letters that appear in the Bulletin of the Royal College of Anaesthetists. May I suggest that to promote a Letters column would help build a heightened sense of College ownership and a community of shared interests amongst Fellows.

As an example of a subject that invites open discussion, I can refer to what caught my attention in the current issue: the work of the Task Force which is studying the naming of our specialty. There are good reasons to reconsider the name which we accepted from Oliver Wendell Holmes in 1846. But that is a separate matter of history and linguistics which I have dealt with in a letter sent directly to Task Force chair, Professor Ludbrook, and have copied to you.

In addition to matters of College business, I hope that a Letters Column will encourage human interest contributions, particularly from older Fellows, a company to which I have graduated. Letters, including mine to Professor Ludbrook, easily provide space for reminiscences that otherwise would remain unshared and forever lost. There are not many of us left who can look back, as I do, on a first postgraduation year at the Royal Adelaide Hospital during which I learned the basics of open-drop ether anaesthesia from Dr Alan Lamphee, and gained inspiration from Pat Hamilton and Mary Burnell. From later years come memories of the visit by Bob Spiers and Len Shea to my burgeoning department at the American University of Beirut. And later yet there came a noteworthy younger visitor from Australia, fresh-faced and eager, who lectured effectively and took great interest in what we were doing. His name was Michael Cousins.

I am delighted to see to what heights the College has risen under the guidance of so many fine leaders, of which he is an outstanding example.

Yours sincerely
Bernard Brandstater

.....
Editor's Note: Professor Brandstater is a long standing Fellow and loyal supporter of the College, having gained his FFARCS in 1963. On the occasion of his visit in 1994 he generously donated to the College, a 436-year old volume containing all the written works of Hippocrates bound in the original leather and manuscript vellum.
.....

Dear Editor

Because it may give food for thought to a wider circle of my Australian colleagues, I am copying to you a letter I have sent to Professor Ludbrook:

Today I have read in the March 05 ANZCA Bulletin that you are chairing a taskforce to examine the appropriateness of the name to be used for our specialty. Here are comments from someone who has been around long enough to hear many different views.

When I was a resident in Philadelphia, back in the halcyon years of Dripps, Eckenhoff and Vandam, the name "anesthesiology" was being proudly popularized to distinguish us from nurse anesthetists. When I subsequently worked as registrar at St. Thomas' Hospital in London (with Wylie, Churchill-Davidson et al), we simply had a Department of Anaesthetics.

Later, at the American University of Beirut, the medical school dean created a new department, appointing me, a 28-year-old novice as its first chairman. He named it the Department of Anesthesiology, after the department he had admired at New York's Columbia-Presbyterian Hospital, when it was headed by Emanuel Papper. When I did a 1963 research fellowship

in San Francisco (with Cullen, Severinghaus, Eger et al), our organization there was simply the Department of Anesthesia.

In the sixties I had a memorable dinner in Boston with Leroy Vandam, who at the time was a member of a search committee looking for a new Isaiah Dorr Professor to succeed Henry Beecher at Harvard. Vandam related to me the problems the search committee was having, stemming from the diverse interests growing out of Beecher's fine team, especially in respiratory care (Bendixen, Pontoppidan at el) and pain management. The committee was inclined to propose a name change from Department of Anaesthesia (as good Bostonians, they stuck tenaciously to the classic "-ae-"), wanting to replace it with "Department of Anaesthesia and Life Support", which indicated its broadened scope of activities. Apparently the committee's recommendation of Richard Kitz was accepted but not the name change.

Around the world various departments have invoked the word "resuscitation" for inclusion in their name, as our French colleagues have used their equivalent "reanimation". Others have opted for "intensive care", "perioperative medicine" or "pain medicine".

But it's time to step back and take a broader view. I now believe that the original borrowing from Greek should be questioned in the light of what I have unearthed in the huge data base of Ancient Greek manuscripts assembled at University of California Irvine. It is named the Thesaurus Linguae Graecae, and makes possible a search for all occurrences of any particular word. With help I was able to download 620 citations of the use of "anaesthesia" in the classic texts. Clearly, this was not a new word coinage attributable to Oliver Wendell Holmes. This word was in common use in Ancient Greece.

The next question, inevitably, was "What did the word mean to the classic writers?" By referring to the reliable translations in the Loeb Classic Library, I was able to distinguish six, possibly seven, different shades of meaning. While some



of them are suitable for our adoption, others are not. Here are some examples:

- 1 total absence of sensibility, oblivion (as in Epicurus: '....the mere insensibility of death')
- 2 insensibility to any physical sensations, not pain only (as in Plato's Timaeus)
- 3 incapacity to enjoy physical pleasure (as in Aristotle: an impoverished quality of life)
- 4 destitute of culture and morality, callous (as in Demosthenes, speaking of the Thebans: '....those blockheads.....')
- 5 without common sense, without tact, stupid (as in Thucydides in: 'The History of the Peloponnesian War')
- 6 dense, obtuse, dull-witted, simple-minded.

I have listed these nuances of meaning in a letter to the Editor of the R.C.A. Bulletin 31 (May 2005), and have added the following comment that expresses my own discomfort with our traditional name:

"What can be done with a name that is firmly established by generations of use, but which is now seen to be inadequate? Not only does it leave no room for the newer sciences of critical life support and pain medicine, but at its roots it has connotations that are demeaning. Who aspires to be professor of stupidity? A rose by any name might smell as sweet, but a specialty that embraces this name does itself a disservice. Holmes, where are you?"

I personally have a preference for the meanings implicit in the words "guardian" and "protector". Both these words seem pretentious in English, but their meaning seems equally apropos in the operating theatre, the I.C.U. or the pain management clinic. Is there a useable equivalent discoverable in our Greek or Latin lexicons?

Bernard Brandstater
Loma Linda University

Dear Editor

In the far off days, when the world was a more casual and relaxed place, the author served as a Part 1 Pharmacology Examiner for the Faculty and then the new College. He occasionally asked viva examination candidates to tell their examiners about the anticholinergic drugs. The antimuscarinic anticholinergics were always

meticulously detailed; the antinicotinic anticholinergics were seldom, if ever, mentioned. Further, it was not easy to guide candidates towards incorporating the antinicotinic anticholinergics into their responses. This seemed to indicate that the antidepolarising neuromuscular blocking agents were not generally considered as being part of the broader class of drugs known as the anticholinergics, which, obviously, they are! In a round about way, should this have led us to wonder if the antidepolarisers had nicotinic actions other than at the neuromuscular junction? Should we have thought we might be missing something that could be important?

In 1992 & 1993 Eriksson and his colleagues [1,2] in Linköping, Sweden and San Francisco, USA, published, for the first time in the anaesthesia literature, studies demonstrating that there are receptors in the carotid body sensitive to the antidepolarising relaxants. This work has recently and independently been validated in the rat and there is evidence that the receptors are nicotinic [6]. Briefly, if there is even a minor degree of postoperative residual curarization [PORC] present then the operation of the carotid body can be depressed. This does not appear to be of much importance until it is recalled that the function of the carotid body nicotinic receptors is the transduction of the partial pressure of dissolved oxygen in blood and that they provide the input for the 'hypoxaemic ventilatory response'.

Minor degrees of PORC may ablate the normal response to hypoxaemia in the post anaesthesia patient already depressed by residual sedation and further depressed by narcotics. The sum of these depressive phenomena may be to allow for frank respiratory arrest.

We already know - almost instinctively - that residual sedation and narcosis each and additively depresses respiratory drive. Now the remaining member of the anaesthesia triad has been shown to be directly causal, via a receptor, to a facet of post-operative respiratory depression.

Hat trick!

The list of reports on the entity and/or incidence of PORC is venerable and long and they are still appearing [4, 5]. Not a lot of attention attaches to them. The bleak fact is, as far as the author is aware, the connection between PORC and the reduction of a part of respiratory drive has not permeated the educational structure to which

trainees are exposed. It is now thirteen years since its revelation in the anaesthesia literature.

The argument for intraoperative objective estimation of neuromuscular function being a requirement during anaesthesia sequences involving the use of myoneural relaxants, rather than as a to-be-available resource [6], has recently attracted editorial comment [7, 8]. First World anaesthesia practice is moving in this path and it behoves our College (its Fellows, collectively) to be in the vanguard of such a change, so helping their College to maintain its eminent world position in patient safety.

The proposal is made, - "that the Australian and New Zealand College of Anaesthetists supports the practice that the objectively determined adequacy of recovery from the action of muscle relaxants be documented in the patient's anaesthesia case notes [9], by anaesthetists, on the patient's departure from the Operating Room so protecting their patients from a notified hazard and themselves from the risk of criticism for having failed to do so."

Thank you for giving me the opportunity to present this information to the College. I make myself available if there be any way in which I can aid its deliberations on the matter.

Yours faithfully
John Newstead
Christchurch NZ

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2. Eriksson LI, Sato M and Severinghaus JW; Effect of a vecuronium-induced partial neuromuscular block on hypoxic ventilatory response. *Anesthesiology* 1993; 78: 693-699
3. Igarashi A, Amagasa S, Horikawa H and Shirahata M; Vecuronium directly inhibits hypoxic neurotransmission of the rat carotid body. *Anesth Analg* 2002; 94: 117-22
4. Baillard C, Gehan G, Reboul-Marty J, Samana CM and Cupa M; Residual curarization in the recovery room after vecuronium. *Brit J Anaesth* 2000; 84 (3): 394-5
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6. Australian and New Zealand College of Anaesthetists; Recommendations on routine monitoring during anaesthesia, PS18 (2000); 3 [para 3.8]
7. Viby-Mogensen J; Postoperative residual curarization and evidence-based anaesthesia. *Brit J Anaesth* 2000; 84: 301-3 (editorial)
8. Eriksson LI; Evidence-based practice and neuromuscular monitoring: it's time for routine quantitative assessment. *Anesthesiology* 2003; 98: 1037-9 (editorial)
9. Australian and New Zealand College of Anaesthetists; Recommendations on the recording of an episode of anaesthesia care (the anaesthetic record), PS6 (2001)



Report

Highlights from June Council

Education

Supervisors of Training Workshop at the ASM

Supervisors of Training Workshop Attendees will be exempt from the restriction that ASM Delegates may register for one ASM Workshop only.

Modules for Training

This issue of commonality across the Colleges in their approach to education was raised. Reference was made to a number of ANZCA's web based modules on Professional Attributes and Professional Practice being modified, where necessary, for use by other Colleges.

Educational Material for Advanced Trainees

The Education and Training Committee supports in principle, the development of a Fellowship/OTS examination DVD as a resource for examination candidates.

Diving and Hyperbaric Medicine

Candidates for the ANZCA Certificate in Diving and Hyperbaric Medicine may sit the Examination on completion of 12 months approved training time and attainment of the SPUMS Diploma in DHM, however the Certificate will not be awarded prior to completion of the full 18 months approved training.

Formal Project Professional Document

That the following statements be included immediately as an addendum to Professional Document TE11 Formal Project Guidelines, and be incorporated into the body of the document at the time of the next scheduled review:

- 1) That there be compulsory supervision for the Formal Project.
- 2) That trainees submit with their formal project, a signed statement that this is original work and that sources of assistance and documented works or ideas of others have been appropriately acknowledged.

Examinations

ANZCA Examinations Hong Kong

In the past, the ANZCA Primary Examination has been conducted under the supervision of Professor Cindy Aun at the Prince of Wales Hospital with the Examination being held in the physical facilities of the Hong Kong Academy. Following Professor Aun's retirement, ANZCA will now seek the assistance of the Hong Kong Academy to facilitate ANZCA Examinations in Hong Kong.

Continuing Education and Quality Assurance

CD Recording of CME Meetings

The Trial recording of CME Meetings onto CD for distribution to Fellows and trainees has been approved.

Consumer Representatives to College Committees

Council has expanded the Consumer Group to six. Consumer representation will now be included on the OTS Assessment Panels for Australia and New Zealand, Education and Training Committee, Hospital Accreditation Committee and the General Examinations Committee.

Professional Documents

The following documents were reviewed and accepted:

PS26 *Guidelines on Consent for Anaesthesia or Sedation*

TE18 *Guidelines for Assisting Trainees with Difficulties*

Professional

Queensland Inquiries

The College will be making submissions to the Forster and the Morris Inquiries currently being conducted in Queensland.

The Forster Inquiry relates to the Queensland Health Systems Review and the Morris Inquiry (Bundaberg Hospital) relates to the Role and Conduct of Queensland Medical Board in relation to assessment, registration and monitoring of Overseas Trained Medical Practitioners.

Anaesthesia Continuing Education Co-ordinating Committee - ACECC

Establishment of Special Interest Groups

ACECC is drafting Guidelines establishing the Criteria, for the establishment of new Special Interest Groups.

College Awards and Elections

ANZCA Council Citation

Dr Rupert McArthur (SA) was awarded a Council Citation, particularly for his training, retraining and assessment of General Practitioner Anaesthetists.

Death

Council noted with regret the death of the following Fellows:

Dr Geoffrey James Dalgarno (NSW)

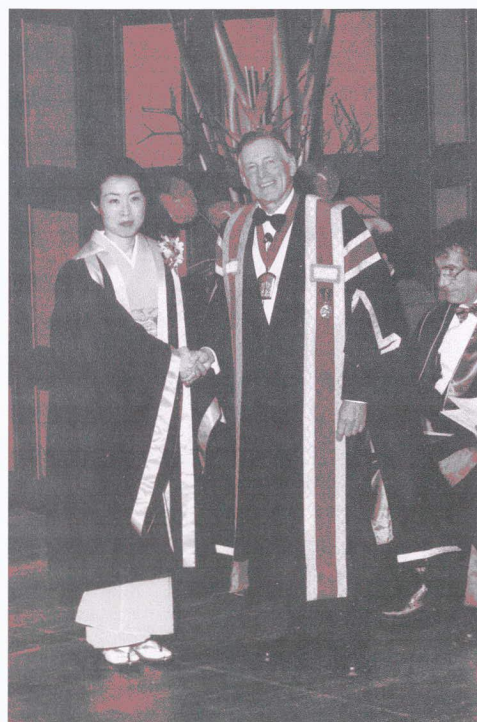
– FFARACS 1962, FANZCA 1992



Better Balance of Life and Work

Auckland's Greenlane Clinical Centre has on its staff the first Japanese born person to qualify as a Fellow of the Australian and New Zealand College of Anaesthetists (FANZCA).

A quietly determined Dr Tomoko Hara has settled in New Zealand after overcoming some significant obstacles, while being blessed with some good fortune on the way.



She now has permanent residency in New Zealand. She had to gain fluency in spoken English, maintain her visa entitlements, and learn a whole new way of life.

Tomoko graduated from medical school in her home city of Okayama, with a population of some 500,000, half way between Osaka and Hiroshima, in 1991 and worked as a trainee anaesthetist, first in the University Hospital at Okayama and later in Hiroshima.

In Japan, she specialised in paediatric cardiac anaesthesia, but found the 60 to 90 hours' work each week – normal for many medical staff in Japan – not to her liking.

"Here, there is a better balance between life and work, and a better quality of work," Tomoko says.

The Okayama University Hospital Department of Anaesthesia had links with Melbourne's Royal Children's Hospital Intensive Care Unit and she left Japan for the first time when an opportunity arose for her to gain more experience in her specialty at the RCH over 12 months.

"In Japan, she specialised in paediatric cardiac anaesthesia, but found the 60 to 90 hours' work each week – normal for many medical staff in Japan – not to her liking."

Subsequently, Tomoko was able to obtain a registrar's job at the Royal Melbourne Hospital, where she spent another 12 months working as an anaesthetic registrar.

Just as her Australian visa was running out opportunity knocked again, when a former colleague in Japan, who at the time was working in New Zealand, advised her of a position at the Greenlane Clinical Centre, which she took up in February, 2001. Initially, she had a fixed contract for 12 months.

An enthusiastic and determined professional, Tomoko gained a six-month extension of her contract, and in 2002 gained a qualification in echocardiography, widely used in cardiac work.

"Then, another opportunity when eligibility for overseas trained anaesthetists to sit for the Australian qualification was widened, allowing me to sit the examination for my FANZCA," Tomoko says.

"My efforts in learning spoken English paid off, since 80 per cent of the examination mark relies largely on oral answers.

"Japanese schools taught English writing and reading and very little spoken English,

but I listened regularly to a radio education channel for more than five years to hone my spoken English.

"Most of the education material available in English was produced in the United States, and when I first came to Australia I could not believe they were speaking English. It took a while to get used to what they were saying.

"Patients in Australia and New Zealand are more open and ask questions of their doctors, which they don't do in Japan," Tomoko says.

"Here, there is a better life style and quality of work, which I appreciate.

"Initially, my family – father, mother and brother – were disappointed that I had decided to live in another country, but my mother visited New Zealand recently and after I think they now better understand my choice," Tomoko says.

In her spare time, Dr Tomoko Hara enjoys gardening, and scuba diving, which she has done in several Pacific island nations, and off New Zealand's North Island coast.

Dr Tomoko Hara was among more than 100 new Fellows who formally received their FANZCA from the President, Professor Michael Cousins, at the College Ceremony held during the 2005 ASM in Auckland.



Australian and New Zealand College of Anaesthetists

Robert Orton Medal

Graham Chudleigh Fisk

The Robert Orton Medal is the highest honour the College can award to its Fellows in Anaesthesia. This Award is made at the discretion of the Council, the sole criterion being distinguished service to Anaesthesia.

The following Citation was presented by Associate Professor Kate Leslie at the College Ceremony, for the award of the Robert Orton Medal to **Graham Chudleigh Fisk**.

Dr Graham Fisk is well known for his pioneering work in specialist paediatric anaesthesia and intensive care practice and his broad contribution to education and scientific endeavour in our specialties.

Graham Chudleigh Fisk was born in Sydney in 1928, the son of Sir Ernest Fisk, a pioneer of radio in Australia and one of the founders of AWA, and Florence Chudleigh, a music teacher. He graduated from Oxford University MA (Hons) in Physiology in 1952 and BM BCh in 1953. During this time he rowed for Britain in the coxed fours in the Helsinki Olympic Games. After initial house officer positions at the Middlesex Hospital in London in 1953-4, he was appointed as a Surgical Intern, then as Assistant Resident in Surgery at Bellevue Hospital, New York University, New York.

Following his return to Australia, Dr Fisk commenced training in anaesthesia at the Royal North Shore Hospital in Sydney, obtaining his FFARACS in 1959. This was followed by a period of post-fellowship experience at Guy's Hospital in London where he was actively involved in teaching.

Graham Fisk commenced his distinguished career as a paediatric anaesthetist with his appointment as Honorary Anaesthetist to the Royal Alexandra Hospital for Children in 1960. At this time he also held an honorary appointment at the Royal North Shore Hospital, however, by 1967 he had confined his activities totally to paediatric practice. In 1969 he moved to the Prince of Wales Hospital, Sydney as Director of Paediatric Anaesthesia and subsequently also as Director of Paediatric Intensive Care and was responsible

for the development of paediatric anaesthesia and intensive care services at this institution until his resignation in 1976. The management at Prince of Wales Hospital was supportive of Dr Fisk's diverse activities in research, teaching and the affairs of the Faculty of Anaesthetists and Australian Society of Anaesthetists.

Dr Fisk made major contributions to the development of cardiac anaesthesia and cardiopulmonary bypass techniques, post-operative care, airway management and other intensive care services for children. He undertook clinical and laboratory research, supported by the NHMRC and other grants, and published more than 50 scientific papers in the 1960s and 70s. Like many anaesthetists of his generation, he was an inventor and innovator: he developed a paediatric ventilator and adapted endotracheal tubes for endobronchial use in small babies. He is also remembered as a skilled presenter and chairman at scientific meetings in Australia and abroad and was a member of the ASA's Scientific Program Committee for many years. With T.C.K Brown, he was the author of a major paediatric anaesthesia textbook "Anaesthesia for Children".

Apart from his research contributions, Dr Fisk had a major influence on anaesthesia and intensive care education. He was a member of the Panel of Examiners from 1968-71 and Chairman of the Final Examination Committee from 1975-8. During this time, he undertook a major review of the Faculty's Examination system, introducing modern educational techniques and workshops for Examiners. Graham Fisk was appointed the Faculty's second Lennard Travers Professor in 1975 and used this award to undertake a period of full-time study at the University Teaching Methods Unit of the University of London on the application of educational objectives and methods of assessment.

In his role as Chairman of the Final Examination Committee, Graham Fisk was a driving force behind the creation of the Objectives of Training. This document was one of the first of its kind published by a post-graduate educational body. In this work he collaborated with Dr Don



Harrison, who was the Chairman of the Primary Examination Committee at the time. The Objectives of Training defined for the first time the goals of education and training of the Faculty and formed the basis for the comprehensive modular training program that we have today in the Revised FANZCA Program.

Graham Fisk is mentioned in numerous citations and memoirs as an "inspiration". His "sheer professionalism, skill and dedication" inspired others to follow him into clinical anaesthesia, life-long learning and research. He was a superb clinician, widely known for his airway skills and management of cardiac anaesthesia. He was respected by surgeons and undoubtedly remembered fondly by his patients, of whom he said *"Our patients are people able to respond to and be reassured by kindly handling ... we should be working together ... to create an environment where the child does not feel threatened or neglected."*

Graham was awarded the Faculty of Anaesthetists, RACS Medal in 1990 in recognition of his outstanding contributions to the Faculty of Anaesthetists in the fields of anaesthesia and intensive care. This Orton Medal recognizes his wider contribution to the specialties of Anaesthesia and Intensive Care as a whole.

Dr Fisk's award was accepted by his three sons; Jonathan, Martin and Timothy. Unfortunately, following a fall earlier that day, Dr Fisk was awaiting surgery in the Auckland Hospital. Dr Fisk has made an excellent recovery.



Australian and New Zealand College of Anaesthetists

Robert Orton Medal

John Raymond Archdall Rigg

The following Citation was presented by Dr Walter Thompson at the College Ceremony, for the award of the Robert Orton Medal to **John Raymond Archdall Rigg**.

Associate Professor John Rigg is well known to the anaesthesia communities in Australia and New Zealand and indeed the world as an outstanding clinical investigator, a leader in research methodology and a scientist with both vision and clinical acumen. He conceived, developed and drove the "MASTER Anaesthesia Trial" which has placed Australasia at the forefront of Multicentre Clinical Trials and fostered a whole new generation of clinical investigators.

John Rigg was born in Perth and educated at Scotch College, where he excelled academically, particularly in mathematics. He went on to study medicine at the University of Western Australia, graduating in 1965. His internship and residency years were spent in Perth. In 1968 he moved to Melbourne and he subsequently worked at Prince Henry's Hospital, the Royal Children's Hospital and the Royal Women's Hospital. The move was to have a tremendous impact on his future career. In Melbourne he came under the influence and mentorship of Blair Ritchie, Tom Crankshaw, Kevin McCaul and Ludwig Engel. Blair Ritchie stimulated his interest in research, particularly research into respiration, the control of ventilation and the respiratory aspects of intensive care medicine. Tom Crankshaw sparked his interest in the basic sciences and Kevin McCaul fostered his commitment to obstetric anaesthesia and analgesia. He was admitted to Fellowship of the Faculty of Anaesthetists, the Royal Australasian College of Surgeons in 1969. His first publication appeared in the *British Journal of Anaesthesia* in 1970 and was entitled "The ventilatory response to carbon dioxide during partial paralysis with tubocurarine". During 1970 and 1971 he held visiting and sessional appointments at the Alfred Hospital, Royal Women's Hospital and the Royal Children's Hospital in Melbourne and continued his interest in respiratory research and the ventilatory management of patients in intensive care.

Other significant events at that time were the visits of John Severinghaus and, more particularly, Moran Campbell to Melbourne.

Moran Campbell was instrumental in securing a position for John in the Department of Anaesthesia, headed by Don Catton, at the new McMaster Medical School in Hamilton, Ontario in 1972. With Campbell and Catton as his mentors his interests in anaesthesia and respiratory research flourished. They also encouraged him to become involved with undergraduate teaching at a time when McMaster was leading the world in the development of undergraduate curricula and particularly the move to problem based learning. He established a vibrant research program and received funding from the Medical Research Council of Canada for 8 years in a row, which placed him at the forefront of both anaesthesia and medical research in Canada. In addition to his teaching and research he remained active in clinical anaesthesia and was also instrumental in setting up the Intensive Care Unit at McMaster. While his interests in intensive care were to be overtaken by his growing interests in clinical anaesthesia and respiratory research, the time spent in intensive care did kindle a fascination with the question of "outcomes" after major surgery, which was to become significant at a later date. Also at that time he acquired an interest in Epidemiology and Biostatistics, which was to play an important part in the design and methodology of his later research. In 1977 he was appointed as an Associate Professor and became the Head of the Section of Anaesthesia at McMaster University.

He chaired the Research Committee for the Faculty of Health Science and in 1980 he was the first anaesthetist ever appointed to the Grants Committee of the Medical Research Council of Canada. In the period 1972 to 1981 he was instrumental in the genesis, completion and publication of some 50 research projects and had established McMaster amongst the leading institutions for anaesthesia research in Canada.

In 1979 he was invited to undertake a sabbatical year at Flinders University and that re-acquainted



him with the attractions of living and working in Australia. He returned to McMaster but in 1981 he accepted an invitation to become the inaugural Head of the Centre of Advanced Studies, Division of Health Sciences at the Western Australian Institute of Technology. The establishment of the position was a bold but premature initiative designed to facilitate the evolution of the Institute into a University. John resigned from that position in 1982 and entered private practice anaesthesia in Perth with a major commitment to the King Edward Memorial Hospital for Women as a Visiting Consultant Anaesthetist. He made major contributions to the Clinical Association and to Postgraduate Medical Training at King Edward. He also maintained his interest in epidemiology and research and in 1998 he was appointed Clinical Associate Professor in the School of Population Health at the University of Western Australia. In recent years he has also been the Director of Quality and Safety at St John of God Hospital in Subiaco and has been a member of both the Council of Safety and Quality in Healthcare and the Health Standards Surveillance Council for the Government of Western Australia.

Despite all those important and ongoing contributions, his major contribution has been the establishment and completion of the Multicentre Australian Study of Epidural Anaesthesia (MASTER Anaesthesia Trial). In 1987, following the publication by Yeager, Glass et al of a paper entitled "Epidural anaesthesia and analgesia in high risk patients", John realized that a large randomised and preferably multicentre study would be required to evaluate the role of "epidural block in



improving outcome in high risk patients". While he would be the first to acknowledge the very important help that he received from Konrad Jamrozik, Brendan Silbert, Michael Davies, Paul Myles, Phillip Peyton and many other colleagues in anaesthesia and intensive care in Australia, Canada and the United States there is no doubt that Professor Rigg was the originator, the advocate, the prime mover and the guiding hand behind the MASTER Trial for 14 over years. He facilitated the development of a protocol that balanced the imperatives of science with the realities of clinical anaesthesia. John and his co-investigators managed to secure funding of over \$790,000 from industry, the College, the National Health and Medical Research Council and the Health Department of Western Australia. Between July 1995 and May 2001 they recruited and randomised 920 high-risk surgical patients from 25 hospitals in six countries. The study was completed in 2001 and ultimately the results from 888 patients were

analysed on an intention to treat basis. The seminal article was published in the *Lancet* in 2002. While they were able to demonstrate improved analgesia on day one and after coughing plus a modest reduction in the incidence of respiratory failure in the epidural group, they were unable to demonstrate an improvement in outcomes with epidural analgesia. The MASTER Trial has been recognized both for its rigor and scientific merit and has become a benchmark for the conduct of randomized clinical trials in anaesthesia.

John has recently retired from clinical practice and is justifiably very proud of the fact that the MASTER Trial has fostered a new generation of clinical investigators in Australasia and has been the impetus for the establishment of the ANZCA Clinical Trials Group and the ANZCA Multicentre Clinical Trials Secretariat. He looks forward to spending more time with his wife Alison, their three children plus their families in addition

to pursuing his interests in golf, bush walking, bridge, music and travel. Knowing John, he will also be keeping a watchful eye on the progress of anaesthesia research in Australasia.

Walter Thompson



Australian and New Zealand College of Anaesthetists' Medal

ANZCA Medal

John Michael Gibbs

The Australian and New Zealand College of Anaesthetists' Medal is awarded at the discretion of the Council of the College in recognition of major contributions to the status of anaesthesia, intensive care, pain medicine or related specialties.

The following Citation was presented by Dr Leona Wilson at the College Ceremony, for the award of the Robert Orton Medal to **Professor John Michael Gibbs**.

John was born in Torquay to parents with strong New Zealand connections (and further back penal Tasmanian connections!). He attended school in England and then Auckland at Kings College. He graduated from Otago Medical School in 1958 and after his house surgeon years in Southland Hospital in Invercargill, started his anaesthetic experience there. Formal anaesthetic training was undertaken in Dunedin Hospital and the Nuffield Department in Oxford. He gained his FFARCS in 1964 and FFARACS in 1969. In 1965 he returned to Dunedin from Oxford to take up a specialist position with Dunedin Hospital and an academic position with the University of Otago. In 1973 he spent a year at the Royal Postgraduate Medical School in London but the rest of his academic career was with the University of Otago, initially in Dunedin and later in Christchurch, setting up the academic Department of Anaesthesia in the new Christchurch School of Medicine.

In 1972 John was awarded the Gilbert Brown Prize for his paper "The effects of ketamine on cerebro-spinal fluid pressure" and was appointed as a Primary Examiner (Physiology). Shortly after he was elected to the New Zealand Committee of the then Faculty of Anaesthetists, RACS, chairing it in 1982-4 and starting his life long dedicated service to the Faculty, then the College. During that time he was also the President of the New Zealand Society of Anaesthetists. He was elected to the Board of the Faculty of Anaesthetists which, with our formation into a separate College, became the Council of the College. He served for twelve

years. While a Board Member/Councillor, John fulfilled the roles of Education Officer, Assessor, member of the Executive Committee and Chair of the Hospital Accreditation Committee. He was involved in the initial set up of the Welfare of Anaesthetists Group, and is currently involved in one of the College Taskforces.

John's involvement in teaching anaesthesia was lifelong. As well as his undergraduate teaching duties with the University of Otago, he taught on the Dunedin Primary Examination Revision Course for many years, also teaching in the Brisbane course. In Asia he taught and examined in Malaysia, Singapore and Hong Kong. In 1978 he was the Australasian Visitor to the Australian Society of Anaesthetists Annual Conference. He had many and varied research interests which included investigation into neurolept analgesia, ketamine, humidification of anaesthesia gases, post-operative analgesia and he worked as part of the team investigating anaesthesia and hypoxic pulmonary vasoconstriction.

John was instrumental in raising the profile of anaesthesia in our community. He was the initial Chairman of the Anaesthetic Mortality Assessment Committee and was responsible for its establishment. After its demise, due to the effects of the police obtaining a report to it, he was then involved in trying to develop its successor, work that has not as yet been completed. He was the author of a public statement in New Zealand on the division of responsibility for patient care between surgeons and anaesthetists.

For his work on the Anaesthesia Mortality Assessment Committee and other contributions to the work of the NZSA, he was awarded the NZSA Meritorious Services Award in 1995, only the third recipient of that award. He was the co-author of the history of the NZSA with Basil Hutchinson and Tony Newson.

The medico-legal field was another of John's interests. He was a member of the New Zealand Advisory Panel for the Medical Protection Society,



working with the Society on many cases. He took part in or led inquiries into medico-legal matters at Waipukurau, Middlemore, Whangarei and Rotorua Hospitals.

In all his endeavours, John's involvement was marked by loyalty, fairness and humanity. He was always alive to the personal needs of other people. With College activities John put the needs of the organisation ahead of his own, was intensely loyal and was the ultimate "team player". He has been a mentor to many New Zealand anaesthetists, some of whom have become involved in College's affairs.

Tonight it is my pleasure on behalf of the Australian and New Zealand College of Anaesthetists to recognise John Gibbs's contribution to our profession.

Leona Wilson



Australian and New Zealand College of Anaesthetists' Medal

ANZCA Medal

John Aubrey Henry Williamson, AM OStJ

The following Citation was presented by Associate Professor Tony Weeks at the College Ceremony, for the award of the ANZCA Medal to **John Aubrey Henry Williamson**.

John Williamson was born in Chinchilla, Queensland and, having schooled in Caloundra and at The Southport School, progressed to The University of Queensland. There he met Noeleen, BSc (Hons), his wife of now 43 years, and also gained a full Bachelor of Science in 1960, majoring in biochemistry. He completed his MBBS in 1962 and worked as a First Year Resident Medical Officer at Townsville General Hospital. He then took on responsibilities as Medical Superintendent and worked as a general practitioner in Muttaborra and Aramac Districts, Western Queensland before commencing in private general practice in Innisfail, North Queensland.

He was appointed Anaesthetics Registrar at Royal Melbourne Hospital and then at the Alfred and Royal Children's Hospital Melbourne. In 1970 he was Senior Anaesthetics Registrar at the Royal Women's Hospital Melbourne and mentored by the late Kevin McCaul. He returned to Queensland in 1971 and was Consultant in Anaesthesia and Intensive Care at Townsville General, Townsville Mater, Kirwan Women's and Park Haven Private Hospitals.

John broadened his experience with one year appointments as Consultant in Anaesthetics in South Glamorgan Area Health Authority, South Wales and then as Assistant Professor of Anaesthetics, Saskatoon University Hospital, Saskatchewan, Canada before returning to Townsville in 1978.

During his time in Townsville he was active as a Diving and Hyperbaric Medicine Consultant to the Australian Institute of Marine Science and the Great Barrier Reef Marine Park Authority.

His list of publications demonstrates his extraordinary energy to pursue issues of interest and to share his knowledge for the benefit of the whole community. He has published on topics

including, electrical safety, central venous catheterisation, the Australian box-jellyfish (*Chironex fleckeri*) and other marine envenomations, incident reporting in both anaesthesia and diving, hyperbaric medicine and in the analysis of reports to the Australian Incident Monitoring Study. His publication history is remarkable; 127 papers for which the majority he is first author, seven books and spans 44 years.

In 1990 John moved to Adelaide to take up the position of Director, Hyperbaric Medicine Unit, Department of Anaesthesia and Intensive Care, Royal Adelaide Hospital and in 1996 was appointed Clinical Associate Professor of Anaesthetics. In 1997 he received Honorary Life Memberships of Surf Life Saving Queensland and of its North Barrier Branch.

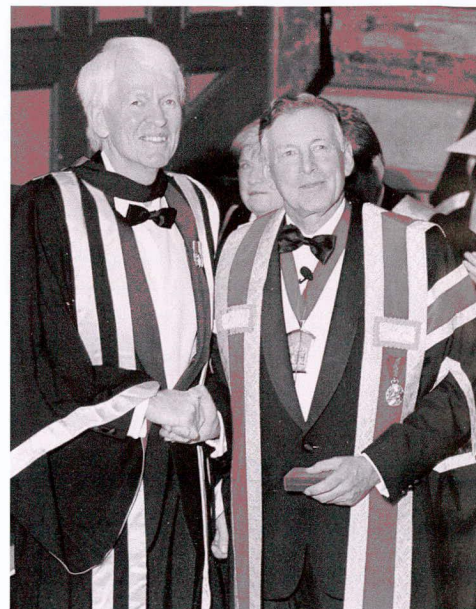
In 1998 he was awarded Membership of the Order of Australia (AM) for services to Surf Life Saving Australia, St John Ambulance Australia, Hyperbaric Medicine and Marine Envenomation.

In addition to these activities, John has been a member of the RAAF Specialist Reserve, serving in Townsville as Senior Medical Officer (SQNLDR), 28SQN, City of Townsville and more recently as Medical Officer (WGCDR), 24SQN, City of Adelaide.

John Williamson has been an outstanding anaesthetist in bringing the skills of anaesthetists to the benefit of the community with his involvement in Surf Lifesaving, in underwater medicine and in the St John Ambulance. His leadership in gaining support for incident monitoring in anaesthesia, hyperbaric medicine and in scuba diving will benefit many patients who will never have the privilege of meeting him. Our specialty would be enriched if more anaesthetists would follow his lead.

Tonight it is our privilege to recognize John Williamson's contribution to our profession.

Tony Weeks





Queensland ANZCA-ASA Combined CME Committee

Evening Lecture Series

Monday 11th April 2005

A new activity recently organised by the Qld Combined CME Committee is a series of 3 Evening Lectures by a visiting speaker, to be held at the Wesley Private Hospital Auditorium in 2005. The meetings are free and CME points are allocated for registered attendees.

The first of these lectures was recently held on Monday 11th April 2005 with guest speaker Dr

David Goodie, VMO Anaesthetist at St George Hospital Sydney. Dr Goodie presented an informative and entertaining lecture on "Bariatric Surgery and Anaesthesia Trick and Traps for the Care of the Morbidly Obese". It was a most enjoyable evening and approximately 40 doctors attended the first meeting with very positive feedback being received. Thanks go to Dr Goodie, the Wesley Private Hospital and to the

sponsor, Abbott Australasia for their support of this event. The next of these lecture evenings is scheduled for 16th August 2005 on 'Medicolegal and Risk Management' and the third lecture will be held in November on a theme to be announced. Details are on the ANZCA, ASA and ACECC calendars. For any further information please contact the College Secretariat Ms Sharon Miethke on qld@anzca.edu.au



Chair of the Qld Combined CME Committee Dr Genevieve Goulding with Guest Speaker Dr David Goodie



Attendees at the lecture evening were (L to R) Drs Ruth Coward, Dinah Blunt, Martina Meyer-Witting and Genevieve Goulding

Retirement from Council

– Dr Mike Martyn

At the June Council Dinner Professor Cousins presented a gift to Dr Mike Martyn, recognising not only his 12 years on Council but his contributions to the College over 20 years. His contributions included Chairman of the Executive, Chairman of the IT Committee, Communications Officer, member of the Tasmanian Regional Committee,

Council Representative to the FPM Board, and ANZCA Representative to the AMA. Dr Martyn and his family presented the College with a painting of Tasmanian Opium Poppies by Amanda Oakes. The painting can be viewed in the Douglas Joseph Room at ANZCA in Melbourne.





Perth Anaesthetists in Groundbreaking Operation

Perth anaesthetists Tanya Farrell and Sharon Smedley were members of the large paediatric surgical team that reimplanted a young boy's hands and one foot after they were severed in a home accident at Easter. The groundbreaking operation, possibly a world first triple reimplant, took place overnight on the Easter weekend at Perth's Princess Margaret Hospital for Children.

Terry Vo, 10 years old, had both hands and his left foot severed when a brick wall supporting a basketball backboard gave way as he "slam-dunked" a basketball at a friend's birthday party.

The three limbs were severed about seven centimetres above the wrists and ankle.

Terry and his hands and foot, in an ice-filled esky, were taken to the hospital by ambulance as three surgical teams - one for each limb - were rapidly put together by Princess Margaret's consultant plastic surgeon Dr Robert Love.

Dr Farrell was on call and was telephoned by Dr Smedley who was assisting at Princess Margaret in an operation on another young boy who had severe injuries. The immediate shared reaction among staff was that "someone has got the emergency information wrong."

There had been previous cases where two limbs had been severed, but not three.

When Terry Vo arrived at the hospital, Dr Farrell recalls that he was composed and fully aware.

"There was not a tear to be seen," Dr Farrell said.

"He was waving his stumps around, and asking the doctors to 'please try to get all my limbs back on.'"

In theatre, Dr Smedley said, the severity of Terry's injuries became a reality when his limbs arrived first, in the container of ice, and work started on cleaning away the brick dust and dirt, and getting them ready for re-attachment.

The two anaesthetists faced the immediate issue of where to insert their essential lines given the



Some of the groundbreaking team at Princess Margaret Hospital for Children. Dr Tanya Farrell (left) Dr Sharon Smedley (2nd from left). Photo courtesy of Ross Swanborough, The Australian, News Limited.

number of people around the operating table. The team included two orthopaedic surgeons, six plastic surgeons, the two anaesthetists, two anaesthetic technicians, and six nurses.

Arterial and central venous lines went into Terry's groin, and adequate IV access was obtained via his neck.

When Terry arrived in theatre, Dr Smedley also noted that, he was "incredibly composed."

"There had been significant blood loss, but with resuscitation his haemodynamic parameters were good," she said.

Other issues in theatre included tourniquet timings, and pain relief for Terry during the simultaneous operations.

With three teams in action, the triple complex microsurgery lasted eight hours.

All three limbs were successfully reimplanted, and they were reported to be "alive and pink". Terry was kept asleep in ICU, as there was a high risk of him returning to surgery in the morning. He was moved to a general ward three days later,

smiling and able to move his fingers and toes. However, a week later, doctors had to amputate his foot when it was found that the muscles were dying.

Terry, now fitted with a primary prosthetic limb, has taken his first tentative, unsupported steps. In late May, he was seen on television news across the nation, smiling and full of his customary good cheer, thanking the medical teams who had looked after him following the accident. His hands are reportedly progressing satisfactorily.

Tanya Farrell and Sharon Smedley remember their first reactions to the news of the emergency, before getting down to the anaesthesia challenge that Easter Saturday night.

"Disbelief" and "surreal" are two words that came to mind then.

Their overall memory, however, is of Terry Vo's strength and calmness, the tremendous response of the medical professionals on the night, and the generosity of hospital staff and the community to Terry during his recovery.



The Geoffrey Kave Museum of Anaesthetic History Report

Showcasing the Museum and College



Ms Elizabeth Triarico
Museum Curator

The Museum is playing an important role in helping to successfully promote ANZCA and the speciality of anaesthesia within the wider community. Interest in the Museum Collection from Rotary and Probus groups from the Glen Waverley area has provided a unique opportunity to showcase the activities of the Museum and College and also promote the work of anaesthetists in general.



Dr Westhorpe welcoming members of the Combined Probus Club of Monash Central to the College. Douglas Joseph Room, Ullimaroo

The interest in the Collection from the first of these community groups came as a direct result of the screening the ABC Catalyst Program, *Awake in Surgery*, which aired on June 17, 2004. The Museum Collection was featured as part of the segment on BIS Monitoring. Following the screening of the program the Museum Curator was contacted by the Secretary of the *Glen Waverley Rotary* group, to arrange a tour of the Museum.

This was the first time that a Rotary group had booked a visit to the Museum. Great care was taken to ensure that the visit would be enjoyable, informative and interesting and, a great deal of effort went into planning the visit and developing the structure of the talk. As the group did not have any prior knowledge of ANZCA or the speciality it was important that the talk included some background on both these topics.

The tour took place on 16 September, 2004. Dr. Rod Westhorpe, the Honorary Museum Curator, welcomed the group to the College and provided a very informative talk on the history of the College, the Museum and also on contemporary anaesthesia in general. The group enjoyed learning about the practice of contemporary anaesthesia and also sharing their experiences as patients undergoing anaesthesia.

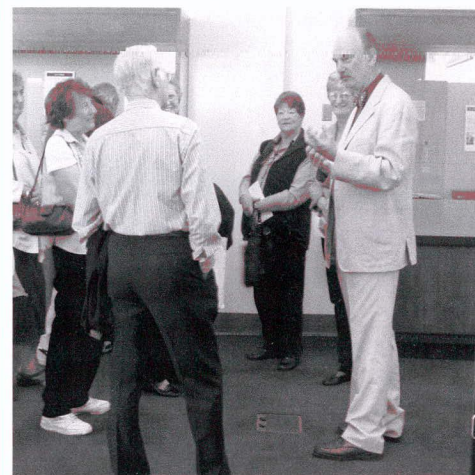


Dr Westhorpe and members of the Combined Probus Club of Monash Central viewing the ANZCA House Foyer Display

The Museum received very positive feedback during and following the visit. According to the thank you letter from the Secretary of the Rotary group the group had a: *most enjoyable and informative visit... We all learned a great deal and the constant flow of questions showed the amount of interest that Dr Westhorpe's talk aroused among our members. We really appreciated your warm hospitality and great morning tea in the lovely surroundings of such a beautiful old building.*

Since this first visit the Museum has hosted tours for members of the Rotary Club of Glen Waverley Inc. and most recently the Combined Probus (professional and business) Club of Monash Central. On April 26 and 28 of this year, the Museum was visited by a total of 35 members of the *Combined Probus Club of Monash Central*. The talk was followed by a tour of the new ANZCA foyer display and the Museum display on Level 5, of ANZCA House.

The visits from Rotary and Probus groups from the Glen Waverley area have been a great success for both the groups and the College. The community groups have all had a very enjoyable experience and have learnt some interesting facts on the development of anaesthesia and the complex work of anaesthetists. Through the activities of the Museum the College has had a unique



Dr Westhorpe and members of the Combined Probus Club of Monash Central Visiting the Museum on Level 5 of ANZCA House

opportunity to promote itself and the work of anaesthetists to an interested general public. The Museum is proud to be able to assist the College in raising a positive profile and gaining valuable support for, anaesthesia and anaesthetists within the wider community. We look forward to many more successful visits from interested groups.

Visits to the Museum displays are welcome and can be made by arranging an appointment with the Museum Curator. All bookings and enquiries regarding the Museum should be directed to, Ms Elizabeth Triarico, Museum Curator on: (61 3) 9510 6299 or etriarico@anzca.edu.au.



ANZCA Regional/National Annual Reports

New Zealand

New Zealand National Committee

Office Bearers and Members

Chair	Dr Peter Cooke
Deputy Chairman	Dr Vaughan Laurenson
Honorary Secretary	A/Prof Jennifer Weller
Honorary Treasurer	Dr Tom Watson
Education Officer	A/Prof. Michael Harrison

A/Prof Jenny Weller, acting Education Officer
February to November 2004

Formal Projects Officer Dr Alastair McGeorge

Committee Members	Dr Vanessa Beavis
	Dr Don Mackie
	Dr Gerard McHugh
	Dr Paul Smeele
	Dr Malcolm Stuart
	Dr Duncan Watts

New Fellows' representatives

Dr Alastair McGeorge 2004
Dr Arthur Rudman 2005

Councillor Dr Leona Wilson

Joint Faculty of Intensive Care Medicine

Representative Dr Ross Freebairn,
Chair, JFICM NZNC

Faculty of Pain Medicine Representative

Dr David Jones

Trainees' Committee-NZ Chair

Dr Marc Adams 2004
Dr Corinne Bennett-Law 2005

NZSA Representative Dr Mark Bukofzer,
President, NZSA

Executive Officer Heather Ann Moodie

Administrative Officer Lorna Berwick

Asst. Administrative Officer, ANZCA
and Administrative Officer, JFICM
Jan Brown



Dr Peter Cooke

Total Number of National Committee Meetings for Year: 3 (2 days each)

Attendance of Elected Members

July 2004

Apologies from A/Prof Michael Harrison (sabbatical), Dr Brent Boon, Dr Sharon King and Dr Tom Watson (overseas)

November 2004

Apologies from A/Prof Michael Harrison (sabbatical)

March 2005

Apologies from Dr Vanessa Beavis and Dr Don Mackie

Dr Tom Watson (one day)

Fog caused travel difficulties resulting in some committee members apologies for:

Two days - Dr Alastair McGeorge and Dr Paul Smeele,

One day - A/Prof Michael Harrison, Dr Vaughan Laurenson

Chairman's Report

Dr Peter Cooke

The New Zealand Committee of ANZCA is formed on a two yearly basis, elections were held in 2004 and the new committee met in July. The retiring members of the committee, Drs Brent Boon, David Jones, Sharon King and Hugh Spencer were acknowledged at the July NZNC meeting and a



Associate Professor Jennifer Weller

vote of thanks was passed in acknowledgement of their contributions over many years.

Dr David Jones maintains an involvement with the committee as a Faculty of Pain Medicine Board member. Our committee is also well supported by our New Zealand councillor, Leona Wilson. The trainee committee was initiated in 2004 and the NZ chair now attends the New Zealand Committee meetings.

Dr Bruce Rudge has been our representative for Standards New Zealand. This has been a significant role that has required review of huge volumes of information. As Bruce steps down from this role, we thank him most sincerely.

The 2004 NZSA/ANZCA Combined New Zealand NZAEC ASM entitled "Crisis in Anaesthesia" was held in Wellington in November. This was a great success and thanks are due to Dr Mark Featherston and his team. The annual meeting of New Zealand Fellows was held during this ASM.

The 2005 Combined NZSA/ANZCA Scientific Meeting, "Infection and the Anaesthetist", will be held in Nelson, 14-17 September and will include the annual meeting of NZ Fellows. I look forward to seeing many colleagues there.

NZNC Communication

GASBAG, the monthly email communication to all New Zealand anaesthetists from the NZNC has now been in circulation for almost four years. It is emailed to all hospital departments. This is a cost effective way of disseminating information from the New Zealand Committee to anaesthetists. Individuals and private anaesthetic groups are welcome to join the mailing list, by contacting the New Zealand office (email address, anzca@anzca.org.nz).



The anaesthesia.org.nz website provides another vehicle for sharing anaesthesia information. This website is currently being redesigned by Dr Richard French on behalf of ANZCA and the NZSA.

Anaesthesia Workforce

This has been one of the main topics that NZNC has discussed over the last year, especially rural anaesthesia services. Discussions on this issue have been held with, and/or submissions made, to the Ministry of Health, the Clinical Training Agency, the Tertiary Education Commission, Medical Council of New Zealand, Royal New Zealand College of General Practitioners, Council of Medical Colleges, Nursing Council, various DHBs and clinical schools.

The New Zealand Committee believes that ANZCA trainees should be offered opportunities to work within rural and provincial environments in New Zealand and that anaesthesia in those environments requires well trained consultants with a wide range of anaesthetic skills. It is a fact that many New Zealand rural and provincial centres offer both vocational and lifestyle opportunities that are hard to beat. It is unfortunate that because training is largely carried out in larger centres of necessity that this acts as a disincentive to new anaesthetic specialists committing to a career in the provinces. We believe that the College has a responsibility to proactively promote rural anaesthesia.

The New Zealand Committee has decided to foster the development of a training program similar to the one provided by the Joint Consultative Committee on Anaesthesia (JCCA). The JCCA is a tripartite committee with representatives from ANZCA, RACGP (Rural Faculty) and the Australian College of Rural and Remote Medicine. The Australian model will require adaptation to the New Zealand environment. Ongoing discussions with the RNZCGP and the University of Otago appear very promising.

The New Zealand National Committee discussion paper, Rural Anaesthetic Workforce Proposal, June 2004, authored principally by Tom Watson and its recommendations have been discussed with the Director General of Health, the Minister of Health and other Ministry of Health officials in order to obtain their support. It is hoped that the recommendations, if followed, will help many District Health Boards improve their rural anaesthesia service.

Medical Council of New Zealand (MCNZ)

NZNC and the office staff work closely with MCNZ in a number of areas, the most significant being the assessment of overseas trained specialists on behalf of the Medical Council. This process has been streamlined over the last few years and a new Memorandum of Understanding was signed this year. I am grateful to our New Zealand Assessor, Dr Vaughan Laurensen, for the time and expertise he gives and to the members of the assessment panel and staff involved.

The MCNZ reviewed ANZCA's application for the re-accreditation of the vocational branch of anaesthesia and in 2004 this was renewed for another 10 years.

The scopes of practice for vocational branches of medicine were reviewed for the Health Practitioners Competence Assurance Act (HPCAA) requirements. ANZCA advised MCNZ of the following wording for the definition of the anaesthesia scope:

Anaesthesia is the provision of anaesthetics, peri-operative care, intensive care and pain management to patients and can include the provision of resuscitation, retrieval/transportation (inter and intra hospital) and hyperbaric medicine to patients. Encompassed in this is the advancement of professional standards, patient safety, education and the advancement of the science and practice of anaesthesia, peri-operative medicine, intensive care and pain medicine.

NZNC members and staff have attended a number of workshops and meetings at the Medical Council, on topics such as cultural competence and cosmetic surgery, as well as preparing submissions on a number of discussion documents.

Council of Medical Colleges (CMC)

The NZNC is an active member of the Council of Medical Colleges and ANZCA is represented on the executive. CMC meets four times a year and maintains correspondence regarding issues that arise between meetings. The CMC is able to provide support to ANZCA with respect to issues affecting anaesthetists. For example, ANZCA has enjoyed both support and wise counsel from other CMC partners with respect to the nurse practitioner issue.

In 2004, CMC held a strategic planning day. Key issues were identified that all colleges were concerned with. To address these issues, colleges were assigned one of four work stream groups to progress ways forward. ANZCA is working on Workstream Three, "Issues Relating to Medical Students, Young Graduates and Trainees".

The CMC Executive recently met with the Director General of Health, Dr Karen Poutasi and senior members of the Ministry team, Drs Gillian Durham, Colin Feek and David Geddis. The purpose of the meeting was to discuss a Memorandum of Understanding that was signed in 1999 between CMC and the Ministry, which had basically lapsed.

CMC's aim is to have more influence on Government policy and to undertake some work on a contractual basis for the Ministry. Indeed this is a modus operandi that many Colleges already utilise.

Another initiative that CMC has facilitated is the formation of a Pan Professional Medical Forum involving the New Zealand Medical Association, the CMC, the Association of Salaried Medical Officers and the Resident Doctors Association.



This grouping (with two representatives from each entity) offers the possibility of effective representation of issues on which the participants have a common position.

Other health-related meetings and workshops

The Chair, Committee members, staff and representatives have attended a variety of health-related meetings and workshops over the last year including:

- Ministry of Health (MoH) – Health Education Workshops and Emerging Infectious Diseases meeting
- Accident Compensation Commission (ACC) – Harm reporting workshop and Interventional Pain Management meetings
- RACS/ANZCA/JFICM/RANZCOG - Perioperative mortality working group meetings
- RNZCGP - Vocational Development Pathway for General Practitioners workshop
- Health Practitioners Competence Assurance (HPCA) Act – Conference, workshop and launch
- New Zealand Anaesthetic Technicians Society - Conference and Executive meetings
- ANZCA - taskforce meetings and a staff workshop
- RACS/ANZCA/NZSA – ‘NZ response to the tsunami disaster’ teleconferences
- Nursing Council of New Zealand – Nurse Practitioner scope of practice
- NZ College of Midwives – Maternity Intervention Rates Forum

Health Practitioners Competence Assurance Act (HPCAA)

This Act came into full effect on 17 September 2004. The Chair attended a social function to mark this event at Parliament on 27 October. In fact ANZCA has supported this legislation with one main reservation. This concern related to the way in which various different health practitioner groups set their own scope of practice, and issues of overlap between groups. This concern was intensified by a scope of practice for nurse practitioners, set by the Nursing Council that appeared to support autonomous practice for nurses within the anaesthetic field. The committee received advice from Chen Palmer & Partners, a Wellington Public

Law Firm on competition law, details of the Regulation Review Act, the parliamentary process, gazetting, the 28-day rule and legal aspects of the Health Practitioner Competence Assurance Act as it relates to scopes of practice.

Many letters and meetings have been held about this issue with the Nursing Council, the Medical Council and many others. It is pleasing to report that at this point the New Zealand Committee is reassured that no sudden changes are imminent. Indeed, it appears that we may have the opportunity to assist with the development of nurse practitioner roles within our field, but in a complementary fashion, as part of our team without compromising standards or patient safety.

NZSA

The New Zealand Committee continues to maintain close links with the New Zealand Society of Anaesthetists. Annual joint meetings occur, the next being in June 2005.

NZAEC

The New Zealand Anaesthesia Education Committee (NZAEC) is now in full operation. This is a joint venture between NZSA and the NZNC of ANZCA. Sharon Barnden has been appointed as the administrative officer and office space is provided at Elliot House in Wellington. The Committee is made up of two members from each of the parent bodies with the President of NZSA and the Chair of NZNC as observers. Dr Ross Kennedy (NZSA) was NZAEC Chair for 2004 and Dr Vaughan Laurenson (NZNC) for the first half of 2005. Other members are Don Mackie (NZNC) and Robyn Chirnside (NZSA). Duncan Watts (NZNC) was on the committee in 2004 and has been coopted for 2005. Key areas of activity that have been progressed during the year are the establishment of a network of meeting convenors to facilitate exchange of information, the formation of a network of those interested in and responsible for providing CME at a departmental level, the maintenance of a database of all CME meetings in NZ (via the ACECC website), and continuing support and ongoing planning of the NZSA/ANZCA combined ASM. A lot of work has been done developing a NZAEC conference manual and this will provide guidance for meeting convenors.

BWT Ritchie Scholarship

The 2004 recipient, Dr Elsa Taylor, has returned to New Zealand after a productive clinical fellowship

year at the Hospital for Sick Children in Toronto. Dr Rebecca de Souza was the successful applicant for 2005 and is currently doing a clinical fellowship specialising in vascular anaesthesia at Addenbrookes Hospital in Cambridge, UK. Both scholars are grateful to the BWT Ritchie Trustees for providing this award to enhance their overseas anaesthesia experiences.

New Zealand Anaesthetic Technicians Society (NZATS)

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

The New Zealand Anaesthetic Technicians Society is preparing an application to obtain registration as Health Practitioners under the terms of the Health Practitioners Competence Assurance Act. ANZCA supports this application.

In Conclusion

It has been a busy year for the New Zealand National Committee. Formal submissions have been made with respect to 20 consultation documents in the course of the year. This takes time and energy but is worth the effort in order to ensure that our perspectives on issues are understood. I would like to acknowledge all the committee members who give freely of their time as well as the many others who contribute to the fellowship, such as examiners, inspectors, lecturers at exam courses and clinicians who provide mentorship and assistance to trainees and peers. It is these activities that keep our college alive and relevant.

Treasurer's Report

Dr Tom Watson

(Year ending 31 December 2004)

The New Zealand Committee expenditure during the year ending 31 December 2004 was up seventeen percent compared with the previous year. Total operating expenditure was \$424,672 (previous year, \$362,401).

Variations in expenditure compared with the 2003 year included:

- Decrease in Melbourne expenses – in the previous year there were more visits to New Zealand by the ANZCA President and CEO.



- Increase in external consultants costs - related to the Health Practitioners Competence Assurance Act and the Nurse Practitioner scope of practice issue
- Increase in staff expenses – salary adjustments as advised by Melbourne
- Increase in CECANZ Share of Costs – closure of CECANZ accounts - final adjustments from the previous two years
- Increase in JFICM costs – offset by the increased JFICM income from trainees fees
- Increase in 'other meeting' expenses – CMC levy increase, more hospital inspections and greater number of Wellington meetings attended by NZNC members

The CME and Pre-Fellowship Training accounts are stable with both closing balances slightly greater than the previous year.

The subscription account receipts are up by nearly 50% due to the increase in the number of Annual Training Fees and also income from SIG meetings held in New Zealand which now come through the New Zealand Office ledgers.

The total assets of the committee are \$154,261 with fixed assets amounting to \$79,484.

National Education Officer's Report

Assoc. Professor Michael Harrison

Revised FANZCA Program

The revised FANZCA Program has been implemented in New Zealand, and discussions regarding the implementation have taken place at teleconferences of NZ Supervisors of Training and the NZ Trainees' Committee.

Training schemes:

A document on the NZ rotations is being prepared at present.

Trainees' Committee, NZ

2004

The trainees' committee for 2004 comprised: Dr Marc Adams (Chair), Dr Martin Misur, Dr Richard Sullivan, Dr Pierre Botha, Dr Andy Cameron, Dr Grant Hounsell, Dr Corinne Bennett-Law, Dr Jenny Weller (Acting EO, NZ),

Dr Peter Cooke (Chair, NZ National Committee) and Lorna Berwick (ANZCA).

Four teleconferences were held throughout 2004.

2005

The first teleconference of the 2005 committee has recently taken place. Members of the 2005 committee are: Dr Corinne Bennett-Law (Chair), Dr Pierre Botha, Dr Richard Sullivan, Dr Grant Hounsell, Dr Heidi Walker, Dr Darren Cathcart, A/Prof Michael Harrison (EO, NZ), Dr Peter Cooke, (Chair, NZ National Committee) and Lorna Berwick (ANZCA).

Supervisors of Training:

Education sub-committee meeting

The annual teleconference of the education sub committee was held in March 2005.

Present were 11 Supervisors of training, Dr Bennett-Law (Chair, trainees' committee), Ass/Prof Michael Harrison, E O and Dr Peter Cooke, Chair, NZNC.

Supervisors due for re-appointments in 2004

TE5 was used as a reference for assessing the SoTs for reappointment, and Melbourne advised accordingly.

Supervisors - Long Service Certificates

A list of supervisors due for Long Service Certificates in 2004 was drafted and the following awards were presented: Dr D Goodall, Dr A Roberts, Dr B Hodgkinson, and Dr Peter Lloyd.

New SoTs

Dr A McKenzie, Dr D Williams and Dr J Ooshuisen

Module Supervisors

Most Departments have informed the office of the names of the supervisors. A request for updated information was sent in April.

Rotational Supervisors:

Dr Malcolm Futter - Northern rotation
Dr Deborah Goodall - Southern rotation
Dr Chris Thorn - Wellington rotation

Clinical Teachers Course

ANZCA has developed a Clinical Teachers Course

that will be offered in New Zealand and around Australia. The first course in New Zealand was held at Elliott House prior to the Wellington NZAEC ASM in November. The following supervisors attended:

Dr Debbie Goodall (Christchurch, SoT)
Dr Chris Smit (Middlemore, module supervisor)
Dr Duncan Watts (Dunedin, SoT)
Dr Frances Beswick (Timaru, module supervisor)
Dr Cam Buchanan (Waikato, module supervisor)
Dr Ben Johnston (Tauranga, module supervisor)
Dr Cornelius Kruger (Greenlane/Auckland, SoT)
Dr Chris Thorn (Wellington, SoT)

Trainee database

The attempt to create a spreadsheet detailing the location of each trainee in New Zealand has continued this year. The movement between hospitals is not easy to track and with part-timers (job-sharing) / locums, maternity/paternity leave and such like it is not an easy task to keep it up to date. I would like to thank those SoTs who have responded to my requests for details.

Hospital inspections

Hospitals have been inspected and re-inspected, and hospitals have been accredited for training anaesthetists. The New Zealand EO has not been directly involved in these in 2004, but is kept informed of developments.

New Zealand Courses:

*Part I FANZCA Course - Christchurch
Course dates: February 2004*

*Part II Revision Course – Wellington
Course in Medical Assessment
for the Final FANZCA Examination
Course dates: April and August 2004*

*Part I FANZCA Course – Hamilton
Course dates: May/June 2004*

*Part II Revision Course – Auckland
Course dates: June /July 2004*

Sabbatical

Acting Education Officer – A/Prof Michael Harrison was out of the country for nine months from 21 February 2004. NZNC agreed that Dr Jenny Weller would be appointed as the interim Education Officer for this period. I would like to thank her for stepping into this role in my absence.



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

Formal Project Officer's Report

Dr Alastair McGeorge

01/04/2004 - 31/03/2005

The year passed with a constant stream of Projects being submitted for initial registration and final assessment. It was very pleasing to see a number of projects of a very high standard. The idea of a New Zealand Formal Project Prize was resuscitated and this year's winner is Dr Steven Fowler.

Unfortunately, despite constant reminders a significant number of trainees are submitting their projects at the end of their 5 years of training expecting to get an instant answer so that they can obtain Fellowship. Trainees need to be encouraged to complete their Formal Projects well before they complete their training time. Finally I would like to express a special thanks to all the reviewers from around the country who give up their valuable time.

Amitha Abeysekera

Drug error in anaesthetic practice: a review of 896 reports from the Australasian Incident Monitoring Study database.

Mark Adams

Informed Consent in the New Zealand Environment

Brendon Bigwood

Brugada Syndrome following Tricyclic Antidepressant Overdose

Pierre Bradley

PICC Line Survey and Theatre Utilisation

Jane Calder

Supplementary Oxygen Administration for Caesarean section under regional anaesthesia

Andrew Cameron

Management of a Parturient with Respiratory Failure Secondary to Cystic Fibrosis

Miriam Canham

The implementation of an anaesthesia trainee intern programme

Mark Chaddock

The Influence of Obesity, Diabetes and Ethnicity on outcome in a General ICU

Warren Chazan

Prion Disease Transmission: Risk/Benefit Analysis of Reusable Laryngeal Mask Airways

Amanda Dawson

Fibreoptic Intubation Skills : National Anaesthetic Workforce Survey

Simeon Eaton

The Atypical Antipsychotics : A Review of the Pharmacology and Clinical Implications for Anaesthesia

Kevin Elks

A study of Anxiety during minor surgery in patients attending the A&E Department BMedSci in Anaesthesia

Kevin Elliott

A Comparison of electromyography and acceleromyography at sub maximal stimulation to assess neuromuscular function

Steven Fowler

Provision for Major Obstetric Haemorrhage: an Australian and New Zealand Survey and Review

Lewis Holford

Med School BSC

Zamil Karim

Perioperative Beta Blocker Use by New Zealand Anaesthetists

David Moore

Drug patient information leaflets in anaesthesia: effect on anxiety and patient satisfaction

Juliet Nayagam

Fatal Systemic Air Embolism during ERCP

Subita Nobre

A Survey of The Early Management of Severe Head Injury

Joanne Paver

Thromboelastography in Burn Injured Patients

Ian Smith

Pelvic Diastasis from the Saddle : Not to be Forgotten

Vera Spika

An Outcome Audit of Patients Excluded from POISE Recruitment because of Chronic Beta Blocker Therapy

Amuntha Vinayagamoorthy

The use of an accidentally placed intrathecal epidural catheter for labour analgesia and delivery

Brent Waldron

Audit of Cell Saver use in a Major Teaching Hospital

Eldon Ward

Repeatability of Measurements Using Wideband External Pulse Monitor

Andrew Wong

Comparison of a Radiant Patient Warming Device with Forced Air Warming During Laparoscopic Cholecystectomy

Peter Cooke

Chair, NZNC Formal Projects



ANZCA Regional/National Annual Reports

Tasmania

Tasmanian Regional Committee

Office Bearers and Members

<i>Chair</i>	Dr Phil Browne
<i>Deputy Chair</i>	Dr Mark Reeves
<i>Secretary</i>	Dr Daniella Eugster
<i>Treasurer</i>	Dr Richard Waldron

Regional Education Officer

Dr Mike Grubb
Dr David Brown
Dr Margaret Walker

Council Representative Dr Mike Martyn

Activities in 2005 have included:

- Reviewing ANZCA policy documents
- Input into TASM (surgical mortality reporting)
- Involvement in ANZCA task forces set up by President Michael Cousins.

Daniella Eugster has moved to Darwin for 2005. We thank her for her input to the Regional Committee.

It has become apparent that the role of treasurer is largely unnecessary now that all finances are run by ANZCA in Melbourne. Reporting of Tasmanian accounts from Melbourne has improved (it was previously nonexistent) due to Richard Waldron's efforts. Transfer of Tasmanian funds to the Federal ASA occurred in March without any consultation with the Tasmanian Regional Committee. Richard has pursued this with the result that communication has improved.

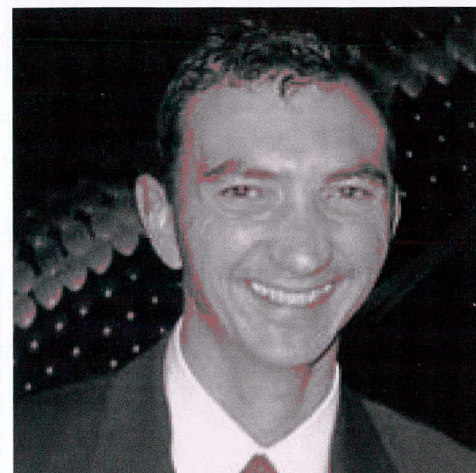
CME activities in 2004 included a successful annual meeting at Cradle Mountain run by Jeremy Wallace and Richard Waldron. Paul Myles returned to Tasmanian as Australasian visitor in May.

Training issues. The revised FANZCA was implemented under the guidance of the supervisors of training. Registrars performed well in First part examinations and a number of formal projects were completed.

ANZCA has input into medical workforce planning through the involvement of Richard Smith in a State Government Medical Workforce committee. Staff numbers and remuneration issues are currently issues under consideration. Resignations of specialist surgeons may affect sub-specialist training of anaesthetic registrars in Tasmania.

The next elections for places on the regional committee are due in February 2006.

Phil Browne
Chair



Dr Phil Browne

ANZCA GOLF DAY

Formosa Country Club
Auckland, New Zealand
9th May 2005

Longest Drive

Bruce Kinloch (Vic)

Nearest the Pin

Rowan Hyde

Four Ball, Better Ball Winners

Peter Moran (Qld)
Larry McNicol (Vic)

ANZCA Trophy, Individual Par Competition

Winner Peter Moran (Qld)
Runnerup Glenn Downey (Vic)



ANZCA Regional/National Annual Reports

New South Wales

New South Wales Regional Committee

Annual Report April 2004 to March, 2005

Office Bearers and Members

<i>Chair</i>	Dr Michael Jones
<i>Deputy Chair</i>	A/Prof Anthony Quail
<i>Regional Education Officer</i>	Dr Ross Kerridge
<i>Formal Project Officer</i>	Dr Richard Morris
<i>Continuing Education Officer</i>	Dr Matthew Crawford

Committee Members

Meeting Attendance

Total No. of Regional Committee Meetings for Year:	6
Dr Michael Amos	6 of 6
Dr Margaret Bailey	5 of 6
Dr Stephen Barratt	6 of 6
Dr Matthew Crawford	1 of 1
Dr Richard Halliwell	5 of 6
Dr Michael Jones	6 of 6
Dr Ross Kerridge	5 of 6
Dr Frank Moloney	1 of 1
Dr Richard Morris	4 of 6
Dr Blair Munford	3 of 6
Dr Greg O'Sullivan	6 of 6
A/Prof Tony Quail	4 of 6
Dr Joanna Sutherland	6 of 6
Dr Tracey Tay	5 of 6

Ex-Officio Members

<i>Councillors</i>	Prof Michael Cousins
<i>ASA Representative</i>	Dr Elizabeth Feeney
<i>New Fellows Representative</i>	Dr Lisa De Gabrielle

Course Organizer Primary Dr Peter Kam

Course Organizer Final Fellowship:
Dr Tim McCulloch

Representatives on External Committees

Dr Stephen Barratt
Medical Training and Education Council,
NSW Health

Dr Michael Jones
Committee of Chairmen of NSW
State Committees of Medical Colleges

Standing Committee of College Chairmen
NSW State Committee,
Royal Australian College of Surgeons

Committee of Management,
Australian Society of Anaesthetists

Assistant Editor, Australasian Anaesthesia

Dr Ross Kerridge
NSW Medical Training and Education Council
(MTEC)

Clinical Chair, Critical Care Diagnoses Stream,
MTEC

Assoc Prof Anthony Quail
Board of The Hunter Postgraduate Medical
Institute

Regional Administrative Officer

Janice Taylor

Administrative Assistant/Course Secretary:

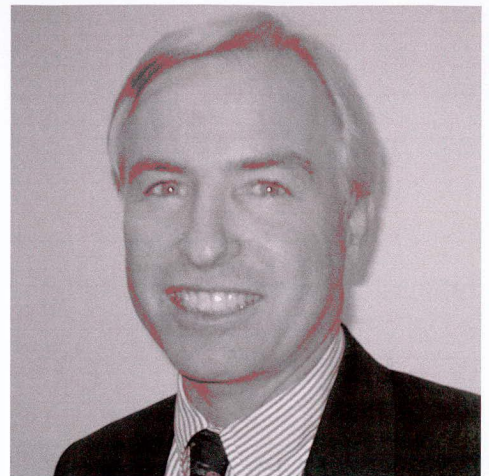
Annette Strauss

Offices and Secretariat

117 Alexander Street,
Crows Nest NSW 2065

The last twelve months have seen a number of developments in NSW with regard to Anaesthesia Training.

The changes brought about by the revised arrangements for training (the 'revised FANZCA') have been gradually bedding down across training centres. The training modules are becoming better understood, and hospitals are developing systems for ensuring all trainees are



Dr Michael Jones

appropriately qualified in each module. This is very much a development in a state of evolution, and their remains areas of lack of familiarity and clarity. It is clear, however, that the workload of supervisors of training is increasing, particularly the administrative/organisational tasks associated with organising networks of trainees, and ensuring all trainees receive regular assessment and feedback.

The change from accrediting specific numbers of training positions to accrediting hospitals has opened the way for accredited training positions to be created that are associated with a defined training pathway. Inevitably, a number of these positions have been established (although most hospitals have tried to avoid this.) New developments such as MTEC (see later) may prevent this problem becoming excessive, but there have already been some trainees disappointed to find that their training time may be longer than they hoped, despite having accredited time in generalist anaesthesia or ICU positions.

A large number of new accredited rural positions were created as a result of negotiations between the NSW Regional Committee and the Department of Health in 2002. It is hoped that in the future this initiative will contribute to helping the rural specialist workforce challenge. This initiative was recently reviewed for NSW Health, and was generally regarded very favourably. The positive contribution (as problem solvers), by anaesthetists and our College, was also noted.

The increased load of trainees passing through paediatric hospitals is a major logistical and educational challenge for the specialists there, and has required change and flexibility on their



part. The Regional Committee has included comment on this challenge in the review of the rural anaesthesia training initiative.

A Trainees Committee has been established with a view to providing input from trainees to both the NSW Regional Committee, and to the College Council. The profile and recognition of the committee needs to become greater. Fellows should encourage trainees to become actively involved with the trainees' committee.

The traditional 'primary' and 'part two' courses conducted by the College have been extensively reviewed by Tracey Tay, Tim McCulloch and Mark Priestley. The 'short' courses have become much more popular, attracting attendees from across Australia and internationally. The long courses require major change. The use of teleconferencing to deliver these courses particularly to trainees in smaller or rural hospitals, is likely to become much more common.

Perhaps the most important change in the near future will be the development of MTEC (the Medical Training & Education Council). This has been established as a Ministerial Council – meaning it reports directly to the Minister, and is separate from NSW Health. MTEC is reviewing the system for medical specialist training of all disciplines in NSW. It has already produced major changes in physicians training. Starting from this year, all physician training is conducted in structured networks which include tertiary, metropolitan and rural hospitals. This was a controversial change, but is perceived to have been a great success. Notably, considerable resources, such as 'dedicated' administrative support and paid time for network supervisors, was provided to assist this change.

MTEC is now aiming to review specialist training in other areas, broadly grouped as procedural (surgery); consultative (psychiatry, rehabilitation, etc); and critical care (emergency, anaesthesia, intensive care etc). Within the latter group, Emergency Medicine training has priority for

review, but anaesthesia will be reviewed. It can be anticipated that MTEC's desired outcome will include a structured approach to training in rotational networks where all trainees have a clear training pathway. In this regard, anaesthesia has been recognised by MTEC as being close to the desired model of training already. MTEC will also be taking an interest in the system of training for CMOs (less specialised medical staff) in critical care areas. It is clear that the work of MTEC will have a great influence on the NSW medical workforce in the future. I have recently been appointed to the position of Chair of the Critical Care stream for MTEC, and look forward to playing a part in these developments.

I have been NSW REO since 1995, which has been a period of interesting change. During this time, I was particularly satisfied by helping increase rural training positions, and bring more equity to the provision of paediatric anaesthesia experience for trainees. I have now resigned as REO. I would like to thank Jan Taylor and the Regional Committee for their support during my tenure, and welcome Tracey Tay as incoming REO. I know Tracey will fulfil this role well.

Formal Projects

Dr Richard Morris

This year 36 formal projects were successfully completed. Only 2 required any revision, with 1 still to be resubmitted. 41 new proposals were submitted on a wide range of interesting topics. The pool of reviewers has been further enlarged with several younger reviewers taking on the task with enthusiasm.

These 36 formal projects were –

1 Gisele Mouret

Stress in a graduate medical degree

2 Jamie McCarney

Sterilisation and Disinfection of Anaesthetic Equipment: A Review

3 Ravi Walpitagama

The use of magnesium sulphate in the perioperative control of hypertension during pheochromocytoma resection

4 Aparna Bhatt

Nerve Growth Factor: Physiology and its role in Pain Medicine

5 Kar-Soon Lim

Chlorhexidine - pharmacology and clinical implications

6 Veronica Payne

Mast Cell Tryptase: A Review Of Its Physiology and Clinical Significance

7 Priya Kumaradeva

Anaesthesia for lower limb surgery in a patient with Charcot-Marie-Tooth disease

8 Gianpiero Traini

Parasaid Study: Analgesic efficacy of paracetamol when added to diclofenac, following lower abdominal surgery

9 Ranjan Chaminda Perera

An Unusual Case Of Hyperkalemic Cardiac Arrest

10 Johnny Petrovski

Streptococcus Infection Causing Mediastinitis, Pericarditis, And Empyema Thoracis

11 Mark Duane

Lung Function Following Cardiac Surgery is not Affected by Postoperative Ventilation Time

12 Adam Osomanski

Design of a Medical Retrieval Bridge: A Case Study in Human Factors Engineering

13 John Leydon

VT arrest in a 3 year old child secondary to raised intracranial pressure and brainstem compression



- 14 Robert Newland**
A survey of the Anaesthetic Registrars that have passed through Westmead Hospital in the last 20 years (1979-1998)
- 15 Anne-Marie Aders**
Anaesthetic Adverse Incident Reports: An Australian 5 Year Study of 1,231 Outcomes
- 16 Lloyd Smail**
Post Anaesthetic Shivering - A literature review
- 17 Simon Hanning**
A Randomised Cross-over Study to Compare the Oropharyngeal Leak Pressures of Two Different Laryngeal Mask Airways
- 18 Timothy Stavrakis**
Audit of Anaesthetic Technique at the Royal Hospital for Women during 2003
- 19 Simon Pattullo**
Airway Assessment and Management: An Audit of Current Practice in Intensive Care and Emergency Medicine
- 20 Helen Nicol**
Audit of Surgical Antibiotic Prophylaxis
- 21 Kirsten Morgan**
Pre-Hospital Trauma Course Manual
- 22 Matthew Griffiths**
Ultrasound Guided Deep Cervical Plexus Block
- 23 Jonathan Gibson**
Awareness in Retrieval Medicine: A Case Report
- 24 Martin Bohm**
Thiazolidinediones: A New Insulin-Sensitising Class of Drugs. Their use in insulin - resistant states and relevance to perioperative management
- 25 James Chee**
Effect of intraoperatively administered ondansetron on postoperative antiemetic requirements after laparoscopic cholecystectomy
- 26 Don Lu**
Peripartum Epidural Tip Culture Clinical Audit
- 27 Kate Pennington**
Perioperative Use Of Parenteral Paracetamol In Children - A Review
- 28 Leonard Lum**
Bowel cleansing agents. Pharmacology and anaesthetic implications
- 29 James Lui**
Case Report: Anaesthetic management of a patient with Somatostatinoma for resection with a critical review of the literature on this disease
- 30 Tod Eggleton**
Posterior Lumbar Plexus Block for Total Knee Replacement and Total Hip Replacement - A Review
- 31 Roger Pye**
Genetic Polymorphisms and coronary Artery Disease
- 32 Navkiran Kaur**
Review Article: Direct thrombin inhibitors
- 33 Geoffrey Silk**
A case report of axillary artery injury and potentially life-threatening upper airway obstruction + literature review of airway obstruction due to haemorrhage external to the airway + case report and literature review of massive blood transfusion in trauma
- 34 Erin Cook**
Post-thoracotomy analgesia - a systematic literature review and recommendations for practice
- 35 Christopher Ashley**
Transoesophageal echocardiography for anaesthetic registrars
- 36 Andrew Wright**
Masters of Business Administration

Continuing Education

Dr Matthew Crawford, Chairman NSWACE

The past year was a quiet period for the NSWACE in terms of conferences. Only two were held due to the World Congress of Anaesthesia making it difficult to hold a meeting in early May. Our meetings conform to a consistent pattern of introducing the subject matter often with

speakers from different disciplines to give us a general update on what is occurring in that field, even if it does not have direct relevance to anaesthesia practice.

As such our first meeting was the 'Rural' meeting held at the Hunter Valley Gardens. It was held on the 3rd-4th of July and was entitled 'Up to speed with trauma' and attracted just under one hundred delegates, who were held spellbound by a number of our speakers, in particular Mr Justin McGuire from the NSW Roads & Traffic Authority. He had some impressive video clips regarding crash testing of cars, trucks and safety barriers as well as the general philosophy of how to reduce road deaths. The numbers for this meeting were somewhat reduced as it clashed with the SPANZA meeting, and it seems that ACEC, ANZCA and SPANZA are still not adequately communicating about the timing of meetings to be held. The problem will occur again this year, despite the simple solution of communication being readily available.

Our second meeting was on the 6th of November and was held at the Sheraton on the Park Hotel in Sydney. The theme was 'Current perspectives in ENT Surgery' and attracted well over 270 registrants. This was an extremely successful meeting as virtually every anaesthetist has some part of their week allocated to ENT surgery. It was a very lively meeting with lots of discussion and input from the audience, particularly in the workshops. The insights that Bruce Benjamin and Neroli Best gave into the development of current ENT surgery and anaesthesia practice were invaluable.

The regular Anatomical workshop was held on the 27th of November and was filled to capacity as usual with 50 registrants. We are very thankful for the expert guidance of Joe McGuinness and Liz O'Hare in running these meetings and to Peter Mills and the Department of Anatomy and Histology at the University of Sydney.

Our committee membership has changed over the past year with the resignation of Michael Jones, to take up the role of Chairman of the NSW Regional Committee of ANZCA. He has been replaced by the very talented Chris Jones, who will be convening our next meeting in Sydney at the end of April 2005 with Mark Priestley. The present committee is Matthew Crawford, Peter Isert, Chris Jones, Ed Loughman, Mark Priestley and Leonie Watterson.



Should you, as a practitioner, have a topic that you think is worthy of a meeting, we would be more than happy to hear from you, either by email to nsw@anzca.edu.au or via mail to the NSW Office of ANZCA.

Professional Affairs

Dr Michael Jones, Chairman

2004 saw the end of an era for the NSW Regional Committee with Drs Frank Moloney and Matthew Crawford leaving after the usual 12 years of hard labour! Both were previous Chairmen of the Committee and had provided an enormous contribution to College affairs. Guests at their farewell dinner included Professor Richard and Mrs Vivienne Walsh, Professor Greg and Mrs Mary Ann Knoblanche (Professor Michael Cousins was an apology) and Mrs Joan and Mr Noel Sheales. This was a terrific night which we combined with Dr Liz Feeney and the ASA to also farewell Dr Greg Purcell. The sage (and blunt!) advice of Frank and Matthew will be greatly missed.

Following elections in June 2004 the Regional Committee was fortunate to have Drs Tracey Tay and Blair Munford join our group. Both already have an impressive background in College affairs and we welcome them.

Much of the last 12 months continued to be dominated by major workforce issues that include Area of Need. Whilst good co-operation does occur between NSW Health, Area Health Services and ANZCA, a significant number of vexacious concerns and difficulties remain. In addition, a restructuring of NSW Health has seen a number of taskforces set up with the ANZCA nominees Drs Ross Kerridge, Roger Traill, Liz Feeney and Frank Moloney joining 5 of these working groups.

As expected, the bulk of other activities related to hospital inspections and OTS assessments. Drs Ross Kerridge and Stephen Barratt have had increasing involvement with the Medical Training and Education Council of NSW (MTEC). This body seems to be developing ever-widening interests and authority and the inputs of Ross and Stephen have been considerable.

There have been some significant changes to ANZCA courses in NSW. The newly designed

2nd Part Long Course has been an outstanding success, mainly due to the contributions of Dr Tim McCulloch, Tracey Tay, Mark Priestley and Michael Rose. Using a PBL template, they have introduced a totally new approach to this course. The Primary Long Course, however, has seen its numbers decline and it has been decided to cease this activity. Instead, Professor Peter Kam has agreed to run his Primary Revision Course twice a year. This Short Course has seen a large growth in registrants from approx 35 – 65 over the last 3 years. Approximately 20% of these registrants come from overseas and about 50% from outside of NSW.

As usual Jan Taylor and Annette Strauss have provided expert secretarial assistance and I thank them and the whole of the NSW Regional Committee for their considerable efforts in 2004.

Michael Jones

Chairman



ANZCA Regional/National Annual Reports

Victoria

Victorian Regional Committee

Annual Report May 2004-April 2005

Office Bearers and Members

Chairman Dr Rowan Molnar
(Resigned 10/04)

Deputy Chairman / Chairman
Dr Peter McCall
(10/4 – 03/05)

Deputy Chairman / Honorary Secretary
Dr Winifred Burnett

Honorary Treasurer / Continuing Medical
Education / IT Dr Rowan Thomas

Formal Project Officer Dr Elizabeth Ashwood

Regional Education Officer
Dr David Bain
(Resigned 03/05)

3rd Year Training Liaison: Dr Andrew Buettner

AMA Representative / Social Officer
Dr Richard Horton

Assistant CME Officer Dr Craig Noonan

Safety Officer Dr Rod Tayler

Paramedical Personnel Dr Daryl Williams

Ex-Officio Members

A/Prof Kate Leslie
Councillor
A/Prof Tony Weeks
Councillor
Dr Rod Westhorpe
Councillor

Co-Opted

Prof Paddy Dewan
Royal Australasian College of Surgeons (Resigned
3/05)

Dr Patricia Mackay
Consultative Council on Anaesthetic
Mortality and Morbidity

Dr Simon Reilly
Australian Society of Anaesthetists Representative

Dr Craig French
Joint Faculty of Intensive Care Medicine
Representative

Dr Julia Fleming
Faculty of Pain Medicine Representative

Dr Reny Segal
New Fellow (from 11/10/04)

Dr Fred Rosewarne
Rural Officer (from 19/7/04)

Dr Annabel Orr
Trainee Issues (from 19/7/04)

Dr Maggie Wong
Co-opted Member (Obstetrics) (from 11/10/04)

Administrative Officer Corinne Millane

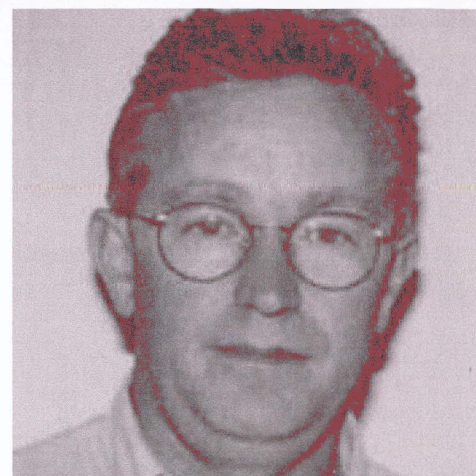
Total number of Regional Committee Meetings
for Year: 2004 = 11 2005 = 2

Attendances of Elected Members

Dr Ashwood	9/11
Dr Bain	10/11
Dr Buettner	7/10
Dr Burnett	7/11
Dr Horton	6/10
Dr Noonan	10/10
Dr McCall	7/11
Dr Molnar	7/7
Dr Tayler	11/11
Dr Thomas	8/11
Dr D Williams	8/10

Introduction

The membership of the VRC has undergone significant change. There are four new Members: Andrew Buettner, Richard Horton, Craig Noonan and Daryl Williams. There are also four new Co-opted Members: Annabel Orr, Fred Rosewarne, Reny Segal and Maggie Wong. Regrettably Sesto Cairo, Co-opted New Fellow, and Andrew Haughton, Co-opted Rural Officer did not



Dr Peter McCall

nominate for election; Mark Buckland (10 years) and Alison Lilley (2 years) did not re-nominate due to work and personal commitments. Having served 12 years Mark Fajgman and Philip Ragg were not eligible to re-nominate. Resignations were received from Rowan Molnar and David Bain during the year. Each of these Fellows has made important contributions and their combined experience will be missed in the future.

As with past years the VRC has carried out its core business of conducting CME and training for Fellows and Trainees including numerous College functions in Victoria.

Consultative Council on Anaesthetic Mortality and Morbidity (CCAMM)

In 2004 the Council met on 12 occasions and reviewed a total of 128 cases including 60 cases of mortality and 68 cases of morbidity. 55 of these cases were referred from quality assurance programs of public hospital anaesthetic departments. 15 cases of mortality were considered to be anaesthesia related and it is noteworthy that in 15 of these cases the medical condition of the patient was a significant factor. In 8 of these cases some organizational issues were identified as being contributory but, with the exception of 1 case, not the sole cause.

Of the 68 cases of morbidity 9 were classified as critical incidents and 45 were considered anaesthesia related. Organisational factors were identified in 14 cases. There were also 7 Sentinel Events referred by the Department of Human Services but in all but 1 the Council did not consider there was any useful clinical information to enable it to provide any opinion.



In October 2004, under new guidelines issued by the Department of Human Services, a new enlarged Council was appointed for 3 years. The new Council consists of 4 representatives of other specialist organizations as well as 15 anaesthetists with wide-ranging subspecialty expertise. In April 2005 Dr Patricia Mackay will retire as Chairman, and the Minister has appointed A/Prof Larry McNicol as the new Chairman. Dr Mackay will remain on the Council as "Emeritus Consultant".

Over the past year the Council has been involved in considerable activity with the production of the triennial report and continuing development of the web site which is now widely consulted. There has also been extensive involvement in the new web-based reporting and database program which it is hoped will be functioning in the near future and will facilitate better and easier reporting as well as rapid feedback and better Council management processes.

Victorian Doctors Health Program

The role of the VDHP is to support and assess doctors and medical students with illnesses and then refer them to appropriately qualified specialists and experts to formulate a management program for their illness: physical, mental or alcohol or drug addiction. Ultimately, the aim is to change doctors' culture, with respect to illness, so that all problems are diagnosed and treated early: before they have an impact on the family, patients and possibly result in a request to present to the Medical Practitioners Board.

All consultations are confidential, and the Medical Practitioners Board is not notified of doctors presenting to the VDHP.

The VDHP considers it essential that all doctors and medical students have their own general practitioner or physician, and have an annual check-up, to ensure early diagnosis and treatment of any illness or substance abuse.

In early 2005 an independent review of the VDHP was conducted; the reviewers were very

impressed with the program and what had been achieved since its establishment in 2001. Recommendations made in the Review are being addressed.

Education

Introduction of Revised FANZCA

With the ongoing support of the College, the FANZCA program continues its consolidation as a training program. Progress has been smooth with few problems in our region. Supervisors of Training and Module Supervisors have adapted extremely well to the "new" system and Trainees have successfully completed a year covered by the FANZCA program.

The first of the College's Clinical Teachers Courses to be run in Victoria this year will be the Assessment Module. The Supervisors of Training workshop at the ANZCA ASM in Auckland will focus on In-Training Assessment. These courses and others will provide further valuable support for Supervisors and Fellows involved in the assessment of Trainees.

Annual Anaesthetic Registrars' Scientific Meeting

The Annual Registrars' Scientific Meeting was held on July 16th, 2004 at ANZCA House and continues to enjoy strong support from Fellows and Trainees. Again the standard of research, presentation and ensuing discussion was excellent. The prize, kindly sponsored by AstraZeneca Pty Ltd, was awarded to Dr Tony Keeble for his presentation "Temperature management during interhospital transfer of intubated patients: A comparison of passive versus active warming".

Victorian Trainee Committee (VTC)

The first Victorian Trainee Committee (VTC) completed a successful term with Annabel Orr as Chairperson. The findings of a survey of Trainees were presented to the Victorian Regional Committee and provided valuable feedback for the College. The major issue for

Trainees was identified as obtaining information about the FANZCA program, and steps are being taken to improve access to such information for Trainees. The new VTC was elected in late 2004 and is soon to confirm Office Bearers. We look forward to further input from Trainees regarding the training program and other College issues.

Orientation Meeting

In February, the VRC held the 2005 Orientation Meeting for new and 1st year Registrars. At this meeting the VRC introduced Trainees to the College and its facilities, and a number of speakers gave them information on study and research techniques. A very successful joint Orientation and VTC welcome cocktails were held immediately following the Course with approximately 50 guests in attendance. Members of VRC and College Staff were also present.

3rd Year Training

In 2004 all eligible applicants for 2005 positions were able to be placed. Moving forward to 2006 onwards however the strategies used in the past will no longer be adequate. Due to the limited numbers of paediatric positions available it is not possible to continually expand the program. Currently there are 36 positions which rotate through nine hospitals. Further expansion beyond this point will dilute the paediatric experience and result in jobs which do not meet the modular requirements for paediatrics. With the changes to the FANZCA program, it is anticipated that there will be more registrars passing through the system which will mean potentially that some eligible applicants will miss out on an OPATS rotation during their 3rd year. This means that in 2005 trainee selection will return to an interview system and a transparent process in order to ensure fairness to all applicants.

Finance

The Committee in 2004 continued its involvement with, and support of, Supervisors of Training Workshops, the Orientation to



Anaesthesia Course, Part 1 and Part 2 Courses and CME events.

IT and Web Services

A strategic review of IT and web services involved IT representatives from each State and from Council. It was decided to locate web hosting at the College and to significantly upgrade the College and Regional websites, providing interactive capabilities and a more intuitive interface requiring less maintenance.

Continuing Education

The number and quality of CME activities for anaesthetists and Trainees in Victoria continues to grow. College sponsored activities included:

22nd June 2004

Victorian Regional Committee CME Evening

Meeting: "Variability in Effect of Muscle Relaxants", The Auditorium, ANZCA House, Prof Doctor Leo H.D.J. Booiij, University Hospital Nijmegen, The Netherlands, Dr Rowan Thomas Convenor and CME Officer.

16th July 2004

Annual Registrars' Scientific Meeting, The Auditorium, ANZCA House, Convenors:

Drs David Bain, Regional Education Officer; Winifred Burnett, Honorary Secretary and Elizabeth Ashwood, Formal Project Officer.

17th July 2004

25th Annual Combined ANZCA/ASA CME Meeting, Sofitel Hotel, Melbourne.

"Risky-Bloody-Obstetrics: Clinical dilemmas in everyday practice", Dr Andrew Schneider, Convenor and ASA CME Officer.

30th June 2004

VMPP – Careers Advice and Training Expo

for Medical Students and Recent Graduates, Melbourne Park Function Centre, Dr Fiona Johnson, Organiser and volunteers

7th August 2004

ANZCA/ASA Communication and Interpersonal Skills Training Workshop Presented by the Cognitive Institute's

Dr Mark O'Brien: Reducing risk through improved interpersonal skills, ANZCA House, Convened by Dr Simon Reilly, ASA State Chairman and Dr Rowan Thomas VRC CME Officer

17th August 2004

Victorian Regional Committee CME Evening Meeting: "A Report for the Victorian Managed Insurance Agency:

Claims against Anaesthetists 1993-2002", The Auditorium, ANZCA House, A/Prof Larry McNicol Director of Anaesthesia, Austin Health, (Dr Tony Weaver assisted with the preparation of this report) Dr Rowan Thomas Convenor and CME Officer.

28th September 2004

Victorian Regional Committee CME Evening

Meeting: "The English Non-Medical Anaesthetists Program", The Auditorium, ANZCA House, Dr Rod Tayler Convenor

The video conferencing of CME Evening meetings has enhanced and contributed significantly to their success and large audiences. All of these Meetings were videotaped and may be borrowed from the ANZCA Library. The pilot Cognitive Institute Communications Workshop was very successful and attracted larger than anticipated registrations. Subsequent survey/s results were very positive and it is anticipated that future workshops will be held.

The 25th Annual Combined ANZCA/ASA CME Meeting was held on 17th July 2004 at the Sofitel Melbourne. The meeting theme, "Risky – Bloody – Obstetrics: Clinical dilemmas in every day practice" focused on obstetrics, haematology for anaesthetists, risk management and issues relating to consent including case presentations and discussion. Contributors included prominent local and interstate anaesthetists, physicians and medical risk management experts.

The 26th Annual Combined ANZCA/ASA CME Meeting will be held on 30th July 2005 at the Sofitel Melbourne. The meeting theme will be "Who are you going to call?" The meeting will bring together experts in crisis management, communication and specialists in the management of difficult anaesthetic situations such as allergy and malignant hyperthermia. Sessions will examine ways to provide assistance to anaesthetists as soon as they need it by examining not only who to call, but also when, why and how to call for assistance. Contributors will include prominent local and interstate anaesthetists, physicians and risk management educators.

It is appropriate to acknowledge and thank the Anaesthetic Departments who organise additional CME activities for Victorian Fellows.

The high standard of these meetings combined with College and ASA activities provide ample CME activities in Victoria. A local Register of Meetings is maintained. Anyone with details of planned meetings wishing inclusion on this list should contact the VRC Administrative Officer via e-mail vic@anzca.edu.com; phone (03) 9510 6299 or fax (03) 9510 6786.

Rural Report

Rural recruitment and continuing education remains an on-going issue. However a number of initiatives have commenced to address this at local, State and Federal levels by government and the professional organisations involved. One emerging issue is the co-ordination of the various independent programs these bodies have set in motion or have proposed. A discussion paper 'Improving Access to Specialist Services in Rural Areas' was released by a working group with wide-ranging representation to attempt to identify key problems and potential models for delivery of health care to rural and remote communities. The Hub and Spoke model with involvement of a Tertiary Referral (Metropolitan) hospital was the preferred option. Much of the discussion paper was of most relevance to the more remote communities in Australia, compared to Victoria where relatively shorter travelling times to specialist centres exist. One area of considerable concern is the lack of rural rotations from some major tertiary referral hospitals (as distinct from outer metropolitan rotations). The Victorian DHS believes that increased numbers and durations of rural rotational programs are an important aspect of improving recruitment of specialists to rural areas.

The Rural Anaesthetist Travelling Speakers Program: has been organised by the VRC and ASA with considerable effort by Dr Rod Tayler (VRC) and Dr Quentin Tibbals (ASA GP Liaison Officer). Over the last 18 months, 19 visits have occurred to rural areas with 205 GP anaesthetists attending. These sessions are awarded QA points by RACGP and further visits are planned for north-eastern Victoria over the coming months.

Rural Anaesthesia Meetings: A very successful meeting was held in Echuca in November, organised on behalf of the ASA by Dr Andrew Schneider.

The Commonwealth Government has funded the Committee of Presidents of Medical Colleges



(CPMC) to provide a Support Scheme for Rural Specialists (SSRS). ANZCA successfully tendered to develop a rural simulator-based crisis resource management program. Following successful simulation 'roadshows' in Orange, Cairns, Launceston and Darwin in 2002-2003, two 2-day courses were held in Albury in November 2004.

Videoconferencing has broadened access to high grade teaching opportunities both for registrars and consultants. The ANZCA registrar teaching program on Thursdays is videoconferenced to sites throughout Victoria and has been supported by registrars on secondment as well as rural registrars. Videoconferencing of CME meetings held in Melbourne is a vital initiative for practitioners outside the metropolitan area. As Melbourne continues to expand and travel times increase, outer metropolitan practitioners as well as rural specialists will avail themselves of this opportunity.

Other Activities: The RANZCOG LEAP (Learning Educational and Professional) Program 'LEAP in a Rural Context' has been made available to rural fellows via videoconferencing and has had an Expert Witness Training Workshop in early 2005 covering introduction to the litigation process and report writing.

Several hospitals including Ballarat Base Hospital provide refresher programs for local GP anaesthetists in theatre but the lack of co-ordinated funding hampers wider development of these programs.

Wellbeing of Rural Practitioners: The Rural Welfare Agency (RWAV) provides wide-ranging assistance for rural doctors including personal support, and professional development services available at www.rwav.com.au. This website includes links to a variety of programs available in regional Victoria.

Safety

The Safety Officer of the Committee is responsible for monitoring drug and equipment issues, which are important to Victorian patients. The Committee has a committed and continued interest in the safety of therapeutic goods and strongly commends a regular review of the TGA Newsletter. Fellows are invited to contact the Safety Officer with issues or problems regarding safety.

Victorian Medical Postgraduate Foundation Inc.

The VRC once again represented the College at the

VMPF – Careers Advice and Training Expo for Medical Students and Recent Graduates, Saturday 30th June 2004. All major Colleges, teaching and country hospitals were represented. The evaluation by the exhibitors, Dr Fiona Johnson and volunteers, was that plenty of interest was shown – more than 50 people stopped by the booth to ask questions. The set up is good and the event worthwhile.

Formal Projects

Victorian Trainees have produced some interesting Formal Projects this year. Several Trainees presented their projects at national meetings, whilst others submitted published work.

Many were presented at the Annual Anaesthetic Registrars' Scientific Meeting (ARSM) organised by the Regional Education Officer, Dr David Bain and the Formal Projects Officer, Dr Beth Ashwood and the Honorary Secretary, Dr Winifred Burnett. For this reason, to aid prize session judging and Formal Project assessment, presenters at the ARSM are now required to submit a declaration of contribution with their abstract.

Dr Andrew K MacCormick

Does the Use of a Lumbar Roll Reduce the Incidence of Transient Lumbar Pain after Spinal Anaesthesia with Heavy Lignocaine in Lithotomy?

Dr Carmen

B G Dang Intubation with alfentanil: a meta-analysis

Dr Elizabeth K Prentice

Assessment of Optimal Prophylactic Treatment for Postoperative Nausea and Vomiting (PONV)

Dr Ian C Forsyth

Informed Consent in Labour Epidurals: Is it effective? Do opioids and nitrous oxide reduce recall of discussed risks?

Dr Darrel K McNeil

Ketamine use for Postoperative Thoracotomy Pain in a Patient with Opioid Addiction

Dr Liadain A Freestone

Voluntary incident and "near miss" incident reporting by anaesthetic trainees in Australian hospitals

Dr Michael Clifford

Does the Health Questionnaire provide sufficient information for adequate planning of anaesthesia?

Dr Scott R Charlesworth

Milrinone for the prevention of arterial graft spasm during free flap surgery

Dr Mark J Alter

Electroconvulsive therapy without succinylcholine

Dr Dean Dimovski

Implementation of patient controlled PCEA for labour in a major regional hospital obstetric unit

Dr Shiva Malekzadeh

Continuous measurement of gas uptake and elimination in anaesthetised patients using an extractable marker gas

Dr Michelle A Natividad

ENIGMA Trial

Dr Anthony C Keeble

Temperature management during interhospital transfer of intubated patients: A comparison of passive versus active warming

Dr David J Canty

Superior Laryngeal Nerve Block in Human Cadavers – an anatomical study comparing two techniques

Dr Michael P Garrett

Anaphylaxis after Repeat Exposure to Aprotinin

Dr Forbes McGain

A study of a neglected disease of the tropics – snakebite mortality at Port Moresby General Hospital, Papua New Guinea 1992-2001

Dr Eleanor M Moreno

The association between exercise induced rhabdomyolysis and malignant hyperthermia

Dr Su-Li Lim

Computer Teaching Module: an aid to learning for Anaesthetic Trainees

Dr Mi-Jin Kim

Entropy and Bispectral Index during Anaesthesia in Children

Dr May L Lim

Anaesthesia for pituitary surgery

Dr Thomas C E Gale

Propofol administration via target-controlled infusion or manual infusion; effects on the Bispectral Index

**Dr Anthony J Hull**

Vanuatu – Anaesthetics and Teaching, a Registrar's Perspective

Dr Eugenie Kayak

Intraoperative Patient Warming Using Radiant Warming or Forced-air Warming during Long Operations

Dr Usha Padmanabhan

Changing Attitudes: Why Epidural Rates are falling in Metropolitan Melbourne

Dr Barbara Chia

A survey of labour ward attitudes to safety and teamwork at Royal Women's Hospital

Dr Matthew Bowman

Factors Predicting Length of Hospital Stay after Open Aortic Surgery

Dr Paula Z Laverty

Women in Anaesthesia: A survey of attitudes and choices

Dr Crispin A F Y Wan

Dynamic superior vena cava obstruction with bradycardia/tachycardia and asystole related to malignant Phylloides tumour

Dr Christie Cameron

A Review of Serious Epidural Morbidity at St Vincent's Hospital, Melbourne

Dr Tomasz J Rawdanowicz

The Utility of Dexmedetomidine for sedation and analgesia during awake carotid endarterectomy surgery

Dr Tzung Ping Ding

Meeting the Standard? Frankston Hospital Labour Epidural Service

Dr Frank Buchanan The influence of Gender on Outcomes following Anaesthesia and Surgery

Dr Craig McGrath

Pulmonary Arteriovenous Malformation Masquerading as Massive Pulmonary Thromboembolus

Dr Sudharshan Christie Karalpillai

Nitrous Oxide and Anaesthetic Requirement for Loss of Responsiveness during Propofol Anaesthesia

Dr Wolker Mitteregger

The use of recombinant factor VIIa in the treatment of life threatening obstetric haemorrhage

Dr Stephen James Nutter

Laboratory analysis of a Low Flow to-and-Fro rebreathing circuit during simulated spontaneous respiration

The VRC remains very much committed to and involved in Health Care Committees and workshops as follows:

Coroner's Health and Medical Advisory Committee - Dr Winifred J Burnett

MPB Working Group on the problem of sexual misconduct - Dr Rowan R Molnar

AMA Victorian Council - Dr Richard Horton

Committee of Chairmen of Victorian State Committees of Medical Colleges - Dr Peter R McCall

RACS Victorian State Committee - Dr Peter R McCall

ASA State Committee - Dr Peter R McCall

NHMRC - Blood Group - Dr Peter R McCall

Consultative Council on Anaesthetic Mortality and Morbidity

*- A/Prof L McNicol (Chair)
- Dr Pat Mackay (Emeritus Consultant)
- Dr Mark Langley
- Dr Philip G Ragg*

*NHMRC Blood and Blood Product Working Group
Dr Craig J French (ANZCA)
- Dr Megan S Robertson (IC)*

*DHS Planning for Intensive Care Service in Vic - Issues Paper Workshop
- Dr Craig J French (ANZCA)
- Dr Megan S Robertson (IC)*

*Victorian Quality Council (DHS)
- Dr R (Tony) Weaver
- Dr Brendan T Flanagan*

*Victorian Doctors Health Program
- Dr Stephen C Chester*

Anaesthesia Continuing Education Co-ordinating Committee - Dr Rodney N Westhorpe

*Tort Law Reform Group
(Comprises representatives from the AMA, RACGP, the OSA, the RACOG and executive members of the Committee of Chairmen (VIC))
- Dr Mark V Tuck*

*Chinese Medicine Regulation Working Party (MPB)
- Dr Tony K Chow*

Victorian Consultative Committee on Road Traffic Fatalities - Dr Andrew J Silvers

*RACS Victorian Trauma Committee
- Dr John T Moloney*

*RACS Victorian Road Trauma Committee
- Dr John T Moloney*

*Australian Resuscitation Council
- Dr John T Moloney*

*Rural Specialist Interest Group
- Dr Francis X Moloney*

Victorian Medical Postgraduate Foundation (VMPPF) - Dr Richard Horton

*RACGP - Professional Peer Support Program Committee
- Dr H Kolawole
- Dr J Warhaft*

Conclusion

The Victorian Regional Committee would like to thank all Fellows who have contributed to the activities outlined above.

Finally the Committee would like to thank all the staff, with a special thanks to Deandra Burrows and Judy Gardener, at College Headquarters for their valuable assistance during the year.

We extend our particular thanks to our Administrative Officer, Ms Corinne Millane for her excellent support.



ANZCA Regional/National Annual Reports

South Australia and Northern Territory

South Australian and Northern Territory Regional Committee

Annual Report May 2004-April 2005

Office Bearers and Members

(* denotes co-opted members)

Chair	Dr Lynne Rainey
Vice Chair	Dr Kym Osborn
Hon. Secretary	Dr Kym Osborn
Hon. Treasurer	Dr Kym Osborn
Regional Education Officer	Dr Glenys Miller
Formal Project Officer	Prof Don Moyes
Coordinator of Training	Dr Suzy Szekely
Committee Members	Dr Lynne Rainey Dr Brian Spain Dr Meredith Craigie Dr Kym Osborn Dr Glenys Miller Dr Pam Macintyre Dr Aileen Craig Dr Suzy Szekely Dr Simon Jenkins

Ex-Officio Members

Councillors	Dr Margie Cowling Dr Neil Maycock
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Faculty of Intensive Care Representative	Dr Robert Young
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Faculty of Pain Medicine Representative	Dr Penny Briscoe
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ASA Representative	Dr Paul McGrath
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New Fellows/Trainee Representative	Dr Aileen Craig
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Course Organiser Primary	Dr Peter Doran Dr Julia Coldrey
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Course Organiser Final Fellowship	Dr Kym Osborn Dr Ian Banks
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Welfare Officer	Dr Margie Cowling
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Administrative Officer	Georgina Douglas-Morse
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Total No. of Regional Committee Meetings for Year: 10

Attendances of Elected Members (No. of Meetings)

Dr Aileen Craig	4/10
Dr Meredith Craigie	5/10
Dr Simon Jenkins	7/10
Dr Pam Macintyre	4/10
Dr Glenys Miller	7/10
Dr Kym Osborn	8/10
Dr Lynne Rainey	10/10
Dr Brian Spain	1/10
Dr Suzy Szekely	10/10
**Dr Margie Cowling	9/10
**Dr Neil Maycock	5/10

** Denotes Ex-Officio Members

The Committee

Dr Margie Cowling retired as Chair of the Committee at the end of her two year term. We would like to thank her for the excellent job she did during this time. Margie remains on the Committee as an Ex-Officio member since she has been elected to the College Council. Dr Neil Maycock was also voted onto the College Council, we would like to congratulate them both.

Offices and Secretariat

Christie Richards resigned from the position of Regional Administrative Officer and has been replaced by Georgina Douglas-Morse.

Finance

The expenses for the SA/NT Regional Committee Office for the year 2004 increased during the last year. The major contributing factor was an increase in the rent and occupancy costs.

The SA CME Committee conducted the Burnell-Jose weekend meeting in November. The meeting was cost neutral.

There are no fees charged for the local SA long courses for the ANZCA Pt I and Pt II courses. Expenses for these courses are minimal.



Dr Kym Osborn

Education and Training

Revised FANZCA

The revised FANZCA programme has been up and running for 18 months and despite some minor hiccups the transition has been relatively smooth. We would like to pass on our thanks to the Regional Education Officer Dr Glenys Miller, the Supervisor's of Training and module Supervisors for their hard work during this time of change.

Courses

The Part One Course continues to be well attended. Dr's Julia Coldrey and Peter Doran have taken over the job of coordinating this course and are doing an excellent job.

The Part Two course is being run by Dr Kym Osborn and Dr Ian Banks who have made some subtle modifications in order to cover the modules in a more organized fashion with continued success.

Rotational Training Scheme

We had two intakes in 2004 and all vacancies were filled. Dr Suzy Szekely ran the rotation extremely well, managing to accommodate the needs of the Trainee's at all times which is no mean feat, we thank her for her dedication and hard work.

Trainee Committee

After a rather slow start our Trainee Committee now has six members and is holding regular meetings. We would like to thank Dr Charles Clegg our past chair and welcome Dr Andrew Beinssen the new Chair who was recently elected following a brief period by Dr Adam Black in the



role. The Trainee Committee have provided valuable input to the Regional Committee and the Regional Education Sub-Committee.

Registrars Scientific Evening

3 Trainees gave excellent presentations. The prize for best paper was a simulator session donated by Abbott Australasia. This was won by Dr Christopher Jackson for his paper entitled "An Audit of Epidural Injections for Back Pain and Sciatica".

Formal Projects

The following projects were completed in 2004:

Dr Julia Coldrey

Use of hypnosis in anaesthetic practice: A survey of knowledge and attitudes

Date: 19 January 2004

Dr Daniel Collins

Overinflation in Acute Lung Injury: Comparison of Dynamic CT with Dynamic Respiratory Mechanics

Date: 2 February 2004

Dr Christopher Jackson

An Audit of Epidural Injections for Back Pain and Sciatica

Date: 2 February 2004

Dr Andrew Potter

Strongyloides hyper-infection: a case for awareness

Date: 3 February 2004

Dr Michael Heytman

The use of alpha-agonists for management of anaphylaxis occurring under anaesthesia:- Case studies and review

Date: 19 March 2004

Dr Ingrid Walkley

Antenatal Expectations and Subsequent Requirements for Analgesia in Labor

Date: 19 March 2004

Dr Lac Truong

Post Anaesthesia Care Unit Discharge: A Clinical Scoring System Versus Traditional Time-based Criteria

Date: 25 May 2004

Dr Todd Maddock

Anaesthetic and Analgesic Techniques for Primary Knee Arthroplasty - A Literature Review

Date: 4 June 2004

Dr Nickolas Stradwick

Litigation and Ethics in Terminal Care

Date: 4 June 2004

Dr Timothy Wright

Estimation of Intramucosal pH by Tonometry

Date: 16 June 2004

Dr Surendra Yogalingam

Post-Anaesthetic Tremors: Aetiology & Pharmacological Management

Date: 16 September 2004

Dr Matthew Grill

Analgesia for Total Knee Replacement Surgery - Current Evidence and Future Directions

Date: 28 October 2004

Dr Phang-Chien Lim

An Audit of Intrathecal Morphine Analgesia for Non-Obstetric Post-Surgical Patients in and Adult Tertiary Hospital

Date: 10 November 2004

Dr Brenton Millard

A Survey of Policies in Australian Hospitals Regarding Parental Presence in the Recovery Area

Date: 12 November 2004

Dr Deborah Simmons

A Review of the Literature Comparing the use of Intravenous and Sublingual Spray Glyceryl-trinitrate for Uterine Relaxation in Obstetric Emergencies

Date: 15 November 2004

Dr Stuart Day

The Oxygen and Volatile Anaesthetic Delivery Characteristics during Spontaneous Ventilation using a Non-rebreathing Coaxial Anaesthesia System

Date: 2 December 2004

Dr Graham Lowry

Patients knowledge of anaesthesia, analgesia, and anaesthetists – A review of practice

Date: 11 January 2005

Dr Andrew Wallis

Optimal dose of intravenous midazolam to achieve amnesia from peribulbar blockade in elderly patients

Date: 17 January 2005

Dr Charles Clegg

The use of dexmedetomidine in sleep apnoea surgery – A case series review

Date: 18 January 2005

Supervisors of Training:

Flinders Medical Centre: **Dr Lynne Rainey,**

Dr David Mcleod

Lyell McEwin Health Service: **Dr Andrew Michael**

Modbury Hospital: **Dr Kar Wah Ng**

Repatriation General Hospital: **Dr Lena Ong,**

Dr Michael Jones

Royal Adelaide Hospital: **Dr Guy Christie-Taylor,**

Dr Ian Banks

Royal Darwin Hospital: **Dr Mike van Gulik**

The Queen Elizabeth Hospital:

Dr Thava Visvanathan

Women's and Children's Hospital:

Dr Marian Andrew

Continuing Medical Education

Dr Kevin Parry continues as chair of CME. Kevin and his team did an excellent job organising 6 evening meetings throughout 2004.

The 2004 CME Committee consists of:

<i>Chair</i>	Dr Kevin Parry
<i>Committee Members</i>	Dr Cormac Fahy
	Dr Deb Simmons
	Dr Margie Cowling
	Dr Tim Hampton
	Dr Grace Koo
	Dr Kym Osborn
	Dr Julia Coldrey
	Dr Ian Banks
	Dr Rob Singleton
	Dr David Zoanetti

Following are the meetings held in 2004 each meeting was video conferenced to Darwin:

17th March

"The Eyes Have It – Anaesthesia for squint, vitreo-retinal & cataract surgery"

Speakers: **Dr Jon Clarke and Dr Pat Moran**



21st April

"A look at Maternal Mortality and what's new in Transfusion"

Speakers: **Dr Scott Simmons and Dr Ben Saxon**

9th June

"Dealing with the Unexpected Death"

Speaker: **Professor Ross Kalucy**

21st July

"Anaesthesia in the Post Transplant Patient"

Speaker: **Dr Andrew Puddy**

18th August

"Surgical Innovation – From Idea to Routine?"

Speaker: **Professor David Watson**

13th October

Registrars Scientific Evening

3rd November

Maurice Sando Memorial Lecture

"Peripheral Nerve Catheters – Are they worth the trouble?"

Speaker: **Assistant Professor Dara Breslin**

This year was the year of the Triennial Burnell Jose Visiting Professorship. Assistant Professor Dara Breslin from Duke University, North Carolina, USA. A weekend meeting was held on the 6th of November in conjunction with his visit and was a great success.

Professional Affairs

ASM 2006

The Annual Scientific Meeting will be held in Adelaide from 13th-17th May 2006 at the Adelaide Convention Centre.

The theme of the meeting will be "All in a Days Work".

Our keynote speakers are:

Dr William Harrop-Griffiths (London, UK)

Dr Geoffrey Shaw (Christchurch, NZ)

Dr William McCrae (Dundee, Scotland)

Dr Terese Horlocker (Mayo Clinic, USA)

Dr Suellen Walker (London, UK)

Assoc Professor Kate Leslie (Melbourne)

-The Douglas Joseph Professor in Anaesthesia

Acknowledgements

We were delighted with the recognition of Professor Garry Phillips with an Order of Australia Medal and Dr John Williamson with his College Citation.

Flashback!

Gwen Wilson Lecturers, Dr Tony Newson and Dr Basil Hutchinson enjoy the RACS and Faculty Dinner at the Jubilee Meeting in Melbourne, 18th May 1977



Tony Newson & Basil Hutchinson
- Fellows' Dinner, Jubilee Meeting, RACS,
Melbourne, 18.5.77



ANZCA Regional/National Annual Reports

Queensland

Queensland Regional Committee

Annual Report May 2004-April 2005

Office Bearers and Members

Chair 2005	Dr Anton Loewenthal
Chair 2004	Dr Michael Beem
Vice chair	Dr Geoff Gordon
Honorary Secretary	Dr Michael Fanshawe
Honorary Treasurer	Dr Mervyn Cobcroft

Regional Education Officer	Dr Julia Byatte
Formal Project Officer	Dr Pal Sivalingam
Continuing Education Officer	Dr Michael Fanshawe Dr Lorraine Robinson

Committee members	Dr Mark Gibbs Dr Michael Haines Dr Sonia Vaughan Dr Charmaine Barrett
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Ex-officio Members	Dr Di Khursandi (Councillor) Dr Kerry Brandis (Councillor) Dr Rob Boots (Faculty of Intensive Care Rep.) Dr Martin Culwick (ASA Representative)
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Co-Opted New Fellows' Representatives	Dr Andrea Nowitz
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Co-Opted Qld Trainees Representative	Dr Ben Lloyd
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Course Organisers

Primary Short Course May	Dr Kerry Brandis
Primary Long Course	Dr Justine McCarthy
Primary Practise Viva Sessions	No convenor available
Final Fellowship Short Courses	Dr Martin Wakefield
Final Practise Viva Sessions	Dr Martin Wakefield
Final Fellowship Long Course	Dr Jane Morris
Advisor of Candidates for Anaesthesia Training	Dr Gerard Handley
Regional Administrative Officer	Sharon Miethke
Administrative Assistant	Anne Strasburg

Representatives on External Committees

Dr Michael Beem, Chairman 2004
ANZCA/RACS Building Committee
AMAQ Committee of Combined College Chairs
Annual Peer Review of applications from Staff and Visiting Specialists for advancement to senior status
Invited member ASA Qld Executive

Dr Anton Loewenthal, Chairman 2005
ANZCA/RACS Building Committee
Quality Management Committee for bowel cancer screening program in Qld

Dr Geoff Gordon
Medical Workforce Specialist Working Party
Staff Panel of Peers
Senior Staff Specialist Status, Queensland Health
Visiting Panel of Peers, Queensland Health
Senior Visiting Specialist Status Queensland Health
Annual Peer Review of applications from Staff and Visiting Specialists for advancement to senior status

Dr Michael Fanshawe
Editorial Committee Australasian Anaesthesia
Scientific Program Convenor ASA NSC 2005
Panel to provide advice for framework in best practice for the procurement and utilisation of blood and blood products in Qld

Dr Julia Byatte
Queensland Committee to Investigate Perioperative Deaths
TAFE Course for Anaesthetic Assistants – Scrutineer for ANZCA

Dr Mark Gibbs
State Health Emergency Response Plan Reference Group
RACS Queensland Trauma Committee



Dr Anton Loewenthal

Dr Diana Khursandi
Medical Advisory Committee of Queensland
Post-graduate Medical Education Committee, University of Queensland
Appointments Committee Royal Brisbane and Women's Hospital
ANZCA/RACS Building Committee

Dr Kerry Brandis
Ensuring Correct Surgery Reference Group

Total No. of Regional Committee Meetings for Year:

April 2004 to March 2005 = 8 meetings

Attendances of Elected Members (No. of Meetings)

Dr Charmaine Barrett	5:8
Dr Michael Beem	5:8
Dr Kerry Brandis	6:8
Dr Julia Byatte	5:8
Dr Mervyn Cobcroft	6:8
Dr Michael Fanshawe	6:8
Dr Geoffrey Gordon	5:8
Dr Michael Haines	4:6
Dr Di Khursandi	6:8
Dr Ben Lloyd	2:2
Dr Anton Loewenthal	6:8
Dr Andrea Nowitz	5:6
Dr Lorraine Robinson	5:7
Dr Pal Sivalingam	3:7
Dr Sonia Vaughan	3:8

It has, without doubt, been a rather tumultuous year for the Queensland Regional Committee.



Dr Michael Beem's tragic accident at Christmas time cut short his Chairmanship of the Committee after only six months in that role. His continued physical improvement since his accident and his optimistic outlook for the future are testaments to his ongoing strength of character. I am sure that all those who know Michael would join me in wishing him all the best for the years to come.

Last year saw the retirement of Mrs Joyce Holland as our long-standing Regional Administrative Officer after more than ten years of tireless service in that position. We all miss Joyce's depth of understanding of College affairs and processes. Her life must be a great deal less hectic not having to deal with the multitude of administrative tasks, committees, enquiries and deadlines, not to mention the trainees and Fellows who always needed guidance with the College. In recognition of her service, a small presentation was made to her at the Combined CME meeting in Caloundra. We are fortunate that Ms Sharon Miethke has joined us as the new Regional Administrative Officer and has taken to the role with dedication and enthusiasm. Indeed the make-up of the Regional Committee as well as the multitude of delegated positions and regional College representatives have changed somewhat in the last twelve months. It is encouraging to see some new faces in the local line-up, and whilst there might be a settling-in period due to lack of "corporate memory" it is more than made up for by fresh ideas from the newer members.

Training

The introduction of the modular system into the training process has led to an increase in the number of trainees and in increased workload for all those involved with the training of registrars. The College has a responsibility to ensure that trainees are provided with adequate caseloads, breadth of experience, and supervision to enable them to complete their training at the level of expertise that the College aspires to. There is increasing concern at the

local level that the revised FANZCA may create bottlenecks and orphaned trainees. It seems likely that the current five-year process will balloon out as trainees find that they are unable to complete all their modules within the allotted timeframe. It will become increasingly important to ensure that modules remain a means to achieving a required standard and not as goals in their own rights. Whilst each trainee's achievements will be unique, it is essential that there is equivalence in experience after successful completion of a module. This remains a challenge for our module supervisors, Supervisors of Training and Regional Education Officer.

The recently established Trainees' Committee continues to function and our regional representative Ben Lloyd is hoping to address a variety of the concerns that trainees have with the some of College processes.

Queensland Fellows continue to support the successful courses held over the year. Both the Primary and Second Part long courses remain popular with trainees. The Primary short course run by Kerry Brandis is always oversubscribed and the feedback from the participants remains overwhelmingly positive. Unfortunately an additional course earlier in the year could not be organised partly due to a shortage of lecturers. I know that a number of our colleagues spend a great deal of their own time preparing and organising for these courses and their efforts are greatly appreciated. If there are Fellows out there who wish to contribute, I'm sure the course organisers will greet them enthusiastically.

The 8th Annual Registrars meeting was held on the 23rd of October at College headquarters in Brisbane. Whilst the initial impetus for these meetings was to enable some trainees to complete the requirements for the Formal project, it now provides an opportunity for peer review by the registrars themselves and acknowledges high standards of achievement through the awarding of prizes. This year's meeting was attended by 55 registrants with 19 presentations being made including 4 from

New Zealand. The Tess Cramond Prize for best presentation was awarded to Dr Nicole Healey for "Sedation for flexible fiberoptic bronchoscopy – A Comparison of two techniques". Two candidates could not be separated for the second prize, the Axxon Health "John Board Award"; Dr Ken Fitzsimmons for "The effect of HMG CO-A reductase inhibitors on mortality in patients with bacteraemia" and Dr Colin Crowe for "Cardiopulmonary bypass simulator".

Whilst on the subject of training I would like to acknowledge the assistance of those involved in the Trainee information evening organised by the Trainee Committee and held at ANZCA House in January, also the Vocational Training Exhibition held at the Royal Brisbane and Women's Hospital and the annual AMA Health Expo at the Brisbane Conference and Exhibition Centre. All the events were well attended with positive feedback from organisers and attendees.

Continuing Medical Education

The 28th Annual Combined CME meeting was held on the 10th of July at the Caloundra Cultural Centre. The theme of "Challenges in Anaesthesia" was completed with a series of interesting lectures including the keynote address "The Ageing Practitioner in Australia" delivered by Professor Barry Baker. There were 150 attendees at the meeting with 17 representatives from the Health Care Industry. Congratulations must be given to Darryl Koch and Richard Scolaro for organising the event.

The Cognitive Institute held a small intensive workshop in November at ANZCA House. The "Masterclass for Anaesthetists" was specifically designed to improve interpersonal communication skills. The workshop format combined with the use of professional actors in role-playing scenarios ensured that the participants took a much more active part than normally expected at a meeting. Buff Maycock's assistance with the preparation of case scenarios helped to make the workshop successful for those fortunate enough to be able to attend.



Alan MacKillop was invited as the guest speaker at the Queensland Regional Committee's Annual General Meeting held on the 27th of July. He spoke on the establishment and ongoing role of the Careflight aero medical service operating in southeast Queensland and northern New South Wales. Careflight has grown from humble beginnings to arguably one of the best services of its kind anywhere. Trainees from the College for Emergency Medicine can have training time with Careflight count towards their fellowship, and this year Careflight has been given approval for Anaesthetic trainees to have a six month rotation as accredited training time towards ANZCA fellowship.

Queensland Health proudly announced the opening earlier this year of the new "Skills Development Centre", its state-of-the-art training and simulation facility located on the campus of the Royal Brisbane and Women's Hospital. The SDC aims to improve the skills of a broad variety of health care professionals. Already the centre has held its first Effective Management of Anaesthetic Crises course and plans are under way to offer further courses to anaesthetic trainees and specialists later in the year.

On the horizon we are looking forward to an even more active year in CME. The preparations for the 29th Combined CME meeting to be held at Port Douglas in July are well under way. In addition Chair of the Combined CME Committee, Genevieve Goulding has been active in arranging a combined ANZCA-ASA CME series of lectures to be held at the Wesley Hospital scheduled for the latter part of this year. Queensland Fellows also eagerly await the 64th National Scientific Congress of the ASA coming up in September to be hosted at the Gold Coast.

Professional Affairs

Whilst training and standards remain core business activities of the College, members of the Regional Committee are increasingly becoming involved in a wider variety of matters that concern College affairs. This requires an ever-increasing time commitment in areas that are often complex and usually involve a number of stakeholders that are outside our normal circle of expertise. We are often asked to provide input to various government and non-government organizations. Some of the issues currently before the Committee include discussions with Queensland Health regarding legislation

concerning recency of practice requirements, workforce and quality issues relating to provision of anaesthetic services for colonoscopy services, consideration of appropriateness of prescribing rights for chiropodists, and dealing with complaints from members of the public, to name a few. Advice regarding applications for accreditation at public hospitals arrives at the Committee several times a month, and frequently we are asked to provide a member representative on hospital appointment committees. The Regional Committee also provides an overseer as requested for Overseas Trained Specialists working in Area of Need positions. Several members of the QRC have been invited by the President to take an active role in the Taskforces set up to address a number of issues of major importance to the College.

The ongoing assessment of competency is an area that concerns us all. We work in a specialty with such a wide scope of practice that assessing an individual's ability to practice in his or her chosen field is increasingly challenging. Public expectation, increased litigation, and government control all combine to put more and more pressure on our College to develop a system to ensure that we as Fellows continue to provide the highest standard of care possible. Identifying where and when the system fails, and then providing an avenue for additional training or supervision are areas that we all need to be involved in.

Whether or not the public health system is in crisis, there is no argument that there is a relative shortage of public anaesthetists, the causes of which are multifactorial. We have more trainees than ever before, and soon we will have more and more specialists completing the training program. This in itself does not guarantee that there will be no more shortfalls in the distribution of the specialty workforce. This is an area of concern that needs to be addressed at both the local and national levels. Fellows need to be actively involved in finding a solution before a solution is forced upon us. Already there are discussions related to alternative models of care delivery. It is our duty to work with other stakeholders in this regard to ensure the best outcomes for our patients.

The headquarters of the Queensland Regional Committee for the past seventeen years has been in a building in Water Street that we share with our surgical colleagues. The new national

President of the Royal Australasian College of Surgeons, Dr Russell Stitz, comes from Queensland and this combined with a number of other issues has led to their College making an offer to buy our one-third share in the building. Obviously the building holds a degree of historical significance as the first local headquarters of our College, and it is in almost continuous use throughout the year by our secretariat, a number of our committees, short and long courses, meetings, workshops and examinations. Our departure would be dependant on finding an even better and more functional venue to see us well into the future.

Finally I would like to thank those Fellows who have given freely their time to help achieve the goals and responsibilities of the College.

Anton Loewenthal
Chairman



ANZCA Regional/National Annual Reports

Western Australia

Western Australian Regional Committee

Annual Report May 2004-April 2005

Office Bearers and Members

Chairman	Dr Simon Maclaurin
Vice Chairman	Dr Chris Cokis
Honorary Secretary	Dr Michael Veltman
Immediate Past Chairman	Dr Grant Turner
Regional Education Officer	Dr Andrew Gardner
Continuing Education Officer	Dr Jennifer Fabling
Continuing Education Committee	A/Prof Michael Paech
Education Officer / WAASM Representative	Dr Nedra vanden Driesen
Webmaster / Simulation	Assoc Prof Richard Riley

Councillors

Dr Lindy Roberts
Dr Wally Thompson

Co-opted

Dr Suzanne Bertrand
Dr Jodi Graham
Dr John Martyr

Trainee Committee	Dr Alan Millard
Mortality Committee	Dr Neville Gibbs
Australian Resuscitation Council	Dr Aileen Donaghy
Day Care Anaesthesia	Dr Stephen Watts
SARG/ Rural Education	Dr Leigh Coombs
ASA Representative	Dr Rob Storer
Faculty of Pain Medicine	Dr Roger Goucke
Faculty of Intensive Care	Dr Bernice Ng
Administrative Officer	Mrs Patricia Luxford

Attendance at Regional Committee Meetings

Dr Simon Maclaurin	6/6
Dr Chris Cokis	3/6
Dr Michael Veltman	5/6
Dr Grant Turner	3/6
Dr Andrew Gardner	5/6



Dr Simon Maclaurin

Dr Jennifer Fabling	5/6
Dr Nedra vanden Driesen	4/6
A/Prof Richard Riley	3/6
A/Prof Michael Paech	4/6
Dr Lindy Roberts	6/6
Dr Wally Thompson	4/6

W.A. Chairman's Report

Dr Simon Maclaurin

Committee Composition

We retain a committed group of West Australians on the committee.

Dr Andrew Gardner has taken over as Regional Education Officer from Dr Lindy Roberts who has done a magnificent job during her time in this role. This is a key portfolio on the committee and we are most fortunate to have such dedicated individuals filling this position.

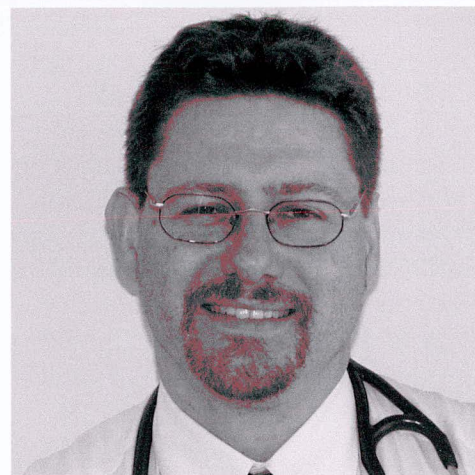
New members coopted include Dr Suzanne Bertrand, Dr Jodi Graham and Dr John Martyr.

Annual Scientific Meeting

The 2004 ASM was held in Perth and from all accounts was very well received. The prodigious efforts of Dr Mark Josephson and his team (especially Drs Roberts and Gardner) paid off with an outstanding conference. Again I thank them very much for all their work, so much of which is unseen but not unappreciated.

Secretariat

This has continued to function extremely well, due largely to the drive and initiative of our Administrative Assistant, Mrs Patricia Luxford. Unfortunately Patricia is leaving mid year and we are in the



Dr Michael Veltman

process of seeking a replacement. Not an easy task considering the very high standard she sets.

General Issues

Registrar numbers are growing each year for a variety of reasons and there is thus increasing pressure on limited training resources; eg paediatric, obstetric and intensive care training slots.

At the Part Two level, to the increased registrar numbers are added Overseas Trained Specialists – thus we have almost 30 likely candidates for the two Part Two/OTS exams this year. This is almost twice our usual number and adds considerably to the teaching load faced by those individuals and hospitals involved. I'd like to thank all involved in training and teaching registrars and OTS exam candidates.

W.A. Regional Education Officer Report

Dr Andrew Gardner

Trainee Numbers

The WA programme currently has 63 FTE BTY1 BTY2 ATY1 and ATY2 positions.

Hospital Rotations

The 50% increase in numbers will place pressure on some bottleneck modules. The regional committee is aware of this impending problem, and introducing strategies to prevent this interfering with training.

Royal Perth Hospital has received conditional accreditation to allow it to continue to have time accredited for FANZCA training.



Trainee Selection

Selection of trainees for the WA teaching hospitals anaesthetic training scheme is coordinated by the Medical Human Resources Department at Sir Charles Gairdner Hospital. Representatives of the major teaching hospitals take part in the process, and community members are also invited to join the selection panel. The process has recently been extensively documented, and this documentation has been submitted to the College. It is worthy of note that there have been no appeals to the process in recent times, confirming the fair, transparent and open process of selection.

Trainee Orientation 2005

Trainee orientation was combined this year with a seminar based on the Welfare of Anaesthetists Special Interest Group workshop on Surviving, Striving, and Thriving in your Anaesthesia Training. This workshop was very successful, and there was good feedback from the trainees.

Trainees

The following trainees are in the WA scheme at 30 March 2005:

Yasir Al Tamimi, Deborah Bell, Roger Browning, Joel Butler, Szu Lyn Chan, Chin Wern Chan, Chui Chong, Russell Clarke, Tamara Culnane, Alistair Davies, Rowan Drayton, Daniel Durack, Nasim Fahimian, Lloyed Green, Angelique Halliday, Nigel Hamilton, Navid Hashimina, Lise Hockings, Shanon Jarvis, Serge Kaplanian, Geraldine Khong, Irina Kirowski, Paul Kwei, Stephen Lamb, Joshua Lau, Martyn Lethbridge, Kate Luscombe, Tai Ma, Rebecca Martin, Shannon Matzelle, Claire McTernan, Shane Merriman, Alan Millard, Christopher Mitchell, Suzanne Myles, Audrey Ng, Julie Ng, Ann Ngui, Edmond O'Loughlin, Marilyn Ong, Angela Palumbo, Jennifer Philip, Steven Philpot, Magda Rhodes, Tania Rogerson, Philip Russell, Markus Schmidt, Mark Schutze, Divya-Jyoti Sharma, Katherine Shelley, Gurbakshish Singh, Jamie Stevens, Luke Torre, Evan Tziavrangos, Marianne Vlaskovska, Heidi Waldron, Samantha Weaver, Denise Yim.

Christopher Duffy is on exchange in Melbourne, with Leonard Lee taking his position in WA;

Julie Macarthur remains on Maternity Leave; Rowena Knoesen has taken leave from the programme due to her husband's transfer

interstate. A short term locum appointment is being held by Ana Licina.

Trainee Representative

Alan Millard was elected the Trainee Representative.

Formal Projects

The following Trainees had formal projects approved. The list of formal projects appears on the College website:

Edmond O'Loughlin, Sarah Kurian, Jennifer Philip, Katherine Shelley, Andrew Lovegrove, Imran Ali, Elaine Christiansen.

Part 1 course

The Part One Course is coordinated by Brien Hennessy and Jay Bruce. Results continue to excellent. Stephen Lamb was awarded a Certificate of Merit in the September 2004 sitting of the primary examination.

Part 2 Course

In 2004 this was coordinated by Priya Thalayasingham, and in 2005 is coordinated by Jeremy Macfarlane. This course is also open to OTS who are sitting the OTS examination.

Medical Careers Expo

Michael Paech organised the anaesthesia presentation at this Expo.

Supervisors of Training

My thanks to the Supervisors of Training for their help in running the programme: Jay Bruce, Soo-Im Lim, John Male, Steve Myles, Felicity Re, Mark Somerville, and Michael Veltman, and to Tanya Farrell who relieved when Soo-Im Lim was on leave.

Appreciation

The tireless efforts of many in the WA Anaesthesia Community facilitate the smooth running of the programme, and the excellent results seen in examinations. To all those who assist with clinical and scientific teaching, as mentors, in the selection of training, my sincere thanks.

The assistance of Patricia Luxford from the WA anaesthesia secretariat is most appreciated,

in the smooth running of the training scheme, and also of the examinations.

Simon Maclaurin as Regional Chair has been a great support to me in this position.

Dr Lindy Roberts

As my predecessor as REO, Lindy Roberts successfully oversaw the transition to the 2004 FANZCA programme, a seemingly seamless transition despite the large amount of work that this required. On behalf of the WA anaesthesia fellows and trainees, I thank her for her work as REO.

Continuing Education Report

Dr Jennifer Fabling

Major Regional Scientific Meetings

The 2004 Winter Scientific Meeting (WSM) was held on 7th August 2004 at the St John of God Conference Centre, Subiaco. This was the first of three such meetings honouring Dr Maxwell T Sloss.

Professor Alan Merry, of the University of Auckland was the Visiting Lecturer. In addition to a busy program in the week preceding the WSM, including teaching and lecturing in Bunbury and at several metropolitan teaching hospitals, he delivered two plenary lectures "Making advances in anaesthesia" and "A death at Duke". These were inspiring and thought provoking lectures. Alan's hard work was appreciated immensely. The standard of free papers at the WSM, was again excellent. WA Anaesthesia thanks Boots Healthcare for their generous sponsorship and their commitment to sponsorship again in 2005.

At the invitation of the Royal Australasian College of Surgeons, the 2005 Winter Scientific Meeting will be held on Saturday 20th August 2005. This is to combine with the surgeons' winter meeting. The intention is to promote collegiality. Dr Michael Corkeron has accepted the invitation to be the second Dr Maxwell T Sloss Winter Visitor.

The 2004 Autumn Scientific Meeting was held on 19th March to the theme "Knowledge preventing problems". Lectures included renal and hepatic updates and medicolegal issues. The Bunny Wilson Lecture was delivered by Dr John Rigg



Other Activities

1. In May 2004 we were fortunate to have lectures from Dr David Crooke "Informed consent for anaesthesia" and Dr Michael Davies "Prevention of Cardiovascular Complications after Vascular Surgery". These speakers were organized by Dr John Rigg.
2. Several videoconferences were held but poor attendance made the venture financially unviable. This is attributed to the time difference from the Eastern States such that these events are scheduled too early for many to attend.

Future Continuing Education

In late April 2005 "Updates in Paediatric Anaesthesia" will be held at Bunker Bay Resort.

Australian Resuscitation Council – WA Branch

Dr Aileen Donaghy represents WA Anaesthetists on this Regional committee. The committee continues to review ARC policy documents, provide feedback to the Federal body and assist with the implementation of any recommended changes where required.

Faculty of Pain Medicine ANZCA

Dr Roger Goucke represents the Faculty on the ANZCA WA Committee and has kept the committee abreast of the many developments in the new Faculty.

Faculty of Intensive Care ANZCA

Dr Bernice Ng has represented the faculty on the Regional committee

Western Australian Anaesthesia Mortality Committee

Dr Neville Gibbs is chairman of the WA Anaesthetic Mortality Committee and has embarked on a process of increasing the awareness of the anaesthetic community of the function and workings of the committee.

Anaesthesia WA Website

Clinical Assoc Prof Richard Riley, Webmaster

The Anaesthesia WA website (maintained by the Anaesthesia WA Continuing Education Committee) is now hosted gratis by the the Clinical Training and Education Centre, University

of Western Australia. Its internet address is : www.ctec.uwa.edu.au/anaesthesiawa/index.html . The website may also be found by using the simpler domain name: www.anaesthesiawa.org.

The main page features a news column and links to ANZCA and the ASA. It also directs the user to pages detailing various committees, educational material and other resources, such as malignant hyperthermia and anaesthetic allergy testing facilities in Western Australia. Many of the information pages are being converted into the Adobe PDF format. PDF files preserve formatting and help protect the intellectual property of authors. Dreamweaver was recently purchased to enable the webmaster to use a current software program for website maintenance. The website also is a convenient portal to Departments of Anaesthesia located in Western Australia. A link to our Emergencies and Guidelines page has been placed on the Australian Anaesthesia website.

Modifications to the website are made following ANZCA and ASA committee approval.

Health Department of Western Australia Committees

ANZCA WA contributes to the state committee on Rural General Practice Anaesthesia.

Western Australian Anaesthetists Support Group

This is a small informal confidential group supporting Colleagues in the midst of personal or professional crises. It is a joint project of ANZCA and ASA in WA.

Thanks

As always, members of the committee have given generously of their time and I thank them for this ongoing commitment to the well being of Anaesthesia in Western Australia. Finally, thanks again to our outstanding Admin Assistant, Mrs Patricia Luxford.

Dr Simon Maclaurin

Chairman



ANZCA Regional/National Annual Reports

Australian Capital Territory

Australian Capital Territory Regional Committee

Annual Report May 2004-April 2005

Office Bearers and Members

<i>Chair</i>	Dr Cliff Peady
<i>Secretary</i>	Dr Grant Devine
<i>Treasurer</i>	Dr John Ellingham
<i>Regional Education Officer</i>	Dr Prue Martin
<i>ASA Representative</i>	Dr Nick Gemmel-Smith (until December 2004) Dr Mark Skacel (from December 2004)

Other Committee members

Prof Thomas Bruessel
Dr Paul Burt

Regional administrative Officer

Mrs Eve Edwards

Meetings Held: 5

Meetings Attended

Professor Bruessel	4
Dr Burl	2
Dr Devine	5
Dr Ellingham	3
Dr Gemmel-Smith	1
Dr Martin	2
Dr Peady	5
Dr Skacel	1

2004 was another difficult year for college fellows within the ACT region. Severe anaesthetic staffing shortages at the major public hospital in the region (The Canberra Hospital) and an inability to recruit within Australasia resulted in the hospital being declared an Area of Need. Questions over this and the level of trainee supervision triggered an ANZCA accreditation inspection of The Canberra Hospital and Calvary Hospital (ACT).

This inspection revealed several areas of deficiency, particularly at The Canberra Hospital.

Since this inspection the anaesthetic manpower shortage in the ACT has to a large extent been alleviated by the appointment of 3.8 FTE Staff Specialists and 2 VMO anaesthetists to The Canberra Hospital. Two of the Staff specialists are Overseas Trained Specialists (OTS) who have registered with ANZCA to proceed towards their Fellowship through the OTS process.

Supervision of ANZCA trainees has improved, and it is anticipated that re-inspection will be more favourable.

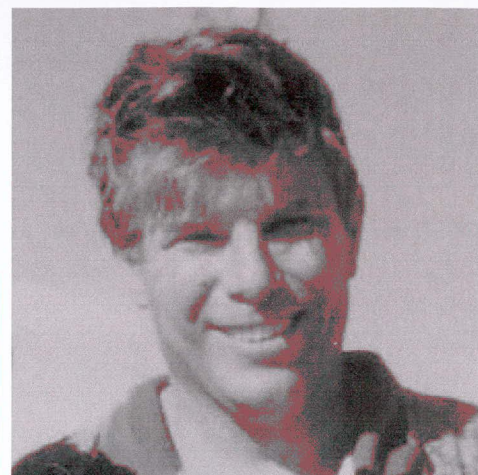
Despite staffing difficulties at consultant level, ACT region trainees enjoyed examination success. Dr William Egerton and Dr Don Lu were successful in passing the Part 2 exam at first attempt. Drs Nigel Ackroyd, Geoffrey Ding, John Lau, Ken Nam, and Valerie Quah completed both components of the Primary exam. A further 4 regional trainees were successful in the physiology component.

Dr John Ellingham organised a very innovative and thought provoking programme for the annual ANZCA / ASA Canberra meeting, entitled "Uncharted Territory". Unfortunately, registrant numbers were reduced compared to previous years, possibly because of the unexpected clash with the Federal election being held on the same day, and also clashing with the ASA ASM held in Sydney the previous week.

Professor Thomas Bruessel has accepted the role of convenor of this years' Canberra meeting, to be held on the weekend of October 15th & 16th 2005 (the last weekend of Floriade), with the theme of "Perioperative Complications". Planning is well under way, and a topical and interesting programme is anticipated.

Increasing use of videoconference opportunities (with assistance from Regional ANZCA / ASA funds recently) has improved regional fellows and trainees access to high quality CME activities. It is anticipated that this trend will continue.

On a more negative side, no progress has been



Dr Cliff Peady

made towards development of an ACT committee to investigate perioperative morbidity and mortality associated with anaesthesia. Discussions with ACT Department of Health have stalled.

However, monthly Anaesthetic Department M & M meetings have been continued at The Canberra Hospital to discuss morbidity and mortality occurring within that institution.

The regional committee would again like to thank Mrs Eve Edwards for her invaluable and cheerful assistance throughout the year.



ASM Launches

At the ASM in Auckland in May two events of historical significance occurred. The first was the launch by the President of Volume 2 of One Grand Chain : The History of Anaesthesia in Australia, 1934-1962, with chapters by Gwen Wilson, Geoffrey Kaye, Garry Phillips and Barry Baker. Edited by Jeanette Thirlwell Jones, this volume completes the task undertaken by Gwen Wilson to record the history of anaesthesia in Australia. A Book of References to Volume 1 was also launched. This had been prepared by Alison Holster, former librarian to the RACP, who had assisted Gwen over the years. Edited by Jeanette, this addition fills a gap left when Volume 1 was published without references. Seen here are Gwen's daughter Jan Johnston with Barry Baker, Dean of the Faculty of Anaesthetists when Gwen published her Bibliography of



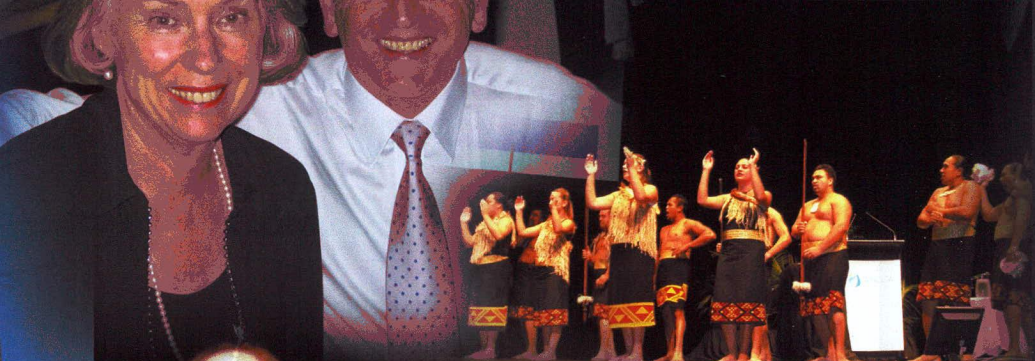
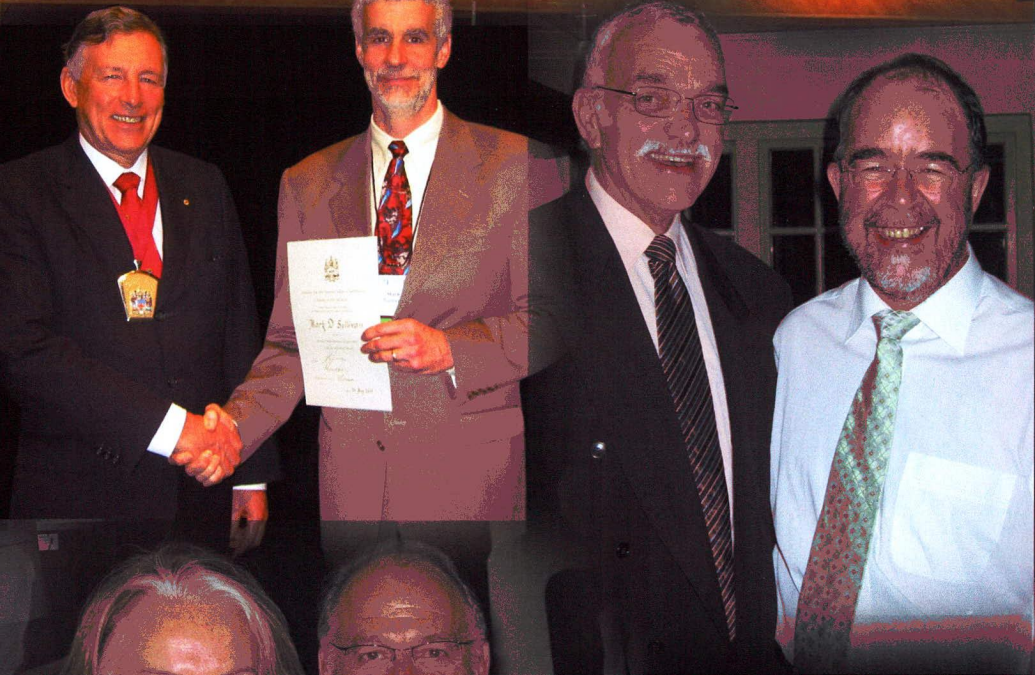
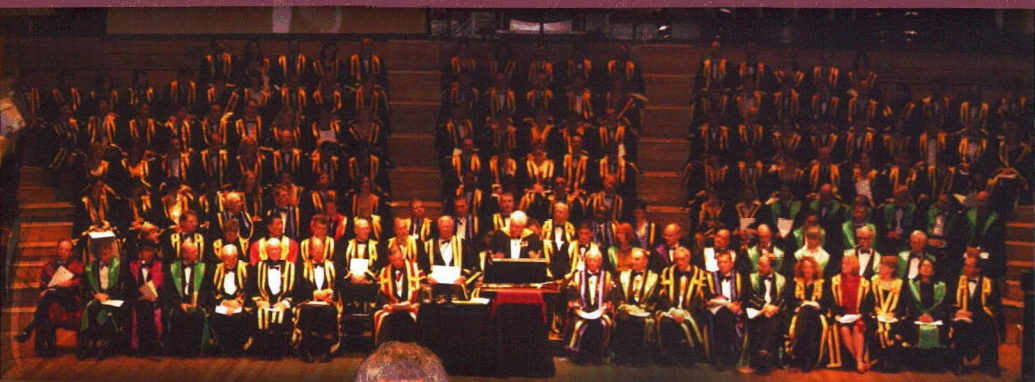
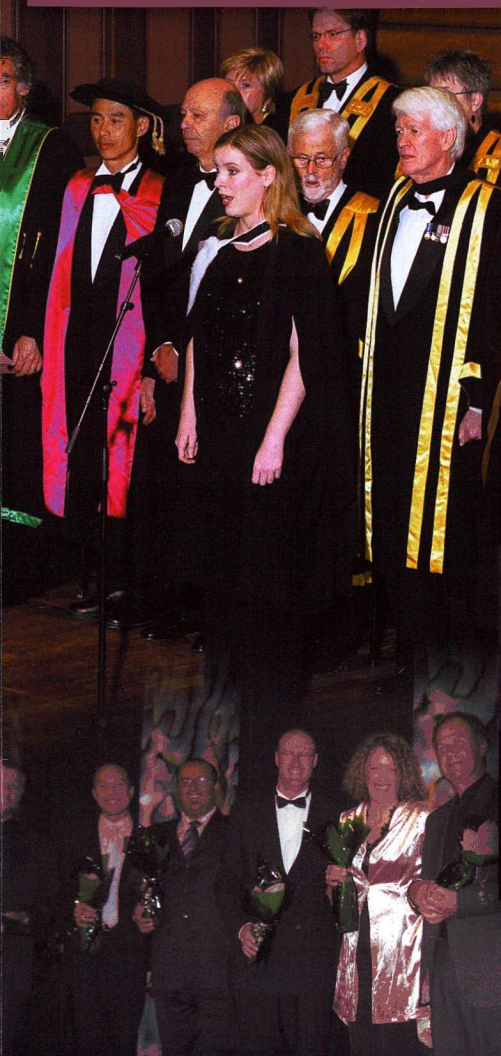
References to Anaesthesia in Australian Medical Journals 1846-1962, together with Alison Holster, Garry Phillips and Jeanette Thirlwell Jones.



At the ASM Professor Cousins also launched a bibliography of Anaesthesia related articles.

The articles appeared in the New Zealand Medical Journal, 1887 - 2000, compiled by Basil Hutchinson, Honorary Consultant Anaesthetist, Green Lane Hospital, Auckland, seen here being congratulated by the President.

Annual Scientific Meeting 2005



Auckland





Pain Medicine

2005 Annual Scientific Meeting

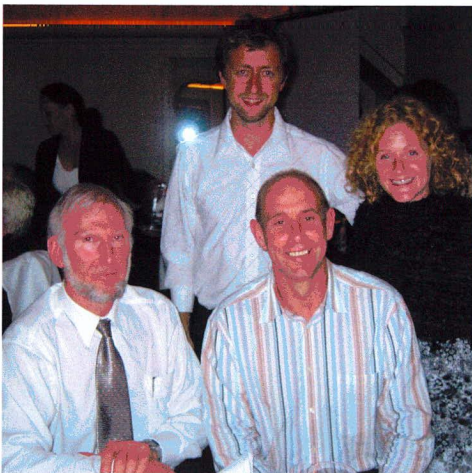
Auckland



Milton Cohen presenting a gift to retiring Board Member Graham Rice at the Faculty Dinner



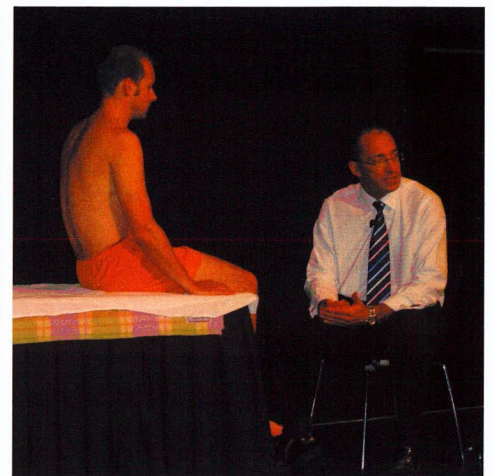
Faculty Scientific Program Convenor, Mike Butler with wife Meg at the Faculty Dinner



David Jones, Kieran Davis and Kathryn Newsham with Guest Speaker, Simon Mitchell



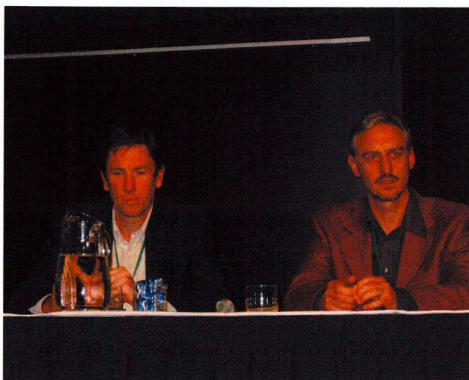
Dilip Kapur, Sandy Macleod and Karla Rix-Trott



Marc Russo (model patient) for Geoff Coldham



Bob and Sue Boas at the Faculty Dinner



Philip Siddall and Mark Farrell



Concept to Commercialisation – The Yeescope

Like many of us, I have had many years experience in clinical practice and thought I would like to improve on a problem area that I had identified. But of course the pathway from idea to actuality was quite daunting. Whilst we might know our speciality well, it was obvious within a short time that I was indeed a novice in the world of industry and business.

This project started nearly 3 years ago because I sought to address some issues in an area of anaesthetic practice. These were failing lights in laryngoscopes and the lack of hygiene practised around endotracheal intubation.

Over the past 25 years all clinicians will have been aware of an evolution in the microbiological environment – MRS in the 1970s, HIV in the 1980s, increased prevalence of Hep B and C in the 1990s, prion diseases in humans in the UK from 1996, and more recently, SARS.

It seems quite appropriate that more stringent regulations are put in place on recycling reusable medical equipment. It also seems quite appropriate for peak bodies such as NSW Health to require sterilisation of laryngoscope blades after each use. Our College has just released its revised 'Guidelines on Infection Control in Anaesthesia' where it states that items to be placed in the upper airway which may cause bleeding e.g. laryngoscope blades, must be disinfected before reuse, and laryngoscope handles should be decontaminated between uses.

The use of single-use blades only partly addresses the problems of potential cross contamination. Repeated cycles of high temperature sterilisation have led to premature failure of this critical piece of equipment and affected its reliability. All Anaesthetists have experienced failing lights on laryngoscopes during intubation, and are aware of the potential for patient morbidity. The fact that every registrar is taught to have two functioning laryngoscopes before commencing a rapid sequence induction is testament to the poor reliability of standard laryngoscopes!

Just as the light was often unreliable in laryngoscopes, so it was too on my medical

defence organisation in 2002. There were rumours of inadequate funding. There was uncertainty in the rising premiums, the amount of the 'call', if the MDO was going to survive even after paying the 'call'. All this was very unsettling, and eroded the security of the work I enjoyed. So I decided to explore this idea and develop it further.

The first step taken was to consult a patent attorney, who advised on different levels of intellectual property protection – provisional patent, Australian patent, international patent - Patents Corporation Treaty, design registration, Australian and international trademark registration. Each of these was to be secured over the ensuing three years.

A major milestone was to find a partner with relevant technical and commercial experience. This I found in Mr Mark Bennett, who with the backing of his company, Bennett Precision Tooling, helped to develop the device with CAD drawings, modelling, prototyping, toolmaking and trial manufacture.

Further encouragement was gained by securing two Government grants to assist in commercialisation of the device: a Comet Grant from AusIndustry, and a BioBusiness Grant from the NSW Department of State and Regional Development. These grants came with business consultants who provided guidance for inexperienced start-up companies. These funds assisted substantially in commissioning a market research project, developing a strategic business plan, securing TGA approval and CE marking, strengthening intellectual property protection and gaining legal and financial advice.

The final step in the development was to secure a manufacturing and distribution agreement with a suitably experienced local company. Commercial production will commence in the near future after fine tuning and product testing.

On 22 March 2005, the NSW Minister for Small Business, David Campbell, officially launched the 'Yeescope', also referring to it in a speech in Parliament on the next day. This public recognition of our project, our product and our



Dr Yee (right) at the ASM in Auckland, promoting the "Yeescope"

Company capped off the key support role played by DSRD as part of the BioBusiness program, and marks the end of the beginning of the 'Yeescope'.

It was with a great deal of curiosity that I experienced being on the other side of a trade display during the recent ANZCA conference in Auckland in May this year. It was an experience which I enjoyed immensely, and a time when I gained a lot of encouragement and feedback from fellow anaesthetists.

This journey has seen me branch out into legal, technical, business and financial fields that are a brand new experience for me. I have been pushed outside my normal working environment in many ways: from learning to talk with lawyers and patent attorneys, to writing grant applications, to researching and presenting data, and to taking financial risks outside medicine. My journey has elicited responses from several colleagues who have confessed to having ideas that they may like to pursue. I hope this article encourages them to pursue their ideas to fruition as well.

It has given me a great deal of satisfaction to see my concept materialise. Having come this far, the future of the 'Yeescope' is now dependent on how useful it is found to be.

Kevin Yee

¹ NSW Health Infection Control Policy. www.health.nsw.gov.au/policies/PD/2005/pdf/PD2005_247.pdf

² Guidelines on Infection Control in Anaesthesia. ANZCA Professional Document: Review PS28 (2005)

³ Yee KF: Decontamination Issues and Perceived Reliability of the Laryngoscope – A Clinician's Perspective. *Anaesthesia & Intensive Care*, 2003, 31: 661-5.

⁴ Yee KF & Hales PA: The case for single-use laryngoscopes (Poster). 13th World Congress of Anesthesiology, 17-23 April 2004, Paris, France.

⁵ NSW Legislative Assembly Hansard p14869. 23rd March 2005



Victorian Medical Postgraduate Foundation

VMPF Medical Careers Expo

Saturday 14th May 2005

The VMPF held their annual Medical Careers Expo on Saturday May 14th 2005 at Melbourne Park Function Centre. The expo targets medical students and resident doctors about to embark on specialty training programs. Most of the Colleges were represented, including Surgery, Physicians, Obstetrics/Gynaecology, Psychiatry, Ophthalmology and General Practice, as well as lesser-known associations (Aerospace Medicine and Pathology). The major hospitals/networks also held booths, as did allied industries such as MDAV and AMA. Overall, 50 associations were showcased.

The Victorian Regional Committee booth was manned by staff from the RMH Anaesthetic Department, including consultants May Lim, Ben Di Luca, PFYs Jim Dennis and Pierre Bradley and a 3rd Year Registrar Erika Dutz. From the minute the doors opened at 9:30 am our booth was inundated with queries from many bright-eyed, eager young residents and medical students. The peak occurred at mid-morning; at this time all five of us were fielding questions with a line of people waiting their turn! Common questions included "how do I get into the program?", "when's the soonest I can get into the program?", "can I have overseas experience accredited?", "what jobs should I do if I don't get in?".

We also took queries from overseas-trained anaesthetists, doctors wanting to be GP-Anaesthetists and parents interested in job sharing. Attendees were provided with booklets with information about the College and the training process. They were also able to view the Training Module and a DVD depicting anaesthetists in action.

At close, our larynxes were sore and dry from almost 5 hours of talking (we each spoke to at

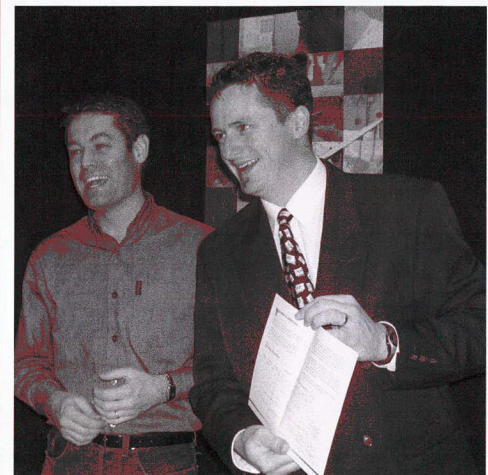
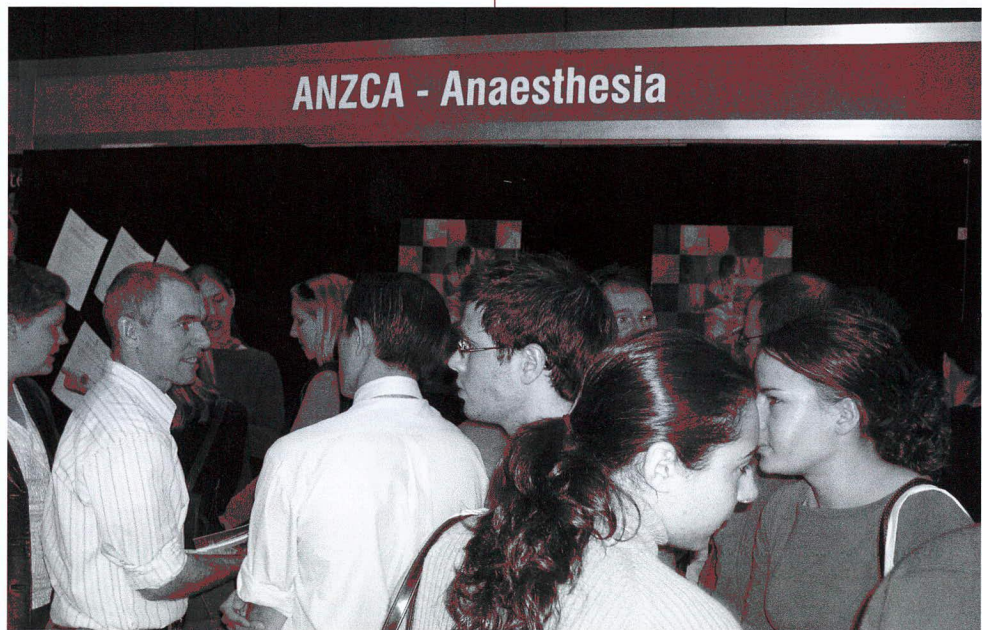
least 10 people), we reflected on the success of the day and our popularity as a specialty!

May Lim

*Consultant Anaesthetists
Royal Melbourne Hospital*

Reny Segal

*Assistant CME Officer
Victorian Regional Committee*





Examinations

Primary Examination

March/April 2005

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

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

Successful Candidates

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

Sue Young Ahn	NSW
Stewart Alexander Allan	NZ
Yasir Altamimi	WA
Sally Liza Barlow	NZ
Kerry Benson-Cooper	NZ
Bin Wern Hsien	SGP
Rebecca Jane Black	QLD
Owen Peter Bourne	NZ
Peter William Lincoln Brennan	NSW
Justin Adam Burke	VIC
Andrew David Cairncross	NSW
David Cardone	NSW
Karen Chan	NSW
Szu-Lynn Chan	WA
Chan Chi Wing	HKG
Betty Wai Yee Cheung	HKG
Chow Chee Yuen	HKG
Clement Chi Hang Chu	NSW
Chui Sze Wing	HKG
Peter Chung	NSW
Andrew James Clarke	QLD
Annick Irene Depuydt	NZ
Pedro Diaz	SA
Brendan Matthew Doherty	NSW
Sam Matthew Duncan	VIC
Mark Alexander Fairley	QLD
Daniel James Faulke	NZ
Benjamin Gibb Freeman	VIC
Fun Li-Ling Wendy	SGP
Fung Yiu Tung	HKG
Natalie Anne Gattuso	VIC
Katrina Christine Gelhaar	QLD
Elizabeth Anne Gooch	QLD



Rear: Dr. Andrew Gardner, Prof. Paul Myles, Drs. David Story, Prof. Guy Ludbrook, Drs. Graham Roper, Terry Loughnan, Gerard Meijer and Brien Hennessy

Front: Dr. Noel Roberts (Acting Chairman, Court of Examiners), Drs. Julia Fleming, Lindy Cass, Jill Bishop and A/Prof. David Cottee (Chairman, Primary Examination Committee)

Steven Alan Gubanyi	QLD	Wai John Lee	NZ
Su Yuan Stephen Han	NSW	Leung Wing Yan	HKG
Andrew Morgan Hart	NSW	Luk Sing Li	HKG
Assad Hussain	HKG	Swee-San Susan Loo	SA
Nicholas James Hutton	NZ	Frances Lui	HKG
Anjanette Mariko Hylands	NSW	Anthony Lynch	SA
Dev Jayram	NSW	Mah Chou Liang	SGP
Shumita Joseph	TAS	Samir Simon Mansoor	NZ
Kam Hau Chi	HKG	Catherine Jane McGregor	NSW
Michael Hua-Tsung Kao	QLD	Shane Merriman	WA
Geraldine Lek-Sumn Khong	WA	Petra Fey Muriel Millar	QLD
Orison Minh Oh Kim	NSW	Agnes Katalin Molnar	NSW
Yen Cheng June Koh	SGP	Jodi Simone Murphy	NSW
Kong Hang Sze Amy	HKG	Raymond Nassar	NSW
Monica May Korecki	SA	Angus John Neal	QLD
Hari Krshnan	MYL	Neo Hong Jye	SGP
Peter Andrew Kuestler	NSW	Julie Lai Wai Ng	WA
Emile Francis Kurukchi	QLD	Wai Leap Ng	NZ
David Hui-Fung Lam	VIC	Ben Luke Olesnicky	NSW
Andrew Kenneth Lansdown	NSW	Phong Ven Nee Stephenie	SGP
John Lau	ACT	Phua Shing Kuan Darren	SGP
Lau Chung Wai	HKG	Timothy Michael Porter	SA
Andrew Paul Lavender	SA	Matthew Prentice	NSW
Lee Tze Wee	SGP	Quah Yeow Leng Valerie	ACT
Tania Louise Lee	NSW	Munawar Ahmed Rana	SA



Lorna Gail Rankin	NZ
Maria Magdalena Rhodes	WA
Angelo Antonio Ricciardelli	SA
Moira Northcott Rush	NSW
Samantha Kim Russell	VIC
Pamela Salerno	NSW
Andrea Salvatore Santoro	NSW
Matthew Richard Scott	NZ
Siew Chern Hwee Raymond	SGP
John Ping Cheung Sim	QLD
Amar Awaz Singh-Jangi	VIC
Poobalan Sivasubramaniam	NZ
Catherine Esther Smyth	NSW
Gabriel Lee Snyder	VIC
Venu Gobal Suresh	MYL
Tan Liang Hui	SGP
Tham Huae Min	SGP
Arun Kumar Thiagarajan	NSW
Emma Janine Thomas	NZ
Lara Joanne Tickell	VIC
Luke Emanuel Torre	WA
Katherine Anna Townend	NZ
Maartje Johanna Tulp	NZ
Natalya Carol Von Papen	QLD
Benedict John Francis Waldron	VIC
Ivan Ward	SA
Andrew James Watson	NZ
Paul Joseph Whiting	NSW
David Edwin Whybrew	NZ
Christopher Hayden Wong	NZ
Jeremy Kwok Doong Wong	VIC
Duncan Morris Wood	NZ

Warrick Allan Grant Wrightson	NZ
Yip Cheng Bee	MYL
Yue Man Cheung Stephen	HKG
Sandy Zundel Wolf Zalstein	VIC

Renton Prize

The Court of Examiners recommended that the Renton Prize for the half year ended 30th June, 2005 be awarded to:

Daniel James Faulke	NZ
Pedro Diaz	SA
Luke Emanuel Torre	WA

Merit Certificates

Merit Certificates were awarded to:

Benjamin Gibb Freeman	VIC
Ivan Ward	SA
Justin Adam Burke	VIC
Gabriel Lee Snyder	VIC
Kong Hang Sze Amy	HKG
Warrick Allan Grant Wrightson	NZ
Andrew Kenneth Lansdown	NSW
Mark Alexander Fairley	QLD



Faculty of Pain Medicine

Dean's Message

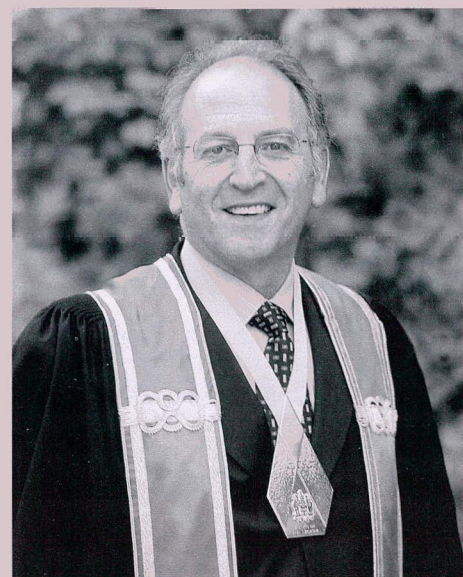
The recent AGM of the Faculty was marked by the retirement of four Board members. Graham Rice FRANZCP has served continuously since the initial Board in 1999 and in the roles of Treasurer and Assistant Censor. Julia Fleming FANZCA was elected in 2002 and established the Research Committee of the Board. Bruce Kinloch FAFRM (RACP) has served since 2000, including as Treasurer. Ben Marosszeky FAFRM (RACP) served on the initial Board and again in 2004. Their contributions have been marked by wisdom, wit and willingness to take on difficult tasks. The Faculty is most grateful for their service. We welcome as new Board members Geoff Booth FAFRM (RACP) (NSW), Brendan Moore FANZCA (QLD), Frank New FRANZCP (QLD) and Ted Shipton FANZCA (NZ).

A year ago I identified three challenges for Pain Medicine as a specialty and for the Faculty in particular. The first of these was to raise the visibility and profile of Pain Medicine in the contexts in which we practise. In many institutions the idea of a "pain specialist" or an on-call roster for "pain" may still be foreign to the established culture. We may still have patients being admitted to hospital or spending longer-than-desirable time in hospital because of pain. In many cases this is attributable to a solution being sought in biomedical terms whereas the resolution frequently requires a broader biopsychosocial paradigm in which pain specialists, by definition, have expertise. As this Bulletin goes to press, our application for recognition of Pain Medicine as a specialty is, at last, before the Australian Medical Council. Taken together with the World Congress of Pain to be held in Sydney in August and the imminent publication, by ANZCA, of the second edition of the Guidelines for the Management of Acute Pain, endorsed by the IASP, RCA, RACP, RACS and RANZCP, the potential for our specialty to make an impact has never been greater.

The second challenge was for the Faculty to strengthen its relationships with our component Colleges. This has occurred, particularly with the Australasian Faculty of Rehabilitation

Medicine (RACP). The Faculty maintains a close relationship with the Chapter of Palliative Medicine (RACP) and links have been established with the Chapter of Addiction Medicine (RACP). Still within the RACP, approaches are in train to the Australian Rheumatology Association and the Australian Association of Neurologists. We have a dialogue with the Division of Consultation Liaison Psychiatry (RANZCP) and with the RACS through the Neurosurgical Society of Australasia. The Faculty has offered to facilitate pathways for trainees in those disciplines, to contribute curricular, teaching material and examination materials to those bodies and to present at their Annual Scientific Meetings. There has been increased activity in this area.

The third challenge was to attract trainees and indeed to broaden the attractiveness of our discipline. In this domain there have been three developments. The Faculty has adopted a change in philosophy with respect to accreditation of training, to create opportunities for multidisciplinary experience. There are two parallel processes of accreditation: of a "training unit" which contains the physical infrastructure and clinical exposure which can be provided to trainees; and of a "training program" of an individual trainee (which may be spread over more than one "unit"). Much progress has been made in developing support and educational material, including the latest iteration of the Objectives of Training and Reading List, creation of the Supervisor of Training Support Kit, radical revision of the Trainee Support Kit and accompanying materials. Resource materials produced by the Faculty include Psychosocial Assessment, Guide to the History of the Patient in Pain and Epidemiology for the Pain Physician. The Pain-Orientated Physical Examination DVD has been distributed to the Fellowship. The third development has been lengthy discussion concerning entry into pain medicine training. It has been resolved to accept Fellowship of the Australian or New Zealand College of General Practitioners and Fellowship of Faculties or



Chapters of the original participating bodies as an entry criterion for a three-year prospective training program. This significant shift in policy is currently before the parent Colleges for ratification.

Whilst it is pleasing to report these responses to these challenges to date, much work remains to increase awareness amongst colleagues of the discipline of Pain Medicine and to promote and provide training opportunities in a climate of fierce competition for funds.

The ASM in Auckland continued the tradition of outstanding Refresher Day and Scientific Programs, centred on the theme of Pain and the Brain. Our Foundation Visitor, Professor Mark Sullivan from the USA, drew on his background of philosophy, psychiatry and clinical research to lead discussions on problems as diverse as the relationship between chest pain and the mind, "somatisation" and ethical issues surrounding unrelievable pain. We are grateful to Mike Butler and Bob Large for their organisation of both programs and to Kieran Davies for the social program. The Faculty greatly appreciates the ongoing support for the Refresher Day from Pfizer.

I would urge all Fellows and trainees not to miss the 11th World Congress on Pain, to be held in Sydney on August 21-26 next.

Milton L. Cohen
Dean



Deans Report

Annual General Meeting

8 May 2005

Fellowship

The Fellowship now numbers 197, of whom 58 have been admitted through training and examination. Although the majority of trainees have been anaesthetists by primary specialty, it has been gratifying to note neurosurgeons, psychiatrists, physicians and rehabilitation physicians taking up the challenge of training in Pain Medicine. At this meeting Professor Robert Boas (FANZCA, NZ) was admitted to Honorary Fellowship, taking the number of Honorary Fellows to seven. We congratulate the immediate past Dean, Leigh Atkinson, on his award of an AO in the Australia Day Honours List.

Valete et saluete

At this AGM, four long-serving Board members will step down. Julia Fleming, Bruce Kinloch, Ben Marosszeky and Graham Rice have each played important formative roles in these early years of the Faculty. Their wisdom, wit and work have been very much appreciated. We have also benefited from the year Mike Martyn has spent with us as the Council representative.

The Faculty congratulates Geoff Booth, Brendan Moore, Frank New and Ted Shipton on their election to the Board.

In January, Margaret Benjamin resigned as Executive Officer of the Faculty, having served since its inception. We have welcomed Helen Morris as our new Executive Officer. In July, Mary Silvestro was appointed as Administrative Assistant.

Recognition of Pain Medicine as a Specialty

The Faculty's case for recognition of Pain Medicine as a specialty was reinforced in the course of responding to a further series of questions by the AMC, mainly concerning possible economic impact. The process has been prolonged, perhaps as Pain Medicine is the first to be processed under the new system. We expect to know the outcome in July.

Intercollegiate Relationships

Following the Intercollegiate Pain Medicine Forum held in July 2004, the Faculty has instituted a strategy for enhancing relationships with its parent bodies and other groups with involvement in Pain Medicine. The Faculty maintains a close relationship with the Chapter of Palliative Medicine (RACP). Links have been established especially with the Chapter of Addiction Medicine (RACP) and the Division of Consultation Liaison Psychiatry (RANZCP). Approaches are in train to the Australian Rheumatology Association, the Australian Association of Neurologists and the Neurosurgical Society of Australasia. The Faculty has offered to facilitate pathways for trainees in those disciplines, to contribute curricular, teaching material and examination materials to those bodies and to present at their Annual Scientific Meetings. Actual and potential realisation of these connections has been gratifying.

After lengthy discussions, it has been resolved to admit to pain medicine training practitioners who hold Fellowship of RACGP or RNZCGP and who can demonstrate significant interest/and or experience in pain medicine. This significant shift in policy has been presented to the parent Colleges for ratification before transmission to the Colleges of General Practitioners.

At the Board meeting of 5 May, it was also agreed that those practitioners who hold Fellowship of a Faculty or Chapter associated with one of the parent colleges is also eligible to enter pain medicine training, the length of training to be nominally three years, with remission from this to be determined by the Censor.

Education

Under the chairmanship of Rob Helme, the Education Committee has completed the latest iteration of the Objectives of Training and Reading List, has created the Supervisor of Training Support Kit and has radically revised the Trainee Support Kit and accompanying materials.

Tim Semple has agreed to coordinate Supervisor of Training activities. Resource materials produced by the committee include Psychosocial Assessment, Guide to the History of the Patient in Pain and Epidemiology for the Pain Physician. The POPE DVD has been distributed to the Fellowship. Development of Faculty Technical Documents ("white papers") in face-to-face meetings is proceeding.

Annual Scientific Meetings

The Faculty's Foundation Visitor for this meeting is Professor Mark Sullivan from Seattle. The Faculty is most grateful to Mike Butler and Bob Large for building an innovative and broad-ranging Refresher Day and Scientific Program around Professor Sullivan, on the theme Pain and the Brain. We also thank Kieran Davies for his work on the social program for this meeting.

For the meeting in Adelaide in 2006, the Foundation Visitor will be Professor Bill Macrae from Dundee, whose theme is the epidemiology of post-operative pain. The South Australian Visitor will be "our own" Suellen Walker, to address the developmental neurobiology of pain.

Examination

Under the direction of Penny Briscoe, the Examination Committee has been actively addressing the challenges of competency and performance assessment in Pain Medicine. The 2004 examination was held in Adelaide in October. Fifteen of the eighteen candidates were successful. The Barbara Walker Prize for excellence was awarded to Dr Eric Visser FANZCA from Western Australia, the third such success for Perth-based trainees. Merit certificates were awarded to Dr Jane Munro FRACP from Victoria and Dr Marc Russo FANZCA from New South Wales. The 2005 Examination will be held in Sydney in October.

Training Unit and Program Accreditation

The Faculty has adopted a change in philosophy and terminology with respect to accreditation of



training, prompted by the ongoing challenge of creating opportunities for multidisciplinary experience for trainees and by changes in the climate of medical training. There are two parallel processes of accreditation: of a "training unit" which contains the physical infrastructure and clinical exposure which can be provided to trainees; and of a "training program" of an individual trainee (which may be spread over more than one "unit"). Under Roger Goucke's direction, accreditation is currently in a transition phase, with revision of questionnaires and evaluation matrices. Trainees will not be disadvantaged during this process.

Research

Under Julia Fleming's chairmanship, a Research Committee has been established. The main activities have been liaison with the College Clinical Trials Group and discussion regarding the allocation of funding to pain projects. A register of publications and of current research by Faculty Fellows is to be established.

American Academy of Pain Medicine Journal, Pain Medicine

Agreement was reached with the AAPM that the Faculty adopt *Pain Medicine* as its publication vehicle, with a discounted subscription for Fellows. Colin Goodchild has been appointed as the Faculty's Senior Editor. At a time when

pain medicine is claiming a global place on medical agendas, this development is a major step towards collegiality, scholarship and the development of the discipline. It is hoped that the Fellowship will strongly support its Journal.

Thank you

I would like to thank the members of the Board, especially the Vice-Dean Roger Goucke, and those Fellows who have contributed to committees, as examiners or as representatives of the Faculty, for your support and devotion to the task. I would commend to the Faculty the vital and skilled roles played during the year by our administrative staff.

Milton L Cohen

8 May 2005



Report

Highlights from the Board Meeting

28 February 2005



Back Row: Drs J A Fleming, G I Rice, B M Kinloch, M Martyn, Professor R D Helme, Ms H M Morris (Executive Officer) **Front Row:** Drs D Jones, C R Goucke (Vice-Dean), A/Professor M L Cohen (Dean), A/Professor R L Atkinson, Dr P A Briscoe (**Absent:** Professor J E Marosszeky)

The Faculty welcomed Ms Helen Morris who commenced her appointment as Executive Officer in early January.

Associate Professor Milton Cohen was re-elected as Dean for a second year.

The Board agreed that the Faculty Executive be delegated authority to make decisions in between Board meetings. The Faculty Administrative Instructions are being comprehensively reviewed by David Jones.

Honours and Appointments

The following awards in the Australia Day Honours were noted:

Professor Garry Phillips AM,
Member of Order of Australia

A/Prof Vic Callanan AM,
Member of Order of Australia

Dr Jill Sewell AM,
Member of Order of Australia

Fellowship

Two Fellows were admitted to Fellowship by examination and training (one FRCA, one FCARCSI) and one FANZCA was admitted to Fellowship via the Alternate Pathway. Discussion was held regarding overseas Fellows (specifically anaesthetists) with qualifications recognised as "acceptable to the Board" for the purposes of

training in Pain Medicine but who in fact would be unable to practice in their primary speciality in Australia without undergoing further training. It was anticipated that the Board may have to address not only training and certification in pain medicine but also credentialling in pain medicine. A position paper addressing this will be prepared, utilising the College's OTS experience.

Intercollegiate Relationships

The February Board meeting was addressed by Associate Professor David Clarke, Chair, Section of Consultation-Liaison Psychiatry (RANZCP Vic Branch). As there had been a change in the training program for Psychiatry, opportunities for CL trainees to be exposed to pain medicine



needs to be nurtured. This process is not helped by lack of publicly funded training positions. Synergies may need to be sought in the private sector, although that is difficult in psychiatry.

The Faculty has been invited to contribute to the AFRM (RACP) Annual Scientific Meeting in May 2006.

Recognition of Pain Medicine as a Specialty

A response to ROMSAC's request for more economic data to support the FPM's application for specialty recognition has been submitted.

Finance

The Faculty accounts for the twelve months to 31 December 2004 were accepted. The Meeting was addressed by ANZCA Treasurer, A/Prof Kate Leslie concerning the *Foundation Fund*. It was acknowledged that a plan is needed for future management of the Fund, agreed by the Board and Council, and a small working party has been formed to discuss A/Prof Leslie's paper and proposals. A further meeting of representatives of Council and the Faculties is scheduled for July.

Education

Products of the Education Committee recently circulated include the Supervisors of Training Support Kit and an advanced draft of the Trainee

Support Kit. *The Pain-Orientated Physical Examination* DVD produced by the Faculty has been distributed to Fellows and Trainees and is available for purchase by others.

AAPM and its Journal, Pain Medicine

Professor Colin Goodchild's nomination to the Senior Editor position on the Board of that Journal has been ratified.

Maintenance of Professional Standards

A MOPS Survey is being undertaken to establish details of Fellows' current participation in MOPS. Fellows can complete the MOPS/CPD Program of either their primary specialty College and/or the ANZCA MOPS Program.

Examination

The 2004 Examination Report has been circulated and is available on the website.

The 2005 Examination will be held at the Prince of Wales Hospital in Sydney on 19-21 October. The Pre-examination Short Course will be held in Adelaide on 8-9 September.

Training Unit and Program Accreditation

Hunter Integrated Pain Service was accredited as a Training Unit and Geelong Hospital, Royal Perth Hospital and Royal Hobart Hospital were re-accredited as Training Units. An expression of interest has been received from the Royal Melbourne Hospital Campus. In view of the feedback provided by the units in the form of Trainee Schedules, document PM2 will undergo extensive revision. The schedules have highlighted how training is provided and the format of training within each unit.

2006 Annual Scientific Meeting, Auckland

Dr Bill Macrae (Dundee, UK) has accepted the invitation to be the Faculty's Foundation Visitor at this meeting

Australian Medical Student Association Convention 2005

ANZCA NSW Regional Committee will be manning a booth at this meeting and the Faculty plans to participate.



Report

Highlights from the Board Meeting

5 May 2005

The Faculty Board met on 5 May to transact usual business; the "new" Board met on 8 May for the purpose of appointing office-bearers and committees.

Fellowship

Fellowship of the Faculty has reached 197. Of these, 7 are Honorary and 5 have retired or resigned. Of the 185 active Fellows, 148 are domiciled in Australia, 13 in New Zealand and 24 in other countries. One Fellow (FANZCA) was admitted to Fellowship by training and examination and Associate Professor Peter Teddy, neurosurgeon in Melbourne, was admitted to Fellowship by election.

The Administrative Instructions of the Faculty are currently under review.

Training Requirements for Fellowship

The Board has been seeking to broaden opportunities for training in Pain Medicine. At the February Board meeting a resolution was passed concerning Fellows of the Australian or New Zealand Colleges of General Practitioners: this issue, now modified, is before Council.

A number of key principles have been articulated with respect to establishing equivalence of qualifications acceptable to enter pain medicine training.

(i) The award of Fellowship of the FPM implies having reached a standard to allow unsupervised practice in Pain Medicine, not restricted to the Australian/New Zealand contexts, but applicable essentially in any country.

(ii) The formula for ascertaining that standard is **Q**(ualification) + **T**(raining) + **E**(xamination) = **F**(ellowship), to be applied equally to local and overseas trainees with primary College Fellowships or progressing towards those Fellowships. In respect of overseas potential trainees, the Faculty would be guided by the decisions of the parent Colleges regarding recognition of other Fellowships (the **Q** component).

(iii) It was resolved in May that as Fellowship of a Faculty or Chapter of a participating College, specifically the Faculty of Occupational Medicine (RACP), the Faculty of Public Health Medicine (RACP), the Chapter of Palliative Medicine (RACP) and the Chapter of Addiction Medicine (RACP), represented completion of a rigorous program of study, experience and assessment and as such was an acceptable **Q**. With respect to Fellowships of RACGP or RNZCGP feedback with the parent Colleges and Faculty is awaited.

(iv) With respect to Fellowships in (iii) above, a pain medicine component need not have been an explicit part of training but three years of training in pain medicine would be required (in contrast to two), with the possibility of some retrospective accreditation (the **T** component). As such the previously proposed requirement to "demonstrate significant interest/and or experience in pain medicine" has been removed.

These discussions have placed the Faculty in a position not only to embrace potential pain medicine trainees from a wider pool but also to respond to actual and potential demands of regulatory authorities.

Recognition of Pain Medicine as a Specialty

The Faculty has now received the revised report from the AMC's pain medicine recognition group, which includes many statements offered by the Faculty and contains new material. The economic aspects have been presented in a way very favourable to the cause. This report will be submitted to ROMSAC on 27 June.

Intercollegiate Relationships

The Faculty presented a session at the recent RANZCP Congress in Sydney. The Dean has been invited to address the RACP Council meeting in July. The Faculty has been invited to present at the AFRM ASM in 2006 and to observe its clinical examination.

A closer working relationship with the Chapter of Addiction Medicine (RACP) is evolving: a meeting of education officers is planned and the Chapter has nominated a representative to the Faculty's working party on long term opioid treatment in non-malignant pain.

It has been decided that the Faculty will concentrate its relationship with the Chapter of Palliative Medicine (RACP) at a Fellowship rather than Diploma level. The Faculty has offered resources to the Chapter.

Education

The RCA has endorsed the second edition of *Acute Pain Management: Scientific Evidence*. Endorsement has also been received from the IASP and APS. The volume will be made available at the IASP Congress in Sydney in August.

Revisions are being made to major educational documents in use. A move towards offering questions on pain medicine for first part examinations of participating bodies is progressing.

American Academy of Pain Medicine and its Journal, Pain Medicine

The first joint issue of Pain Medicine will be 6(4) (August 2005) and will contain an editorial from the Faculty. The Board has affirmed that subscription to the Journal is mandatory: the current arrangement will be reviewed in November 2006.

Examination

The Alternate Pathway to Fellowship has now closed. It was resolved that a candidate presenting for the 2005 examination through this pathway who is unsuccessful may apply to the Board for consideration to re-present for the 2006 examination.



Board Members / ANZCA Committees

Board Members

Dean	Milton Cohen
Vice Dean / Chairman HAC	Roger Goucke
Censor	David Jones
Education Officer	Robert Helme
Chairman Examination Committee	Penelope Briscoe
Chairman Research Committee	Geoff Booth
ASM Officer	Stephan Schug (non Board Member)
MOPS Officer/Treasurer	Leigh Atkinson
	Frank New
	Brendan Moore
	Ted Shipton
Co-opted Member representing ANZCA	Garry Phillips

Examination Committee:

Chair	Penelope Briscoe
Dean (ex officio)	Milton Cohen
Education Officer	Robert Helme
Deputy Chair	Ray Garrick

Members:

ANZCA	Lindy Roberts
AFRM (RACP)	Carolyn Arnold
RANZCP	George Mendelson
	Frank New
RACS	Leigh Atkinson

Education Committee:

Chair	Robert Helme
Dean (ex officio)	Milton Cohen
Chair Examination Committee	Penelope Briscoe

Members:

ANZCA	Jane Trinca
AFRM (RACP)	Geoff Booth
RACP	Michael Butler
RANZCP	Faizur Noore
	Frank New
RACS	Leigh Atkinson
New Fellow Representative	Susan Lord
Supervisor, SoTs	Tim Semple
Director of Education, ANZCA	Russell Jones

Hospital Accreditation Committee:

Chair	Roger Goucke
Dean	Milton Cohen
Censor	David Jones
Chair, Examination Committee	Penelope Briscoe
Chair, Education Committee	Robert Helme
FANZCA	Brendan Moore

Research Committee:

Chair	Geoff Booth
Dean	Milton Cohen
RACP	Anthony Schwarzer
	Robert Helme
ANZCA	Stephan Schug
AFRM (RACP)	Di Pacey
MBBS, PhD	Philip Siddall
Senior Editor, Pain Medicine Journal	Colin Goodchild
Univ of Adelaide (non Fellow)	Andrew Somogyi
Univ of Qld (non Fellow)	Maree Smith

Representation on ANZCA Committees:

Education	Robert Helme
General Examinations	Penelope Briscoe
Primary Examination	Penelope Briscoe
CE&QA	Leigh Atkinson
Constitution Review	Milton Cohen
Workforce	Robert Helme
Board of Anaesthesia, Intensive Care & Pain Medicine Foundation	Milton Cohen
Communications	Leigh Atkinson
Information Technology	Malcolm Hogg
ASM Scientific Program Officers 2006	Tim Semple/Dilip Kapur
ASM	Stephan Schug
Research	Geoff Booth
ACECC	Jane Trinca
Clinical Trials Group	Philip Siddall
Library	Roger Goucke
Salaries Review Committee	Milton Cohen
Asia Pacific	P P Chen
Clinical Indicators Working Party	Paul Wrigley
OTS	David Jones
Risk Management Committee	Milton Cohen

Regional Committees:

Queensland	Brendan Moore
New South Wales	K E Khor
Victoria	Julia Fleming
Tasmania	Gajinder Oberoi
South Australia	Penelope Briscoe
Western Australia	Roger Goucke
New Zealand National Committee	David Jones

External Committees & Organisations:

Australasian Anaesthesia	Lindy Roberts
Neuroscience Trials Australia (NTA)	Robert Helme/Julia Fleming



Honorary Fellowship

Robert Albert Boas

MB ChB (Otago) FFARACS (1967) FANZCA (1992) FRCA (1995)

"The Board of the Faculty of Pain Medicine may admit from time to time distinguished persons who have made a notable contribution to the advancement of the science and practice of pain medicine, who are not practising pain medicine in Australia or New Zealand"

Mr Dean, I have the honour of presenting to you **Robert Albert Boas**.

Born in Lower Hutt, near Wellington in New Zealand, Associate Professor Robert (Bob) Boas graduated in Medicine from Otago University in 1962 before taking up residency posts at Auckland Hospital from which he achieved, in 1967, Fellowship of the Faculty of Anaesthetists, RACS. From very early in his professional career Bob made substantial contributions in the field of Regional Anaesthesia with an early bias towards applications in Pain Medicine. This was at the beginning of an era where nerve blocks for diagnosis and management of difficult pain problems became an accepted standard of practice and when cancer pain especially was a prominent part of the case spectrum.

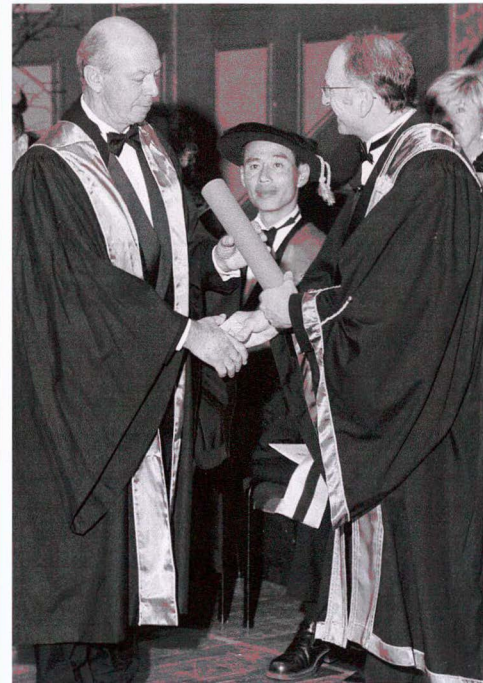
Although from our point of view contributions in this field within New Zealand and Australia are a major focus, it cannot escape our attention that from an early stage Bob had an international focus and collaborated with many other well regarded international figures which resulted in numerous publications relevant to the then developing field of Pain Medicine. These included working in Seattle which had the renowned Pain Clinic developed by John Bonica during the 1960's when such services were only in their infancy, as was the concept of the multidisciplinary approach. New Zealand was to benefit considerably from Bob's interests in pain

as he continued in that vein and in 1972 was founder of New Zealand's first Pain Clinic at Auckland Hospital. Two years later he went on to give valuable advice towards the establishment of a similar clinic in Dunedin. Over the years Bob has been noticed as a very patient, interactively challenging teacher of the art of medicine, especially as it can be applied to the patient with pain and, through involvement with the Pain Societies, this has spread to other than medical personnel. Missing from his CV was mention of the innumerable stimuli he has applied to others to think about pain and its relief.

Indicative of Professor Boas's recognition internationally was his term as a Council Member of IASP and inclusion on Editorial Boards of several international journals such as Pain, Clinical Journal of Pain, Regional Anaesthesia and the European Journal of Pain. From over fifty publications on Bob's CV one can identify the fields of interest to which he has made major contributions - these include the kinetics of lignocaine, all forms of regional anaesthesia and nerve blocks, aspects of the sympathetic nervous system and its postulated roles in pain continuation - then a later shift by reappraisal of this role in the wider context of the now named Complex Regional Pain Syndromes. Many of these publications in particular have been in collaboration with other recognised authorities in the field such as Wilfred Jänig and Michael Stanton-Hicks. Professor Boas's article describing a single needle technique for Lumbar Chemical Sympatholysis showed a systematic and challenging approach to former dogmatism and simplified this procedure.

In recent years, a significant endeavour of Bob's was a learning laboratory for teaching safe regional anaesthesia blocks. In 1996 he was honoured with the John J Bonica Award of the American Society of Regional Anaesthesia.

The award of Honorary Fellowship of the Faculty of Pain Medicine is a fitting recognition of the substantial contributions Professor Boas has made in the broad field of our specialty.



Mr Dean, I have the great honour and privilege to present to you **Robert Albert Boas** for conferment of Honorary Fellowship of the Faculty of Pain Medicine.

David Jones



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 (2003) Requirements for Multidisciplinary Pain Centres Offering Training in Pain Medicine (under revision)

PM3 (2002) Lumbar Epidural Administration of Corticosteroids

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 (2000) 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 (2001) 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 (2000) Recommendations on Monitoring During Anaesthesia (*Adopted February 2001*)

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*)

Joint Faculty of Intensive Care Medicine

Dean's Message

Kia Ora (Greetings),

We have just finished the combined ANZCA / JFICM / New Zealand Region ANZICS Annual Scientific Meeting at Auckland. This was held in the Aotea Convention Centre which proved an excellent venue. Those who attended (over 1300) agreed that it was a very good meeting. Thank you to Tony Williams, Nigel Rankin, and Elaine McCall who did most of the intensive care organisation. From the intensive care perspective, the visiting speakers Keith Walley (Foundation Speaker), Jacques Creteur (NZ ANZICS Speaker), and Carol Ball (Critical Care Nurses Section) contributed well and

that this will provide additional opportunities for training and support to our rural colleagues.

Other subjects discussed included the place of High Dependency Units and Medical Emergency Response programs, how they relate to each other, and how they should relate to the daily activities of intensivists. This "pre-intensive" care area is still provoking a lot of discussion and a wide spectrum of viewpoint still exists. We are still waiting on the results of the MERIT study, but it sounds as though the issues will remain, and further studies may be necessary. The health authorities are very interested in this area of practice.

"These are interesting times for College organisations. The shortage of medical manpower has stimulated a raft of Government initiated processes..."

complemented each other. Good numbers attended all the sessions. The local themes, such as rural intensive care also attracted a lot of interest. One third of intensive care in New Zealand is done outside the five main metropolitan centres. Much of this is done in small hospitals of less than 300 beds. Speakers included David Austin, who described the establishment of their excellent ICU at Northland, and Ross Freebairn followed with a description of how smaller ICUs can participate in and generate research, as they have done in Hawkes Bay. It should be noted that the Joint Faculty program now allows Trainees to do their Basic Training and their Elective Advanced Training year in smaller hospitals, who have a structured ICU, but cannot quite meet the Advanced Training Core specifications. It is anticipated this will lead to a second 'tier' of accreditation for basic training, and the Board will examine detailed criteria at its forthcoming meeting in June. We envisage

The New Fellows Conference at the Edmund Hillary Outdoor Pursuit Centre was an outstanding success. Set in the mountainous area of a central New Zealand national park, the combination of leadership seminars and challenging activities were stimulating and educational. Thank you to Alistair MacGeorge from Auckland for such an imaginative program.

At the time of writing, the Board Election has been held and the full results of the Poll will be available at the forthcoming Annual General Meeting in Sydney on 10th June. It was pleasing to note competition for the eight positions. One of the noteworthy results is that we have elected Board representatives from New Zealand and every State except one. Thank you to those who stood, but were not elected. There are several Board members who will be retiring in June. Ray Raper has been a stalwart over many years playing a very significant role in the development of the Joint Faculty, particularly in the previous Joint Specialist Advisory

Committee - Intensive Care, and more recently as Chairman of the Hospital Accreditation Committee. In his role as Co-ordinator of Advanced Training (Intensive Care) for the RACP he has been instrumental in maintaining a smooth transition for physician trainees wishing to achieve dual certification. Ray has just been honoured with the John Sands Medal from the RACP and his citation is published elsewhere in this Bulletin. We will miss his fine mind and sense of humour. Jonathon Gillis will be finishing after contributing on the interim and definitive Joint Faculty Boards. He has brought something special as a paediatric Fellow and also looked after the Maintenance of Professional Standards portfolio for some time. Steve Edlin was with us for a short time only, but facilitated a much needed advance in establishing the Conjoint Rural Committee, building on the work of others. He feels that his undoubted talents can be used better elsewhere, starting with a holiday in the south of France! Lastly, Rob Boots who had been co-opted as a Queensland Fellow over the previous year will be stepping down from the Board but continuing the good work in Queensland as Chair of the Regional Committee. It is noteworthy that Rob and others in the region are developing one of the better Regional Committee programs for Supervisors, Trainees and others. Thank you to these four, who have contributed so well.

These are interesting times for College organisations. The shortage of medical manpower has stimulated a raft of Government initiated processes, many overlapping, and with an enormous group of organisations and individuals involved. It reminds one of "Brownian Movement". However, it has highlighted the need for Colleges to continuously self-examine its policies and procedures to ensure our processes are sound.

The major projects include:

- a) Productivity Commission Study of the Health Workforce – the Commission will be

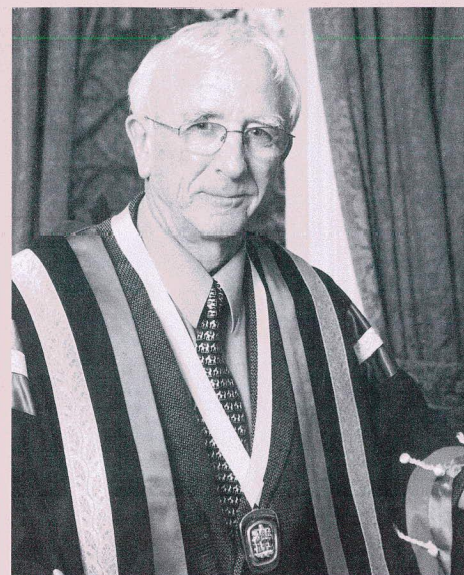


conducting a wide ranging study and reporting back to the Council of Australian Governments in February 2006. We are waiting to see their issues paper before submitting any views.

- b) Medical Specialist Training Steering Committee – basically this committee will be looking at broadening training into areas outside public teaching hospitals.
- c) Australian Competition and Consumer Commission – the RACS has been extensively reviewed. Other Colleges, including ourselves have had to provide information, and at this stage we are waiting to see how we stand and how much some stringent requirements for the RACS will flow on to other Colleges.
- d) Overseas Trained Doctors Training and Support Issues – we have made suggestions about how we could aid this process, but it has been clear that indemnity issues have become a problem to the Government, and there has been some stagnation of the process.

There are many other smaller projects such as facilitating retired doctors back into practice, but it will remain to be seen how much success occurs. A consortium of universities have suggested to the Government that they could produce a lot of the medical training. There is a watching brief on this and considerable scepticism around motives. With so much pro bono work from Fellows, one can only imagine how much the costs for trainees would rise if the Universities were running their training programs.

Jack Havill
May 2005





JFICM Regional/National Annual Reports

New Zealand

New Zealand National Committee

Annual Report 31 March 2004 to 31 March 2005

Office Bearers and Members

Chair	Dr Ross Freebairn
Vice Chair	Dr Seton Henderson
Honorary Secretary	Dr Tony Williams
Honorary Treasurer	Dr Grant Howard
Elected member	Dr Mike Gillham

Ex-Officio Members

Dr Jack Havill; Dean of JFICM
Dr Peter Roberts; Royal Australasian College of Physicians
Dr Gerard McHugh; Australian and New Zealand College of Anaesthetists
Dr Peter Hicks; Australian and New Zealand Intensive Care Society
Dr Claudia Schneider; New Fellows Representative
Dr Amy Bertinelli; Trainee Representative

Administrative Assistance Jan Brown

Total Number of National Committee Meetings for year: 3

Attendances of Elected Members:

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

Education and Training

Currently New Zealand has 47 Trainees.

Annual General Meeting

Was held at the Aotea Centre, Auckland on 9th May 2005.

Chairman's Report

The New Zealand National Committee, JFICM has been involved in a number of issues in 2004/2005:

Clinical Training Agency

There has been on-going debate regarding various issues over the year.

- (i) Funding for intensive care training posts has been overlooked by the CTA. Those completing Fellowships in JFICM (not conjoint Fellowships) are not funded at all though the CTA currently which means that these positions are a cost to the District Health Boards and could be an area of conflict over time as funding becomes an issue.
- (ii) Website update to include the specifications for the new advanced training program has been another area of frustration between the CTA and our Committee which we hope will be resolved shortly!

Ministry of Health

Labelling of Medication. The similarity of labelling is a concern to us. The Committee has been involved in attempting to ensure that systems are in place to prevent confusion. Most recent contact was by Dr Grant Howard to the Quality and Safe Use of Medicine Committee.

Medical Council of New Zealand

We are undertaking the re-accreditation of the vocational scope of practice of intensive care medicine.

RACS Mortality Audit

Dr Howard is representing the Committee on this working group.

Air Ambulance Strategy

There has been much discussion on this subject both by ANZICS and the NZNC, JFICM. A fresh document is being released and Dr Hicks is organising a one-day meeting for medical staff once this had been circulated.

Organ Donation

The NZ Medical Association approached the Faculty through the Council of Medical Colleges (CMC) as they are party to the WMA statement on organ donation which advocates the primacy of patients wishes (over the desires of the family). New legislation is likely in the next year, and NZMA are advocating that this "right" be upheld by legislation. Peter Hicks and I met with the NZMA to try and resolve their issues. NZMA are keen to try and find a way forward, but have not yet changed any of their views. NZMA have asked for a further meeting with their new Executive. They are keen to avoid sending a confused message to the public, if ANZICS / JFICM views differ from NZMA.

ACC

Dr Peter Roberts who is the RACP representative on the JFICM Committee has been selected as the CMC nomination (following JFICM nomination) on the Patient Clinical Advisory Group.

Submissions made by NZNC, JFICM:

- 1) Review of the HDC Act and Code 2004. –'Informed Consent for therapeutic research'.
- 2) Review of Regulations of Human Tissue and Tissue Based Therapies. We supported ANZICS with this.
- 3) MOH and Tertiary Education Commission (TEC) Qualifications Supply analysis. This was another opportunity to advise the Ministry of the importance of funding the JFICM posts separately.
- 4) Assuring Medical Practitioners' Cultural Competence (MCNZ). The aim was to set a standard and decide what to include in this area.

Ross Freebairn

Chairman, New Zealand National Committee, JFICM.

May 2005



JFICM Regional/National Annual Reports

South Australia

South Australian Regional Committee

Annual Report 2005

Education

Trainees: Local trainees' enthusiasm and hard work were rewarded with 5 trainees successful in the Joint Faculty Fellowship Examination in 2004. "Tub's course" (the Australian Short Course on Intensive Care Medicine) was very successful and, once again, was heavily oversubscribed. Thanks to all Fellows who make this course possible through their efforts as members of the Faculty. Steve Lam joined the Regional Committee as Trainee Representative.

Supervisors of Training: Robert Young resigned as Supervisor of Training at the Royal Adelaide Hospital and David Evans took over that role from January 2005. All South Australian Supervisors of Training remain as co-opted members of the Regional Committee to facilitate communication between the different training Units.

Continuing Education

Local Meetings: A combined JFICM and ANZICS meeting on Consent was addressed by Justice Tom Gray of the South Australian Supreme Court and Anita King of the SA Law Society. The meeting was very successful with consensus achieved on consent in intensive care by the large number of local intensivists present. A meeting is planned for 2005 with the State Coroner, Mr Wayne Chivell, to discuss the new SA Coroner's Act.

ANZCA ASM Adelaide 2006: Mark Finnis has agreed to be the Intensive Care Convenor and David Evans will convene the New Fellows' Conference. The Committee continues to have serious reservations about the number of national meetings held annually and the demands of convening another Scientific Meeting only 6 months after the Annual Scientific Meeting of ANZICS and ACCN which is also to be held in Adelaide.

Other Matters

A reciprocal arrangement was set up in 2003 whereby the Chair of ANZICS (SA) and the Chair of the JFICM (SA) were to be invited to the meetings of the other's Regional Committee. Given the overlap in the membership of the ANZICS and Joint Faculty Regional Committees, it was agreed to run concurrent meetings of these 2 committees. This has proven to be successful and will continue in future.

Acknowledgements

The Committee welcomed Georgina Douglas-Morse to the post of Regional Administrative Officer.

Dr Robert Young

Chair, South Australian Regional Committee



JFICM Regional/National Annual Reports

New South Wales

New South Wales Regional Committee

Annual Report 2004-5

Office Bearers & Members

<i>Chair</i>	Dr Yahya Shehabi
<i>Vice Chair</i>	Dr Ian Seppelt
<i>Secretary</i>	Dr Elizabeth Fugaccia
<i>Elected members</i>	Dr Edward Stachowski
	A/Prof John Myburgh (also <i>ex-officio</i>)
	Dr Ray Raper (also <i>ex-officio</i>)

ACT Representative: Dr Helen Bidstrup

New Fellows' Representative
Dr Michael Davis

Ex-officio Board Members Dr Richard Lee

Elections of Regional Committee membership

Nominations for NSW Regional Committee membership was sought from NSW Fellows, membership of the Committee remained largely unchanged. However, at the first meeting of the Committee in July 2005, election of office bearers was as follows:

<i>Chairman</i>	Dr Yahya Shehabi
Nominated by	Dr Michael Davis
Seconded by	Dr Edward Stachowski
<i>Vice Chair</i>	Dr Ian Seppelt
Nominated by	Dr Richard Lee
Seconded by	Dr Edward Stachowski
<i>Secretary</i>	Dr Elizabeth Fugaccia
Nominated by	Dr Richard Lee
Seconded by	Dr Edward Stachowski
<i>Treasurer</i>	Dr Ray Raper
Nominated by	A/Prof John Myburgh
Seconded by	Dr Richard Lee

The Committee moved a vote of thanks to Eddie Stachowski for his leadership and services over the past 2 terms.

Total number of Regional Committee meetings held: 3

<i>Dates of meeting</i>	21st July 2004
	11th November 2004
	30th March 2005

Attendances of elected members

Dr Edward Stachowski	3
Dr Elizabeth Fugaccia	3
Dr Yahya Shehabi	3
Dr Ian Seppelt	2
A/Prof John Myburgh	2
Dr Ray Raper	3

Hospital accreditation

The current status of hospitals accredited at C24 and C12 remained unchanged. Inspections were undertaken for Sydney Children's Hospital and the Children's Hospital at Westmead; inspections are planned for Prince of Wales Hospital and Royal North Shore Hospital in 2005. Representation at interviews for intensive care position across NSW hospitals was made on behalf of the JFICM.

Intensive care survey

Out of a total of 564 active trainees in 2005, more than 30% are from NSW and the ACT. Eddie Stachowski and Liz Fugaccia conducted a survey on behalf of the NSW Regional Committee of all intensive care trainees to identify factors that play major role in selection of intensive care as a career. Results of the survey were presented at the last ASM in Melbourne and appeared in the JFICM bulletin in November 2004.

NSW Intensive Care Long & Short Courses

A long course program for trainees studying toward the Fellowship Examination is progressing exceptionally well. The course has the active support of 11 Intensive Care Units around the Greater Sydney Metropolitan region. The units involved include Blacktown, Concord, Liverpool, Nepean, Prince of Wales, Royal North Shore, Royal Prince Alfred, St George, St Vincent's, Westmead and Wollongong.

Australian Critical Care Education Incorporated, a non-profit, charitable organisation formed by a cohort of intensivists, conducted the first paid at cost intensive care short course with exceptional success. The course is becoming a very popular destination to all trainees participating in the intensive care examination. The intention is to conduct the course twice per year.

The NSW RC took an active participation in the latest final fellowship examination held in Sydney with St George and Prince of Wales Hospitals participating in the exam making it convenient and smoother to run with the increasing number of trainees presenting to the clinical section.

Bimonthly meetings at Prince of Wales Hospital

The NSW Regional Committee held a meeting at the POW Hospital attended by more than 70 intensivists and trainees in March 2005 on "workforce in critical care" where Ray Raper presented the revised view of the IC-2 policy draft document. The meeting created significant debate with Prof Michael Frommer, University of Sydney, presenting his model for the Hospitalists in an option paper presented to the DoH in NSW.

The meeting held in May 2005 was attended by the Dean Dr Jack Havill who presented the JFICM Board's view on many of the current issues facing the speciality. The Dean met with many trainees and NSW Fellows amidst an atmosphere of collegiality and professionalism.

Other activities

The Regional Committee continues to represent the JFICM on the College Chairmen Standing Committee with tri-monthly meetings attended by the NSW Health Director General to examine issues related to medical workforce and other NSW health initiatives.

Also the Regional Committee will be represented by Ian Seppelt to the ECHTEC (Eastern Collaborative Health Training & Education Centre)



JFICM Regional/National Annual Reports

Tasmania

project run by NSW Health and Sydney University.

This year will see the first combined ANZICS / JFICM ASM held in Sydney, the NSW Regional Committee pioneered this meeting with John Myburgh convening the inaugural ASM.

Yahya Shehabi

Chairman NSW Regional Committee

Dated: 26 May 2005

Tasmanian Regional Committee

2005 REPORT

This is the first yearly report of the Tasmanian JFICM Regional Committee. This report sees the Tasmanian Fellowship increased in both numbers and spirits with recent appointments in both Launceston and Hobart taking the total number of Fellows in the state to just over 10. Public hospital staff specialists have benefited significantly from the recent "better hospitals" program introduced by the state government, which has seen the much needed injection of funds into the public health system. The package has allowed the appointment of new staff and also increased the total "package" provided to salaried staff specialists in particular the use of a motor vehicle and access to a generous research and education fund.

The Tasmanian Regional Committee held its inaugural meeting in February of this year. The meeting emphasized the close relationship between the Tasmanian ANZICS and the JFICM. The traditional ANZICS meetings continue to be held in Launceston and it was agreed that Faculty business could very conveniently be "dove tailed" together with these meetings. These regular meetings bring together all practitioners of intensive care medicine within the state and have proved them popular and well attended. A more formal structure is planned.

The Northwest Regional and Mersey Community groups recently held a successful and very enjoyable 1 day meeting attended by Profs Robert Laden and Geoff Parkin on the theme of Renal Replacement therapy. We look forward to the forthcoming CME meeting to be held in Burnie in August.

The current composition of the Tasmanian JFICM Regional Committee is

<i>Chair</i>	Dr John Gowardman, Dr Launceston
<i>Secretary</i>	Dr Allan Beswick, Hobart
<i>Treasurer</i>	Dr Alan Rouse, Northwest Regional, Burnie
<i>Members</i>	Dr Scott Parkes, Co-opted RACP rep Dr Marcus Skinner, Co-opted ANZCA rep.

John Gowardman

May 2005

Admission to Fellowship of the Joint Faculty of Intensive Care Medicine

The following have completed all requirements for admission:

Admission to Fellowship by examination under Regulation 5.1:

<i>John James Bates</i>	<i>Vic</i>
<i>Winston Kuen Cheung</i>	<i>NSW</i>
<i>Christopher Graves</i>	<i>QLD</i>
<i>Tung Ching Doris Lam</i>	<i>HK</i>
<i>David Vytautas Pilcher</i>	<i>Vic</i>
<i>Hui Lei Dominic So</i>	<i>HK</i>
<i>Stephen Joseph Warrillow</i>	<i>Vic</i>



JFICM Regional/National Annual Reports

Queensland

Queensland Regional Committee

Annual Report 30 May 2004 to 30 May 2005

Office Bearers and Members

Chair	Dr Rob Boots
Vice Chair	Dr Chris Anstey
Honorary Secretary/Treasurer	Dr Dan Mullany

Ex-Officio Members

Qld ANZICs/Rural Representative	Dr Michael Corkeron
SOT Representative	Dr John Evans
Trainee Representative Co-opted Member	Dr Nikki Blackwell
External Affairs Co-opted Fellow	Dr Ranald Pascoe
New Fellows Co-opted Fellow	Dr Jeremy Cohen
CME and Training Co-opted Fellow	Dr John Fraser
Elected Members	A/Prof B Venkatesh Dr Anthony Slater
Regional Administrative Officer	Ms Sharon Miethke

Total Number of Qld Regional Committee Meetings for year: 6

Attendances of Committee Members

Dr R Boots	6
Dr Anstey	3
Dr D Mullany	4
A/Prof B Venkatesh	2
Dr A Slater	4
Dr R Pascoe	3
Dr J Fraser	3
Dr J Cohen	2
(Commenced July 2004)	
Dr M Corkeron	2
Dr J Evans	2
(Commenced July 2004)	
Dr N Blackwell	2
(Commenced 2005)	

Chairman's Report

With the election of the new Qld Regional Committee, the first meeting planned to establish clear direction and an activity program for the present term of the elected members.

The consensus was to have an active committee that would support the trainees and Fellows in educational endeavours and the supervision of trainees. This has been a very busy and exciting time for the members of the committee. The key elements of the 2004-2005 program were:

1. Supervisors of Training Support Forum.

This comprises a 3 monthly meeting of SOT'S sponsored by the Joint Faculty. The broad aim is to provide a forum to discuss training issues, ensure that the Joint Faculty's training policies and rules are understood and provide support for educational instruction and other needs for training supervisors. The first of these meetings was held in April. This was a very productive meeting. It was decided that the meeting would be facilitated by the Regional Committee Chairman with the organiser of the Brisbane Metropolitan program (Associate Professor Bala Venkatesh) seconded to the group. The discussion highlighted confusion over the role of SOTs for trainees taking the overseas training program route to fellowship, differences between our parent colleges in approaches to training, the trainee in difficulty and the problems of a continuity of training for an individual trainee when moving between institutions and supervisors. The minutes of these meeting will be presented to the Board for consideration and should provide Queensland SOTs with direct input into the policy and procedures of the Joint Faculty's training program.

2. Education Evenings

A 2nd monthly program of educational evenings has commenced with the assistance of sponsorship from the trade and co-organised with QLD ANZICs. The aim is to showcase local fellows to provide seminars to the fellows and trainees. We have had three meetings now

which were available to 14 sites by videoconference within Queensland and Northern NSW. The meetings are recorded and a DVD copy of the session will be available from the local Joint Faculty Office. It is hoped these DVDs will provide an educational resource for the fellowship.

3. Regular Newsletter

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

4. Training on the Run Workshop 29th and 30th August 2005

This program was thought to be helpful to supervisors of training and fellows in assisting in the training and supervision of intensive care trainees. This is a program designed by the University of Western Australia and the Department of Employment and Training to assist in gaining the skills for teaching at the bedside, assessment and evaluation, and dealing with the problem trainee. A meeting scheduled for earlier this year was deferred to maximise the ability of supervisors of training and other clinicians involved in training to attend. Contact Sharon at the college if you would like to come. Professor Egerton and Dr Rob Boots will facilitate this meeting. Professor Egerton, an experienced educator with the RACS, a member of the Australian and New Zealand Association for Medical Education and Director of Postgraduate Medical Education at Royal Brisbane Hospital will bring his great experience to help facilitate the meeting.

5. Procedural Skills Workshop 6th April 2005 Royal Brisbane Hospital

This was organised for our trainees in a workshop format to assist in some of the practical skills for intensive care. The sessions covered in the Queensland Regional Committee's first attempt at such a workshop concentrated on balloon pumps, PACs, bronchoscopy and



JFICM Regional/National Annual Reports

bronchoscopic intubation, intercostal catheters and percutaneous tracheostomies. There was no registration fee and the meeting was supported by a grant from the Joint Faculty in addition to Mayo Health Care, Edwards Life Sciences, Medtel, Olympus and Boots Health Care. We had 30 registrants and several from interstate. The feedback has been excellent with requests for further such sessions and other topics to be included including dialysis therapies and basic suturing techniques. Our thanks to the official

“The consensus was to have an active Committee that would support the trainees and Fellows in educational endeavours and the Supervision of Trainees.”

organisers – Jeremy Cohen and John Fraser, the additional tutors – Greg Comadira, Peter Scott, Dan Mullany, the sponsors, Royal Brisbane Hospital, the organisers of the Brisbane Metropolitan training program for allowing us to schedule the meeting into one of the regular Wednesday afternoon sessions, Nikki Blackwell and of course our secretary Sharon for bringing this successful meeting together.

6. Vocational Expo 20 May 2005 Royal Brisbane Hospital

Rob Boots and Carole Foot represented the JFICM at the annual Queensland Vocational Expo. This meeting showcases most of the medical specialties and targets final year medical students and junior medical staff in Queensland. Experience at this meeting has been positive with approximately 25 young doctors expressing serious interest in intensive care. Information is made available about the training program and the life and work of intensivists.

7. Simulation Group

With the opening of the Queensland Health Skills Development Centre, expressions of interest have been asked of the Queensland fellowship to assist in developing training and

ongoing education in high fidelity simulation similar to that available to anaesthesia.

8. Visit by Professor Keith Walley Thursday 12th May

Professor Walley visited from the ANZCA ASM in New Zealand and was in Qld on the 12th and 13th May. The Queensland Regional Committee of JFICM hosted him at Royal Brisbane Hospital and the Prince Charles Hospital. A keynote

speech was delivered on Genetics in ICU. This was recorded and should be available on DVD from the QLD office.

9. Trainee Representative

Expressions of interest were sought from the QLD trainees for representation on the regional committee. From three names, the Regional Committee decided to appoint with the view that this position next time should be elected from the trainees. Nikki Blackwell has injected considerable enthusiasm and organisational skill to the committee, especially in relation to the procedural skills afternoon.

Rob Boots

Qld Regional Chairman

Western Australia

WA Regional Committee

Report 2005-05-16

The year began with David Simes handing over the Chairmanship to Cyrus Edibam. I would like to thank David for his great contribution in the role of Chairman over the last few years.

The last year saw the visit to Western Australia of Dr Jean-Louis Vincent. He attended the WA Annual Scientific Meeting in August 2004 and as usual provided the local Fellows with an entertaining and provocative program. February 2005 saw the visit of our current Dean, Dr Jack Havill to WA. He had the opportunity to discuss many important workforce and educational issues relevant to the specialty with a large number of local fellows and trainees. In addition, he presented his vision for the future of the Joint Faculty. I would like to thank all those involved in making his visit the success it was.

It is a tumultuous time in Western Australian health as the whole hospital and health system is facing reform. The current plan aims to close Royal Perth Hospital, the largest of the three teaching hospitals in Perth and merge it with Fremantle Hospital in a new complex in the Perth's southern suburbs over 5-8 years time frame. There are going to be widespread changes to the distribution of Intensive Care beds and workforce. It is hoped that the Regional Committee in conjunction with ANZICS can contribute constructively to this process. In addition, role delineation between tertiary hospitals, for certain complex services will occur in a shorter timeframe and may necessitate discussions about the need for rotating training programs and core training status of units.

The number of Fellows is steadily increasing in Western Australia. It is now in excess of 30.

Finally I would like to thank Patricia Luxford, the Secretary to the WA Regional committee for all her good work over the years. She will be retiring this year.

Dr Cyrus Edibam

Chairman, WA Regional Committee



ANZCA/JFICM/ANZICS/FPM

Annual Scientific Meeting, Auckland

The combined meeting held with ANZCA, ANZICS New Zealand Region and the Faculty of Pain Medicine was held in Auckland from 7 – 11 May 2005.

Fellows were treated to a broad program under the heading of 'Improving Outcomes' and topics were well covered by a good range of speakers. Professor Keith Walley delivered the Foundation Visitor's Lecture entitled 'The Heart in Sepsis' as well as talks on 'The role of Vasopressin in

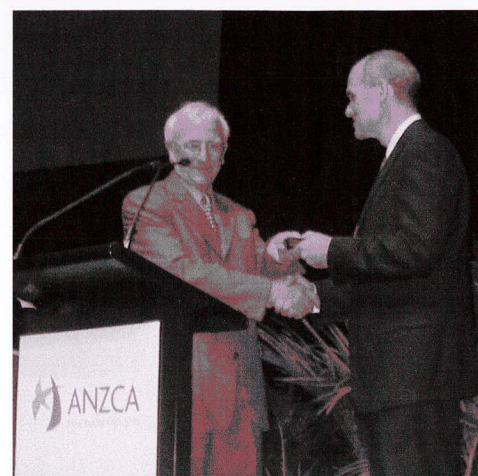
Other sessions included Protecting the Brain, Prehospital Care of the Critically Ill, Manipulating the CVS and Outcome After Cardiac Surgery and an Integrated Care Session. The Program closed with three great presentations on ICU Outside the Major Centres.

Both the ANZICS and JFICM Regional Annual Meetings were held and provided a forum for the New Zealand Members to discuss relevant issues.

"The great venue and beautiful environs of Auckland as well as warm weather were all reasons for the record attendance..."

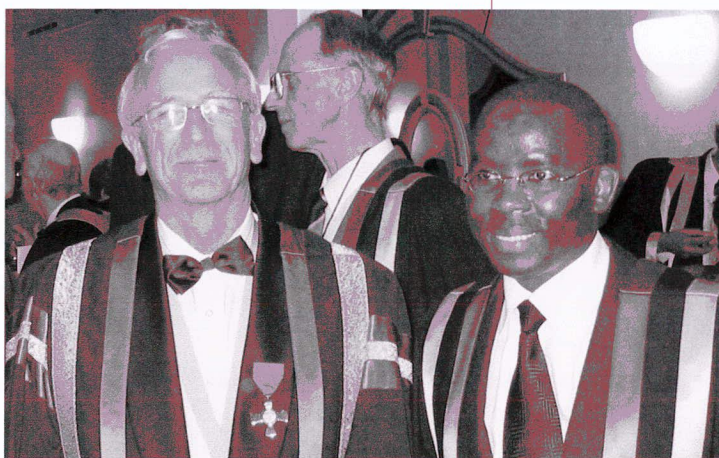
Distributive Shock' and 'Pathophysiology of Shock States'. Dr Jacques Creteur beautifully described "Imaging the Microcirculation" and the New Zealand Visitor Professor David Menon

New Fellows Drs Ros Purcell and Charles Mashonganyika presented at the ANZCA College Ceremony on the Saturday night and enjoyed the Reception afterwards. The Intensive Care Dinner



The great venue and beautiful environs of Auckland as well as warm weather were all reasons for the record attendance at an ANZCA ASM. Our thanks go to the Organising Committee, and particularly Nigel Rankin and Tony Williams for an excellent meeting.

Presentations can be accessed online with a Medeserv password at www.anzca.edu.au/infocentres/asm2005/index.htm



Dean, Dr Jack Havill with New Fellow Dr Charles Mashonganyika



Drs Ros Purcell, Kim Vidhani, Neil Matthews and Ms Carol Cunningham-Browne at the College Ceremony

spoke eloquently about the impact of Critical Care on Outcome in Head Injury, a topic to be further explored shortly in Sydney. The session on Epidemics and Terrorism featured a great talk from Tom Buckley on his experiences during the SARS outbreak, and the topical nature of the session was highlighted with a report the next day of a possible threat involving the release of foot and mouth disease on nearby Waiheke Island.

was held at the TeaRoom of the Heritage Hotel, formerly the iconic Farmers Department store, and a record number of attendees enjoyed a great night.

Reportedly the New Fellows Conference at the Sir Edmund Hillary Outdoor Pursuit Centre in Tongariro was the best ever, and this will be the topic of a separate report from our intensive care representatives.



JFICM Queensland Regional Committee

Procedural Skills Workshop

6th April 2005 Royal Brisbane Hospital



Dr Rob Boots demonstrating to workshop participants



Workshop presenters (L to R) – Drs John Fraser, Dan Mullany, Greg Comadira, Mark Ziegenfuss, Jeremy Cohen and Rob Boots

This initiative was organised for our Queensland Trainees in a workshop format to assist in some of the practical skills for intensive care. The sessions covered in the Queensland Regional Committee's first attempt at such a workshop concentrated on balloon pumps, PACs, bronchoscopy and bronchoscopic intubation, intercostal catheters and percutaneous tracheostomies. There was no registration fee and the meeting was supported by the Joint Faculty of Intensive Care Medicine in addition to Mayo Health Care, Edwards Life Sciences, Medtel, Olympus and Boots Health Care. We had 30 registrants and several from interstate!! The feedback has been excellent with requests for further such sessions and other topics to be included. Our thanks to the official organisers – Dr Jeremy Cohen and Dr John Fraser, the additional tutors – Dr Greg Comadira, Dr Peter Scott, Dr Dan Mullany, Dr Marc Ziegenfuss, the sponsors, Royal Brisbane Hospital, the organisers of the Brisbane Metropolitan training program for allowing us to schedule the meeting into one of the regular Wednesday afternoon sessions, Nikki Blackwell and of course our Queensland Faculty secretary, Sharon for bringing this successful meeting together.

Review Policy Documents

The following policy documents and joint statements are due for review during 2005. Fellows are invited to forward comments to the JFICM Executive Officer.

- IC-4 Supervision of Trainees
- IC-7 Secretarial Services
- IC-8 Quality Assurance

Documents can be accessed at:
www.jficm.anzca.edu.au/publications/policy/index.htm



Joint Faculty of Intensive Care Medicine

Policy Documents

- IC-1 (2003) Minimum Standards for Intensive Care Units
- IC-2 (2000) The Duties of an Intensive Care Specialist in Hospitals Accredited for Training in Intensive Care
- 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 (2000) Secretarial 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



Professional Document: Review TE18 (2005)

Australian and New Zealand College of Anaesthetists ABN 82 055 042 852

Guidelines for Assisting Trainees with Difficulties

Hospitals accredited by the College for the training of anaesthetists should aim to provide environments in which the necessary learning and experience for the development of sound, independent specialist practice is readily achieved. See College Professional Document TE1 *Recommendations for Hospitals seeking College Approval for Vocational Training in Anaesthesia*.

The process of selection of medical graduates into anaesthesia training and their re-selection during training should ensure that those chosen are considered to have the necessary attributes to satisfactorily complete the course. Nevertheless, personal and professional difficulties may arise during training. This document aims to help with the identification and resolution of these difficulties. It should be read in conjunction with College Professional Documents TE5 *Policy on Supervisors of Training in Anaesthesia* and TE14 *Guidelines for In-training Assessment of Trainees in Anaesthesia*.

1. Identifying Trainees with Difficulties

1.1 Identifying trainees with difficulties affecting performance, or those whose performance or progress is below an acceptable standard, is an essential role for everyone involved with the training program. In all situations, the welfare of patients as well as the trainee must be carefully considered.

1.2 Professional and personal development during training requires that trainees:

- 1.2.1 Contribute to the work of their training department.
- 1.2.2 Reach work-related performance standards (appropriate to their level of training). These standards will be established jointly by the trainee and the relevant Supervisor of Training as part of the In-training Assessment process (see College Professional Document TE14 *Guidelines for the In-training Assessment of Trainees in Anaesthesia*).

1.2.3 Progress towards necessary levels of responsibility and autonomy.

1.2.4 Meet other training requirements such as successful completion of examinations.

1.3 Trainees may have difficulties at any stage of training notwithstanding optimal selection and training processes.

These may include:

- 1.3.1 Failure to pass College examinations.
- 1.3.2 Clinical performance below expectations, independent of having been successful at College examinations.
- 1.3.3 Personal problems which interfere (temporarily or permanently) with training and adequate performance of duties.
- 1.3.4 Personality traits which impair effective professional communication or teamwork.
- 1.3.5 Substance abuse with opioids, alcohol or other drugs.

2. Processes to be Followed

Staff members with concerns about any aspect of a trainee's performance must discuss their concerns promptly with the Supervisor of Training and Head of Department.

When it is considered that problems exist, the procedures below should be followed, with a further review of the trainee's performance after an agreed period. The major objective is to overcome difficulties in a supportive and collaborative manner.

In situations identified as in 1.3.5 above, the Head of Department should follow the requirements and process prescribed by the local regulatory/registering boards for doctors. The Welfare of Anaesthetists

resource documents may be a useful adjunct to the process.

2.1 Initial Steps

After discussion with the Head of Department, the initial interview with the trainee, led by the Supervisor of Training, should include the following aspects:

- A formal time should be set aside for the discussion with sufficient advance warning for the trainee.
- The presence of a support person should be offered.
- Shortcomings in performance/progress should be clearly identified by the supervisor of training.
- The trainee should provide a self assessment, using the opportunity to provide an explanation (may identify issues related to 1.3.3, which could be used to offer support in the most appropriate way)
- Clear expectations on required performance/progress should be given.
- Agreed, achievable goals should be set.
- An agreed definite time frame for improvement determined.
- Assistance and resources available to assist the trainee should be identified and offered.
- Documented action plan including follow up meeting dates.

The Supervisor of Training should inform the Head of Department of the outcome of the meeting and document the discussion.

2.2 Remedial Learning

The Supervisor of Training and/or the Head of Department should organise special learning experiences if appropriate to assist with issues such as examination presentation, the acquisition of deficient clinical skills or interpersonal skills development. The trainee has a responsibility to assist with these processes.



2.3 Advice and Counselling

2.3.1 Formal or informal advice is an important component of trainee guidance. The Supervisor of Training and/or Head of Department must ensure that appropriate advice is available. Early and effective advice plays a part in trainees' professional development.

It is appropriate for the trainee to have a mentor to provide advice, feedback and support. The Supervisor of Training or the Head of Department should discuss mentorship and the choice of the mentor with the trainee. However, the choice of a mentor is for the trainee alone. A mentor should have no formal involvement with the trainee's appointment or reappointment. It is possible that all trainees will need help on occasion. The trainee may seek advice from:

- A Mentor, as above
- A senior member of the Department.
- The Regional Education Officer.
- The Advisor of Candidates for Anaesthesia Training (see College Professional Document TE17 *Guidelines for Advisors of Candidates for Anaesthesia Training*).
- A member of the Welfare of Anaesthetists SIG.
- A spouse, partner or family member.

2.3.2 In some situations, the trainee must be advised to seek professional counselling. The trainee should be assisted to find an appropriate person when he/she requests. Prompt medical or psychological intervention may be essential on occasion.

Counsellors may include:

- The trainee's General Practitioner.
- An appropriate medical specialist.
- A psychologist, psychiatrist or cleric.
- A member of the Doctor's Health Advisory Service.

- A member of an Alcohol and Drug Dependency agency.

- A Medical Careers advisor.

2.4 Monitoring Progress

The progress of the trainee following institution of any procedure referred to in this document must be monitored at prospectively determined times. Progress monitoring may supplement the formal In-Training Assessment process (see TE14 *Guidelines for the In-Training Assessment of Trainees in Anaesthesia*).

It is expected that most trainees will respond to the above measures

3. Unsatisfactory Progress

If the trainee's performance does not improve as expected along the agreed performance plan, advice from the College should be sought through the Regional Education Officer or the Chief Executive Officer (see policy TE4 *Policy on the Duties of Regional Education Officers in Anaesthesia*.) After ensuring that appropriate counselling and remedial measures have occurred the Regional Education Officer (or the CEO) may recommend any of the following options, depending on the nature of the problem, within the rules of Regulations 14 and 15 relating to examinations.

Options for the trainee may include:

- 3.1 A further period of specified training with special assistance and review of progress.
- 3.2 Training time not being recognised until specified conditions have been met.
- 3.3 Leave of absence to be followed by a period of specified training (see Regulation 15.6 dealing with interrupted training).
- 3.4 A career change, on a temporary or permanent basis.

The processes of procedural fairness must be observed so that the trainee is formally notified of steps being taken. The Supervisor of Training must advise the College of any action that alters the training status of the trainee. The trainee may appeal to the College against any decision that affects his/her training. The College will consider the appeal according to its established procedures.

4. Disciplinary Action

Disciplinary action in respect of employment or medical registration is a matter for the employer or the relevant Medical Board if there is evidence of serious breaches of care. In some situations (e.g. evidence of opioid misuse) it may be appropriate (or required) for the Head of Department to report the matter to the Medical Board or Medical Council. Additional assistance and support may be available through these bodies. Any disciplinary action (especially dismissal) requires due process to be followed. The matters noted in paragraph 5 are of particular relevance.

5. Documentation

The Supervisor of Training and/or the Head of Department must maintain adequate permanent records of discussions with the trainee. The records should include the date of the discussion, the matters raised and the views expressed by the trainee. Any warnings regarding possible loss of accredited training or disciplinary action must be clearly stated. Such warnings must be understood and acknowledged in writing by the trainee. A failure to accept or acknowledge a warning would be grounds for initiating a disciplinary process as set out in paragraph 4.

It is advisable to seek assistance from the hospital Human Resources Department to ensure compliance with employment legislation.

6. Additional Information

Human Resources Departments should be consulted for advice on employment matters. The Welfare of Anaesthetists SIG Action Plans may be found on the College Web Site (www.anzca.edu.au) and contain information about a number of the issues noted in this document.

Relevant Professional Documents

TE1 *Recommendations for Hospitals seeking College Approval for Vocational Training in Anaesthesia*

TE4 *Policy on the Duties of Regional Education in Officers in Anaesthesia*

TE5 *Policy on Supervisors of Training in Anaesthesia*

TE14 *Guidelines for the In-Training Assessment of Trainees in Anaesthesia*



TE17 *Guidelines for Advisors of Candidates
for Anaesthesia Training*

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Promulgated: 2000
Reviewed: 2005
Date of current document: Jun 2005

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College Website: www.anzca.edu.au



Professional Document: Review PS26 (2005)

Australian and New Zealand College of Anaesthetists ABN 82 055 042 852

Guidelines on Consent for Anaesthesia or Sedation

Introduction

Consent should be obtained for all medical treatment. It is a basic tenet of our society that everyone has a right to determine what is done to his/her own body, and is entitled to know the implications of any treatment before it is administered and to seek clarification of any issues that may be of concern.

General Principles

The standard for consent in Australia is established by the common law. In New Zealand it is embodied in the Code of Health and Disability Services Consumers' Rights.

Consent for treatment provided by an anaesthetist is different from a statement as to the necessity for anaesthesia (which may form part of the consent for an operative procedure).

Although legal processes that test the validity of consent differ, both Australian and New Zealand law state that the provision of information is an integral part of obtaining consent for a medical procedure.

The process of obtaining consent for medical treatment involves discussion in which both the patient and the doctor participate actively, and which is open, honest and effective.

The statements below are a general guide, and do not take precedence over local legal requirements.

In 1.3 – 4.7, the word "patient" means "the patient, or the person giving consent on behalf of the patient".

1. The Elements of Consent

- 1.1 Consent must be given voluntarily and without coercion; refusal or withdrawal of consent must be a realistic option. The environment, and timing of the consent process, and presence of support people (if so desired by the patient), are important in this regard.

1.2 Consent may only be given by a person capable of doing so.

1.2.1 All persons are presumed to be competent to give consent, unless there are reasonable grounds for believing otherwise. A judgement that the patient is incapable of giving consent must be supported by appropriate evidence, such as that of very young age, lack of mental capacity, unconsciousness or presence of sedative medication.

1.2.2 The age at which a young person is able to consent independently to medical treatment depends not only upon their age, but also the nature of the proposed treatment and local legislative requirements. To be able to give consent, the young person should be able to understand the nature, purpose and possible consequences of the treatment, as well as the consequences of non-treatment. (Currently there is variation across the Australian States and Territories and New Zealand with respect to the details of consent to medical treatment by young persons, and local legislation must be consulted). If in any doubt, consult appropriate management representatives or legal or other advisers.

1.2.3 In the absence of capacity to give consent, another person can give consent on behalf of the patient in certain legally defined circumstances, such as the parent or legal guardian of a child. In such circumstances, the person giving consent has a legal duty to always act in the best interests of the person for whom consent is being given.

1.2.4 If no person is able to give consent, then treatment can only proceed if it is in the patient's best interests, reasonable

steps have been taken to ascertain the views of the patient, the doctor believes that it would have been chosen by the patient if he/she was competent to do so, or the doctor takes into account the views of other suitable persons who are interested in the welfare of the patient, and that further delay is likely to be detrimental to the patient. It may be necessary to arrange for a legal guardian to be appointed. In these cases, it is strongly recommended that appropriate legal or other advice be obtained.

1.2.5 If the situation is so urgent that immediate intervention is necessary to preserve life or prevent serious harm, it may not be possible or sensible to obtain full consent. In such cases, there must be provision of information and discussion of the treatment undertaken with the patient, or other suitable persons, as soon as possible.

1.2.6 In some circumstances, statutory bodies, such as a Guardianship Board, may give consent or authorise others to give consent.

1.2.7 It must be recognised that the patient can change her/his mind, and withdrawal of consent must be respected (e.g. during multiple attempts at regional blockade).

1.3 Consent must be informed.

1.3.1 The patient should be provided with the information that a reasonable patient in the position of that patient might wish to know, and to which she/he might attach significance. It is necessary to provide information about all material risks inherent in any proposed treatment.

1.3.2 Basic information about the proposed treatment should be provided,



even if the patient requests no information. Where the patient clearly does not wish for further information, and states this wish, information should still be firmly offered and if still refused, that fact should be documented, and no further information forced on the patient.

1.3.3 The discussion of risks and benefits should include those associated with the proposed treatment, alternative treatments, or no treatment at all.

1.3.4 In considering risks to be discussed with the patient, ask:-

1. Would a reasonable person, in the position of the patient, be likely to attach significance to the risk?
2. Are you aware, or should you be reasonably aware, that this particular patient would be likely to attach significance to that risk?

In other words, is it possible that the patient, if informed of that risk, would change their mind about having the procedure?

1.3.5 Risks:

1.3.5.1 Discussion of risks should be based on the provider's assessment of the proposed treatment, the seriousness and nature of the patient's condition, the complexity of the proposed treatment, the questions asked by the patient, and the patient's attitude and apparent level of understanding.

1.3.5.2 Known risks should be explained when an adverse outcome is rare but the detriment severe, and an

adverse outcome common but the detriment slight.

1.3.5.3 The uncertainty of adverse outcomes/events should be explained, as should the difficulty of relating the incidence of such events to the patient. (see appendix)

1.3.5.4 Where blood products may be required, discussion should take place concerning the advantages, disadvantages and alternatives to blood products.

1.3.5.5 The risk of doing nothing should be discussed.

1.3.6 Opportunity must be given to discuss the nature and risks of the treatment, and the alternative treatment(s), and to have questions answered honestly and accurately.

1.3.7 Where appropriate, the financial implications of the proposed treatment should be discussed.

1.3.8 Information should be provided in a form the patient is likely to understand. This may include the option of presenting information in the printed form or via computer or other electronic means (e.g. by video). Printed and visual aids are useful. Prepared information sheets or "consent forms" can help understanding, but are not a substitute for the required discussion with the patient.

2. Documentation of Consent

The extent of documentation may be dictated by local legislation and practice but it is wise to record significant details of the consent as part of the patient's notes, including reference to the discussion of relevant material risks and the agreement by the patient to undergo the treatment.

In order to defend claims that "informed consent" information was not given or was inadequate, it is highly recommended that detailed notes of the discussion and all risks considered are kept by the provider.

3. Standard Consent Forms and Information Sheets

The use of standard "consent forms" and information sheets will not necessarily be sufficient to maintain "informed consent". Standard information forms are useful, but are no substitute for information to an individual patient. Under the requirements of "informed consent", the information to be given to a patient must be specific to the particular patient. It must take into account the particular circumstances, and requirements, of the patient.

Similarly, a simple form signed by a patient is not conclusive proof that valid consent has been obtained.

Prepared consent forms and prepared information sheets certainly can have their place and can be used as an aid or educational tool, as well as a prompt or checklist for the discussion that must take place between doctor and patient. They are also useful for the patient to take away after the discussion as a reminder of some of the issues that have been considered. However, they are not, **in themselves**, adequate to ensure that informed consent has been obtained.

4. Personnel

4.1 Disclosure of information and discussion must be performed by a person who understands and is able to discuss the risks and benefits of the proposed treatment and the alternative treatments, which includes no treatment.

4.2 A qualified interpreter (not a family member) should be used wherever necessary.



4.3 Disclosure of information and discussion is best performed by the anaesthetist who will be conducting the treatment.

4.4 Ideally, consent should be obtained by the anaesthetist who will be conducting the treatment. (The treating anaesthetist may be liable if inadequate consent is obtained by another person on the anaesthetist's behalf).

4.5 When the procedural anaesthetist can only see the patient immediately prior to anaesthesia, a separate anaesthetist may interview the patient and provide information for the elements of consent noted above.

4.6 The procedural anaesthetist must still discuss the proposed treatment with the patient to ensure that all appropriate preparation has occurred. The need for this interview must be considered when sedative premedication is to be given.

4.7 Those involved with the consent process are individually responsible for appropriate documentation.

Appendix

Examples of risk which might be discussed with the person giving consent include:

- a) Common adverse effects of general anaesthesia, which include fatigue, altered mental state, sleep disturbance, nausea, vomiting, sore throat, bruising from venepuncture
- b) Less common but not rare adverse effects such as spinal headache and dental trauma
- c) Rare adverse effects which are unpredictable, such as anaphylaxis, awareness, neurological damage or death in healthy people
- d) Adverse effects which are related to pre-existing disease, such as death in a patient with recent myocardial infarction undergoing emergency surgery.

The information provided in these Guidelines should be considered in conjunction with the following College Professional Documents:

PS6 Recommendations on Minimum Requirements for the Anaesthesia Record

PS7 Recommendations on the Pre-Anaesthesia Consultation

PS20 Responsibilities of the Anaesthetist in the Post-operative Period

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*Promulgated: 1994
Reviewed: 1999, 2005
Date of current document: Jun 2005*

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Australian and New Zealand College of Anaesthetists

Professional Documents

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

- TE1 (2003) Recommendations for Hospitals Seeking College Approval for Vocational Training in Anaesthesia *Despatched with August 2003 Bulletin*
- TE3 (2003) Policy on Supervision of Clinical Experience for Vocational Trainees in Anaesthesia *Despatched with August 2003 Bulletin*
- TE4 (2003) Policy on Duties of Regional Education Officers in Anaesthesia *Despatched with August 2003 Bulletin*
- TE5 (2003) Policy for Supervisors of Training in Anaesthesia *Despatched with August 2003 Bulletin*
- TE6 (2000) Guidelines on the Duties of an Anaesthetist *Bulletin July 2000, pg 86*
- TE7 (2005) Guidelines for Secretarial and Support Services to Departments of Anaesthesia *Bulletin February 2005, pg 56*
- TE8 (2003) Guidelines for the Learning Portfolio for Trainees in Anaesthesia *Despatched with August 2003 Bulletin*
- TE9 (2005) Guidelines on Quality Assurance in Anaesthesia *Bulletin February 2005, pg 57*
- TE10 (2003) Recommendations for Vocational Training Programs *Despatched with August 2003 Bulletin*
- TE11 (2003) Formal Project Guidelines *Bulletin November 2003, pg 92*
- TE13 (2003) Guidelines for the Provisional Fellowship Program *Despatched with August 2003 Bulletin*
- TE14 (2001) Policy for the In-Training Assessment of Trainees in Anaesthesia *Bulletin November 2001, pg 84*
- TE17 (2003) Policy on Advisors of Candidates for Anaesthesia Training *Despatched with August 2003 Bulletin*
- TE18 (2005) Guidelines for Assisting Trainees with Difficulties *Bulletin June 2005, pg 99*
- EX1 (2001) Policy on Examination Candidates Suffering from Illness, Accident or Disability *Bulletin November 2001, pg 75*
- T1 (2000) Recommendations on Minimum Facilities for Safe Anaesthesia Practice in Operating Suites *Bulletin March 2001, pg 68*
- T2 (2000) Recommendations on Minimum Facilities for Safe Anaesthesia Practice outside Operating Suites *Bulletin March 2001, pg 72*
- PS1 (2002) Recommendations on Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia *Bulletin November 2002, pg 78*
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- PS10 (2004) Guidelines on the Handover of Responsibility During an Anaesthetic *Bulletin November 2004, pg 79*
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- PS14 (1998) Guidelines for the Conduct of Major Regional Analgesia in Obstetrics *Bulletin November 1998, pg 81*
- PS15 (2000) Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery *Bulletin November 2000, pg 75*
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