

# bulletin



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

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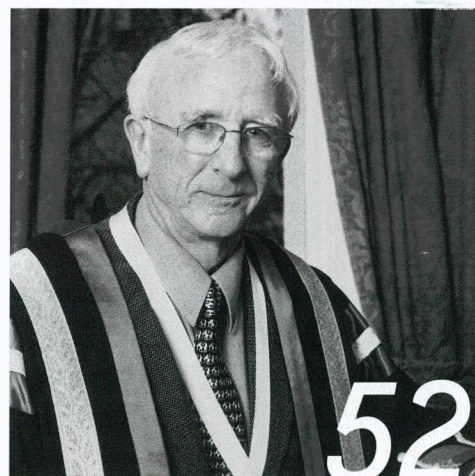
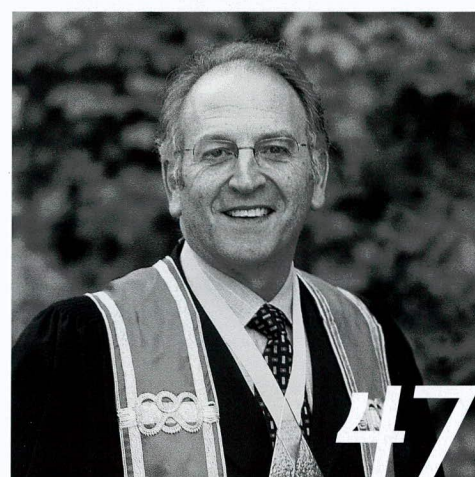
DECEMBER  
**05**

- *New MOPS Program for 2006*
- *New CEO Appointed*
- *ANZCA Workforce 2005 – Survey Results*
- *2006 Research Grant Awards*



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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

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# President's Message

## **Productivity Commission Report "Australia's Health Workforce"**

In September 2005, the Productivity Commission published a Position Paper which has been prepared "for further public consultation and input". This 271-page document was considered and a response made by the deadline of Friday 11th November, 2005. ANZCA has already identified a number of significant errors which were carefully rebutted in the response. I once again repeat my advice from previous Bulletins, that individual Fellows should channel all of their responses through ANZCA. Regional/National Committees will also maintain close contact with ANZCA headquarters if discussions are required with State Health Departments or other bodies. I again ask Fellows to examine the 10-Point Strategy for ANZCA's response to the changing healthcare environment (see June 2005 Bulletin, Pages 4-5) and ANZCA's statement on "The Anaesthesia Patient Care Team" (pages 6-7) where the 15-Point commentary on "The Conduct of Anaesthesia is a Specialised Medical Practice" is provided.

One of the important areas of contention in the Productivity Commission Report is the figures on the Specialist Anaesthetist Workforce, which are not up to date. We are now exceeding the AMWAC Recommendations, and there is new evidence that there has been a significant increase in the number of trainees, the number of successful candidates at examinations, and a significant increase in the success rate in the OTS examination process. Also, our tripartite JCCA Program for General Practitioner Anaesthetists in remote areas continues to be a strong point that is not available in countries such as the USA. This was all drawn to the attention of the Productivity Commission.

## **Taskforces – Update**

At the September and November 2005 Council Meetings, reports were received and considered by Council on the following Taskforces:

- Private Practitioners Involvement in ANZCA
- Integrated Approach to Quality and Safety
- Professionalism – A Code of Professional Conduct
- Relationship of Regional/National Committees with ANZCA
- Taskforce on Data
- Name of the Specialty

Council was broadly in agreement with the Recommendations made by these Taskforces

*"...there is new evidence that there has been a significant increase in the number of trainees, increased throughput through our ANZCA examinations and a significant upswing in the success rate in the OTS examination process."*

and has now asked for comments from the Regional/National Committees in a timely manner, so that Council can move ahead with implementation of the Recommendations. Fellows are encouraged to visit the ANZCA website and examine the Recommendations of these and other Taskforces.

In December the reports of the final three Taskforces will be received:

- Perioperative Medicine
- Non-Medical Members of the Anaesthesia Care Team
- Relationship of Younger Fellows to ANZCA

In view of the unprecedented changes that are currently mooted in healthcare, the work of these Taskforces is providing crucial input to ANZCA Council, and all Fellows are strongly encouraged to examine the Recommendations of the Taskforces and to provide input on an urgent basis.

## **Trainee Representatives on ANZCA Committees**

ANZCA and its two Faculties have been progressively increasing trainee involvement in Committees and other aspects of the College. All trainee representatives on ANZCA Committees are members of the ANZCA Trainee Committee which was recently set up to consolidate the input of trainees to ANZCA Council. ANZCA Council sees a progressive increase in involvement of trainees in most aspects of the work of the College.

## **Transition from Trainee to Fellowship**

The Committee of Presidents of Medical Colleges (CPMC) has agreed to ANZCA's proposal that it develop an Intercollegiate New Fellows' Conference with the aim of addressing issues that are important to Fellows across different Colleges. One aspect of this is the need to improve strategies for helping trainees in the transition from trainee to Fellowship. Other aspects will be pursued by the ANZCA Committee on Education and Training, as indicated in the Highlights of the Council Meeting.

## **Research and the ANZCA Foundation**

Fellows will be pleased to hear that there were 51 applications for research support for 2006. Because of the high standard of these applications, Council has made special arrangements to be able to support 20 of these applications. However there are still a number of good quality applications that could be supported if ANZCA funds were available. As I have previously emphasised in this Bulletin,



one of the most effective ways of making a connection with the general community and Politicians, is to provide "good news stories" about important new developments in clinical management which come about as a result of high quality research. We are now very much at the stage when this has become of the utmost importance. Thus I once again exhort Fellows to respond to the call for donations to the ANZCA Foundation. You will note the "thermometer" adjacent to this message shows that we have managed to raise so far only just over \$200,000. Some of our Fellows have given extremely generously, while others have contributed absolutely nothing. I ask such individuals to please reconsider – it is in your interest.

The most difficult task that I have taken on as President, has been to launch the ANZCA Foundation. I have been working very hard to assemble a Board of prominent community members and have recently been successful in gaining the agreement from sporting identity, Kieren Perkins and senior business identity, James Strong who will join the Board of the Foundation. I am sorry to say that I have not received a single suggestion from any ANZCA Fellow about an individual who they have cared for who may be interested in joining the ANZCA Foundation Board. I am quite happy to take the initiative once an introduction has been made, but so far no suggestions for introduction have been made! Thus I once again ask for this help from Fellows. Nevertheless, with individuals now available on the ANZCA Foundation Board, it will be possible to move ahead and I am now setting a Launch date for February 2006. You will be aware that the Governor General of Australia has agreed to be Patron of the Foundation and we are attempting to set a date with the Governor General for the Launch in February.

#### **FARM Committee**

Some Fellows may be surprised to learn that the College has set up a Finance, Audit and Risk Management (FARM) Committee. I have been

fortunate to gain the participation of Mr Henry Bosch AO, former Chairman of The National Companies and Securities Commission, as well as a former Head of the accounting firm Ernst and Young, Mr Tom O'Brien AM. These individuals together with the Vice President, Honorary College Solicitor Mr Michael Gorton and Honorary Treasurer will take a wide ranging view of the College finances, and will examine risks to the College across a very broad range. Company law that is now being applied to all Specialist Colleges, requires such a body. We have been fortunate to be able to assemble such high quality individuals.

#### **New CEO Appointed**

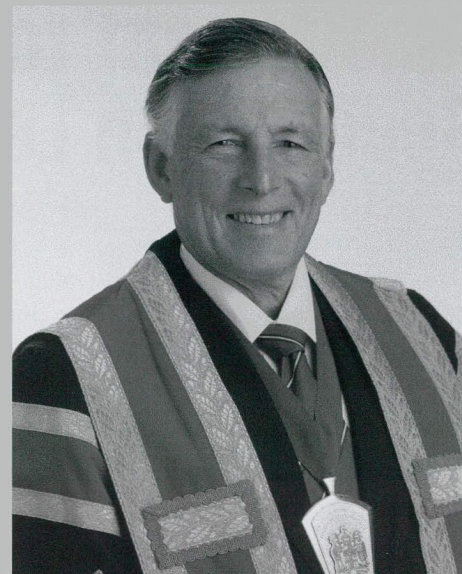
ANZCA had an excellent response to the advertisement for a new CEO. I have great pleasure in announcing the appointment of Dr Mike Richards to the CEO Position, following the retirement of Mrs Joan Sheales. I am sure that all Fellows join me in welcoming Mike to the College and we look forward to an exciting new phase in our development.

#### **Awards**

I am delighted to announce that ANZCA Council has bestowed Honorary Fellowship of ANZCA on our dedicated and long serving CEO, Joan Sheales. This is a richly deserved award and I am sure that all Fellows will join me in congratulating Joan on this honour.

I am also delighted to announce that our Director of Professional Affairs, Professor Garry Phillips has been awarded the Orton Medal. Professor Phillips has provided exemplary service to the College over an extremely broad range of areas and continues to be of enormous assistance to the President and ANZCA.

An Orton Medal was awarded to Dr Pamela Macintyre from South Australia. Fellows will be aware of Dr Macintyre's major contribution in producing the document "Acute Pain Management: Scientific Evidence".



#### **Conclusion**

In conclusion I would like to thank the large number of Fellows who have contributed to the work of ANZCA during the past 12 months. This has been an unusually demanding time. However I have no hesitation in saying that ANZCA has performed at a very high level in every area of its operations. I am confident that ANZCA is in a very strong current position, which will be enhanced by measures that are currently underway. I would like to wish all Fellows and their families a restful, peaceful and reinvigorating Holiday Season.

**Michael J. Cousins, AM**  
President



## Law Report

# Amendment to Specialist Recognition Legislation



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

The Medical Colleges have been concerned for some time that specialist recognition can be achieved through pathways, other than through assessment by the Medical Colleges themselves.

The Health Insurance Act 1973 (Cwth) contained alternative pathways to specialist recognition through special Committees set up by the Health Insurance Commission - the Specialist

rebate purposes of specialists and consultant physicians.

- Consultant physicians domiciled in Australia will also have the advantage of this alternative method of recognition, particularly for sub-specialty purposes. Consultant physicians will be included along with specialists in the alternative method of recognition.

Ageing and/or the Health Insurance Commission. The Minister's delegate will make a determination, having sought advice through the Medical Colleges.

Transitional arrangements maintain any specialist recognition already approved through the HIC or SRAC procedures.

*“Some medical practitioners, whether Australian trained or overseas trained could achieve specialist recognition without having been assessed...”*

Recognition Advisory Committees. Some medical practitioners, whether Australian trained or overseas trained could achieve specialist recognition without having been assessed by a Medical College or without having undergone relevant training through a Medical College.

New applications for recognition as a specialist or as a consultant physician will be handled directly through the Department for Health and

Given the situation recently highlighted in Bundaberg, in relation to a surgeon who was neither assessed nor trained by the Royal Australasian College of Surgeons, these issues are at the forefront of thought in relation to patient safety, transparency of process and risk management.

The Australian government has recently introduced the **Health Insurance Amendment (Medical Specialists) Bill 2005**. The Bill was introduced into the House of Representatives on 23 June 2005.

In essence, the amendments propose:

- The Specialist Recognitions Advisory Committee pathway will be abolished. The Minister for Health or his or her delegate, currently the Health Insurance Commission, will act directly on the Minister's behalf in order to make more timely, the consideration of applications for recognition for Medicare



## Education Report

# Inaugural Meeting of College Educators



**Russell W. Jones**  
Director of Education, ANZCA

Education is increasingly being recognised as core business for Medical Colleges. This recognition is occurring at the same time as significant changes to the strategic landscape within which medical education functions. These changes include the need to respond to a rapidly evolving environment, greater expectations from the public, and increased participation from stakeholders such as the Australian Medical Council (AMC), Australian Competition and Consumer Commission (ACCC) and other Federal and State bodies. In response to this, and an increased awareness of the value of Medical Colleges exploring potentially beneficial opportunities, the inaugural meeting

between Colleges. And third to facilitate the implementation of any educational initiatives (or enquiries) from the CPMC.

### *Managing External Demands*

Effort primarily focused on the identification of external stakeholders/interested parties (for example, consumers, AMC, departments of health, ACCC, Australian Health Ministers Advisory Council (AHMAC), Australian Health Workforce Advisory Committee (AMWAC), hospitals, medical boards, universities, medical defence organisations, etc), the identification of what these parties wanted, and what could be

cost recovery basis, and (3) those Colleges offering courses with limited participation allowing priority participation by their own Fellows and Trainees.

### *Development of Generic Resources or Courses*

All representatives agreed there was considerable potential for the development of generic courses and resources for use by multiple Colleges. It was envisaged that Colleges would have the opportunity to participate in the development and use of resources and courses that were of specific interest to their Trainees or Fellows. Generic topics included leadership, management, communication, IT, quality assurance, basic sciences and ethics. It was decided to explore the potential development of a leadership, teamwork and communication course based on ANZCA's 2005 New Fellow's Conference. Representatives from Colleges of anaesthesia, emergency medicine, medical administrators, obstetricians and gynaecologists, pathologists, physicians, radiologists and surgeons indicated a desire to be involved in this initiative.

*"...facilitate cooperation and communication between the Colleges on all matters educational..."*

of educational representatives of Medical Colleges was held in Melbourne on 13th October 2005. The meeting was funded by the Committee of Presidents of Medical Colleges (CPMC). Participants comprised representatives from the Australian and New Zealand College of Anaesthetists (Chair), Australasian College of Dermatologists, Australasian College for Emergency Medicine, Royal Australasian College of Medical Administrators, Royal Australasian College of Physicians, Royal Australasian College of Surgeons, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Royal Australian and New Zealand College of Ophthalmologists, Royal Australian and New Zealand College of Psychiatrists, Royal Australian and New Zealand College of Radiologists, Royal Australian College of General Practitioners, and the Royal College of Pathologists of Australasia.

done to manage their demands. It was acknowledged that the different agendas and often competing interests of these parties made acquiescing with all requests extremely difficult. Suggested approaches to managing demands included defining the unique place of Colleges within medical education and ensuring that Colleges' interests are adequately represented within external parties.

### *Development of a Compendium of Courses and Resources*

The medical community has long recognised the value of cross speciality training and there are substantial economic benefits to Colleges sharing common resources rather than each 'reinventing the wheel'. To this end it was decided to develop a compendium of the courses and resources that each College has developed and which may be of value to other Colleges. It was understood that development of the compendium did not create a formal agreement and that issues of intellectual property and costs would need to be explored. As an initial step there was widespread agreement to the notion of (1) intellectual property residing with the course/resource developers, (2) charges to be determined on a

### *CanMEDS 2005 Update*

The most significant changes for CanMEDS were reviewed. These changes were a renewed emphasis on framework consistency, addressing overlaps between CanMEDS roles, identification of key elements within each role as a tool for curriculum designers, creation of a taxonomy of physician competency levels, renewed emphasis on evidence based education planning, and the integration of ethics competencies throughout the framework.

The network has three primary aims. First, to facilitate cooperation and communication between the Colleges on all matters educational in its broadest sense including training, continuing medical education, examinations, assessment and accreditation. Second, to establish a primary point of educational contact

Other topics covered during the meeting included continuing professional development; CPMC/AMC workshops on assessment; the selection, training and monitoring of examiners; and the AMC accreditation of Medical Colleges. As the Colleges move towards increasing their educational activities it will be interesting to monitor the contributions that can be made by this network of College educators.



## Series on Past Deans and Presidents

# Noel Morris Cass

Noel Morris Cass was Dean of the Faculty of Anaesthetists, Royal Australasian College of Surgeons from 1968-1970. He was the eighth Dean, following Ralph Clark and succeeded by Kevin McCaul.

It is possible that Noel was fated to be an anaesthetist once his father named him after the Morris motor car that he had always wanted. For it was Lord Nuffield, who created the Morris motor car, and who after bequeathing the funds to Oxford University personally insisted on the first Chair of Anaesthetics in the United Kingdom being created.

Although Noel has come to be considered part of the Melbourne anaesthetic scene, in fact he was

born in Western Australia. He was born in a small timber milling town named Jardee, in south eastern WA where his father was employed as the company doctor. The family moved to Perth when Noel was three years old and he undertook his schooling in Perth at St Anne's School and then Wesley College. He then went to the University of Western Australia and after completing first year science with high marks was able to enter the Medicine Faculty at Melbourne University. He chose Melbourne largely because his father had completed his medical studies there.

Victoria. This year allowed him to recuperate and work at a more leisurely pace and enjoy his career. Whilst in Melbourne, at a party, he heard that Kevin McCaul was looking to appoint an inaugural anaesthetic registrar to the Royal Women's Hospital. He had greatly enjoyed his brief anaesthetic term whilst an intern at the Alfred, had completed his compulsory twelve supervised anaesthetics as a medical student whilst at the Royal Women's and gained experience administering anaesthetics at Bendigo.

In 1952 Noel took up one of two posts as inaugural anaesthetic registrars at the Royal Women's Hospital, Melbourne. The other registrar was Dr Pat Scrivenor, who had come

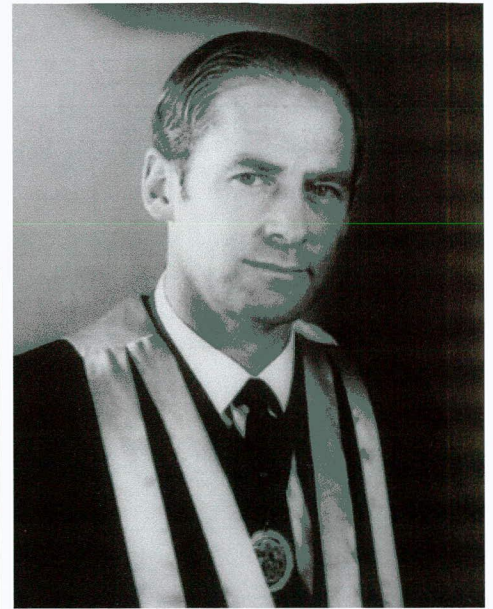
*“Outside of anaesthesia Noel is renowned as a sailor, having won state titles in sailing... He is also a much applauded jazz pianist..”*

over from Perth where she had been under the tutelage of Gilbert Troup. During this year Noel attended the course for the Diploma in Anaesthesia and passed the Primary exam. As a result of this he was offered and accepted a part time scholarship for research in the Department of Pharmacology at Melbourne University. Here he researched the analeptic Bemegride.

Keeping up a series of being first, in 1953 he was appointed as the inaugural anaesthetic registrar at the Royal Melbourne Hospital under Dr Norman James. During this year he sat for and passed the second part of the Diploma in Anaesthesia, Melbourne. Eager to see the world he travelled to the UK in 1954 as assistant ship's doctor on board the *Orcades*. He sat for the primary in the Faculty of Anaesthetists Royal College of Surgeons, being awarded the Nuffield prize for best marks, again the Morris connection. As a result of this achievement he was offered a post as a lecturer in Physiology in the Royal

College of Surgeons in London. In this post he sat for and passed the second part exam and gained Fellowship.

After retiring from the Board after twelve years he left the Royal Melbourne Hospital to take up the Deputy Director's post at the Royal Children's Hospital where he worked with Kester Brown until his retirement in 1986. Throughout this



Whilst in London he was visited by his old mentor Kevin McCaul and offered the post of acting director of anaesthesia at the Royal Women's in Melbourne. He returned home and took up this post for Kevin's absence. After a year at the Women's, he took up private practice and a visiting post at the Royal Melbourne. He also researched cardio-pulmonary bypass techniques. In 1957 his records showed that he worked with 105 different surgeons. He continued his busy private practice and research.

The year 1964 was momentous in Noel's life as he was elected to Board of Faculty, Chair of the Victorian Section of the Australian Society of Anaesthetists, Chair of the Society of Medical and Biological Electronics, and was appointed to the Senior Medical Staff of the Royal Melbourne Hospital. By a strange twist of fate Noel rapidly became one of the most senior members of Faculty Board. Soon after his election a tenure of twelve years was introduced and by 1968 all other Board members had retired leaving Noel the most senior. He became Dean in 1968. Up until the time of his accepting the post of Dean he had been Chairman of the Court of Examiners, a post taken over by Maurice Sando.

After retiring from the Board after twelve years he left the Royal Melbourne Hospital to take up the Deputy Director's post at the Royal Children's Hospital where he worked with Kester Brown until his retirement in 1986. Throughout this



period his research interest was the use of electromyography to assess depth of muscle relaxation. In addition to the above tasks he also was selected to be on the inaugural Editorial committee of the journal *Anaesthesia and Intensive Care*, a position that he still holds. He was also involved in the Medical Defence Association of Victoria, serving on its Board for 24 years and eight as vice Chair.

Noel is married and he and Brenda have had four children. Outside of anaesthesia Noel is renowned as a sailor, having won state titles in sailing classes and still sails regularly. He has arranged social tennis gatherings for decades and has been on the committee of the Royal Children's Hospital Ski club since 1969. He is also a much applauded jazz pianist, having played in the same jazz band in its many guises since 1964. His fame is international, having twice played in venues on Bourbon St New Orleans, the home of jazz music.

I thank Noel for his assistance in the preparation of this article and I have had the privilege of presenting this paper at a meeting in his presence.

**Terry Loughnan**

## STOP PRESS!

The reports of two health inquiries in Queensland, both of relevance to health systems in all States and Territories, and in New Zealand, have been published recently.

The Queensland Public Hospitals Commission of Inquiry is a 538 page document available at [www.qphci.qld.gov.au](http://www.qphci.qld.gov.au). The Commission replaced the Bundaberg Hospital Commission of Inquiry, which had been established to investigate issues relating to the practice of Dr Patel. The Report provides evidence of many aspects of Queensland Health's structure and function, with emphasis on recruitment of Overseas Trained Doctors. The Report cites five major problems which contributed to the unfortunate situations examined in several hospitals:

- Inadequate budget defectively administered
- Defective administration in Area of Need registration
- Absence of credentialling and privileging of doctors
- Failure to implement monitoring of performance or investigation of complaints
- Culture of concealment by Government, Queensland Health administrators and hospital administrators

Anaesthesia is mentioned twice. Evidence was given by an anaesthetist at one hospital on severe understaffing in anaesthesia, where one person was on continuous duty and call for a week.

In another hospital, an Overseas Trained Doctor had been appointed Medical Superintendent with privileges in surgery, medicine, obstetrics, emergency medicine and anaesthesia. An anaesthetic-related death was associated with that doctor.

The Queensland Health Systems Review is a slightly shorter document available at [www.health.qld.gov.au/health\\_sys\\_review](http://www.health.qld.gov.au/health_sys_review). It is a broad review which examines health issues, admits there are some problems and makes some 140 recommendations "for systems change and an organization reform strategy... to achieve improved health outcomes for consumers, patients and the community generally".

The first of these reports could arguably be recommended reading for all medical practitioners because of the lessons it spells out in graphic detail. The second report will be of interest to those interested in health systems generally.





## Report

# Highlights from September Council

### Welcome

The President welcomed Dr Vaughan Laurenson and Dr Cliff Peady, Chairs of the New Zealand National Committee and Australian Capital Territory Regional Committee respectively, to their first Council Meeting.

### Awards

Mrs Joan Sheales was awarded Honorary Fellowship of the College. The Orton Medal was awarded to Professor Garry Phillips AM (SA) and Dr Pamela Macintyre (SA).

## Education and Training

### Trainee Representation on College Committees

The representation of trainees on ANZCA Committees was reviewed following receipt of the AHWOC/ACCC review of the Colleges and of a letter from the AMA Doctors in Training Committee, via the AMA.

Following a discussion, Council resolved that:

- No trainee be appointed at present to the Council
- Trainee representation on Council be reconsidered in two years time, when the changes to the ANZCA Structure have been embedded and the Trainee Committees have been working for three years

- All trainee representatives on ANZCA Committees be members of an ANZCA Training Committee and appointed by Council
- Trainee representatives (who must be advanced trainees) are appointed to such further Committees as Council considers appropriate, after advice from those Committees

### Transition from Trainee to Fellow

Discussion at the recent New Fellows' Conference expressed universal support for the benefits of a compulsory Provisional Fellowship Year. It was suggested that its abolition was seen to be a significant weakness in the FANZCA program and the New Fellows would prefer to see the Provisional Fellowship strengthened to allow it to perform its function as a bridge between traineeship and Fellowship, thereby preventing the employment of Provisional Fellows in a purely service role.

It was noted that the skills and competencies required of a consultant fell into general and more specific categories which is a possible area for focus in the development of educational materials. Many of the necessary elements are already contained in Module 12, however this is currently seen primarily as an assessment tool and the College should consider ways in which it can be further developed as a learning tool.

### Resolutions

1. That the Director of Education, the ETC New Fellow Representative, the Chair of the ANZCA Trainee Committee and the Assessor form a sub-committee to report to the November Education and Training Committee about ways in which ANZCA can support the transition from anaesthesia trainee to Fellow.
2. That educational material be developed to support this process and to support Module 12.
3. That Module 3 cannot be commenced until Module 1 has been running for six months and the structured assessment to move beyond Level 1 supervision has been successfully completed.

### Amendment to Regulation 15.3.2.5

When the interval of prior training under Regulation 15.4.6.3 exceeds 12 months, the Assessor may, at his/her discretion, recognise the time as 12 months of Basic Training and may recognise additional time up to 12 months of Advanced Training. Such approval will not exempt the trainee from completion of BTY2 and the requirements to complete Modules 1, 2, 3 and one of the Modules 4 - 10 for completion of Basic Training. *For this Regulation to apply, the application must be made within 12 months of commencing Approved Training (as defined in Regulation 15.3.1).*

## Examinations

### Primary Examination

Council resolved to continue to support funding of the Primary Examination in Hong Kong.

### Textbooks for ANZCA Examiners

Following Council's agreement to provide textbooks for the Panel of Examiners on appointment and reappointment, it has now been agreed that book vouchers will be provided to Examiners upon application, to arrange their



purchases direct from the College supplier. It was noted that there are a number of books online currently, with this list being expanded in the near future. The books available on-line will generally not be made available via the voucher scheme. It was also noted that currently the College has 280 Journals online.

## Finance

### Subscriptions

Council noted that there had been no increase in Subscriptions or Training Fees for the past seven years and noted the reversal of the Subscription-in-advance Policy for the year 2005.

Council then approved an increase in the fees as follows:

#### Annual Subscription for ANZCA Fellows for 2006

A\$1140 + GST where applicable  
(Due and payable on 1st January 2006)

#### MOPS Fee for Non Fellows for 2006 (retained)

A\$300 + GST where applicable

#### OTS Assessment Fee for Australia for 2006 (retained)

A\$1300 + GST

#### Occupational Training Visa Assessment Fee for 2006 (retained)

A\$100+ GST

### Annual Training Fee for 2006 -

#### Australia

A\$1145

#### New Zealand

NZ\$1145+ GST

#### Hong Kong

A\$1145

#### Malaysia

\$1145 Ringgit

(Local currency converted into A\$)

#### Singapore

SGD\$1145

(To be capped at amount in A\$ equivalent to that paid by Australian trainees)

#### Register of Training Fee for all trainees for 2006

A\$1170

#### Examination Entry Fee for 2006

A\$2300

### International Scholarship

Council awarded the ANZCA International Scholarship for 2006 to Dr Luke Nasedra (Fiji)

## Internal Affairs

### Administration of Council Meetings

Council resolved that the mechanism for a secret ballot to Council Meeting for Councillors participating via teleconference will be the private disclosure of their vote to a scrutineer.

### Taskforces

Council considered the reports from the Private Practitioner Involvement in ANZCA; Professionalism; and Integrated Approach to Quality and Safety Taskforces. The reports have now been referred to the Regional and National Committees, ASA and NZSA for comment and input, prior to final review by Council.

Finance Audit and Risk Management Committee (FARM)

The College FARM Committee has now been established and will hold its inaugural meeting shortly.

The Committee comprises:

- Vice President, Dr Walter Thompson
- Honorary Treasurer, Associate Professor Kate Leslie
- College Honorary Solicitor, Mr Michael Gorton AM

- Former Chairman National Companies and Securities Commission, Mr Henry Bosch AO

- Former National Head of Ernst and Young, Mr Tom O'Brien AM

### ANZCA Foundation

Council appointed Wrights Creative Communications to assist in the launch of the ANZCA Foundation.

### Posthumous College Awards

Council resolved that:

1. The College may from time to time bestow a posthumous award upon a deceased Fellow where that Fellow has met the usual criteria for recognition as approved by Council
2. Such an award will normally be considered only when the formal application is received by the College within two years of the Fellow's date of death
3. At the time a posthumous award is presented, the deceased Fellow's partner and immediate family will be invited to receive the award on the Fellow's behalf

### Appointments

Council resolved that Dr Tony Bergin (QLD) be appointed ANZCA representative to the Australian Day Surgery Council; and that Dr Colin King (NZ) be nominated ANZCA representative on the RACS CCrisp Committee.

### Continuing Education and Quality Assurance

Council resolved:

- To keep a central database listing speakers who have been approached for Curriculum Vitae by Regional Organising Committees
- That the names of such invited speakers be retained on the College list for a period of two years.



### Quality Activities

Council resolved that the MOPS Audit Format be unchanged in 2006.

### ASM Media Coverage

Council resolved that in future, the book of Abstracts not be released to the media and that a media release relating to the Scientific Program be prepared under the direction of the Communications Officer and the Scientific Convenor selecting appropriate presentations and providing the authors and presenters with appropriate information and guidelines in relation to the publication of scientific material.

### Gilbert Brown Prize

Council resolved that the Gilbert Brown Prize be accompanied by a cash prize of up to \$1,000 for educational purposes, or attendance at a continuing education conference and that in addition to the medal, the winner will receive a certificate recognising the award.

### Formal Project Prize

In addition to the medal, the Formal Project Prize winner will receive a certificate recognising their achievement.

### Professional Documents

TE1 – *Recommendations for Hospitals seeking College Approval for Vocational Training in Anaesthesia* – Until its next review in 2008, an addendum be added at section 2.11.1, with the other items renumbered accordingly (page 77).

PS40 - *Guidelines for the Relationship Between Fellows and The Health Care Industry* – As amended was approved (page 79).

The Revised Joint RANZCOG/ANZCA /RACGP/ACCRM Position Statement on the Provision of Obstetric Anaesthesia/Analgesia Services was approved by Council.

## ANZCA Trials Group Pilot Research Grants for 2006

The ANZCA Trials Group invites applications from Fellows of ANZCA, JFICM and or FPM for pilot research grants for projects related to anaesthesia, perioperative medicine, or pain medicine.

The aim of the grants is to assist researchers in the following areas: pilot-phase testing of trials, collection of baseline data using surveys or establishing a network of investigators. The Trials Group will award up to five Grants at A\$5,000 with support from the Trials Group Research Coordinator.

To be eligible for a pilot research grant, a proposed study must first be endorsed by the ANZCA Trials Group.

Applicants should send a description of the proposed research project, a copy of their curriculum vitae and a covering letter indicating that they are seeking endorsement from the Trials Group and wish to apply for a pilot research grant. Applications will be adjudicated by the Trials Group Executive.

Applications, or further enquiries, should be sent by mail or email to:

#### Ornella Clavisi

Research Coordinator

#### ANZCA Trials Group

Australian and New Zealand College of Anaesthetists

630 St Kilda Road, Melbourne Victoria 3004

Tel: +61 3 8517 5326 Fax: +61 3 8517 5346

Email: oclavisi@anzca.edu.au

## From the Archives

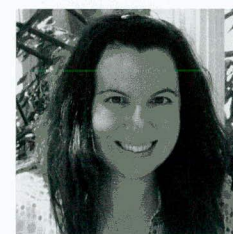
The following excerpt is taken from a letter sent by Dr Geoffrey Kaye in May 1981, to the late Sir Anthony and Lady Jo Jephcott in New Zealand. Dr Kaye was aged 78 at the time.

“Like you, I’ve been on my travels! There was an invitation to the Flinders University of South Australia, fares and accommodation provided. Of course, I couldn’t accept on those terms, having nothing to offer in return; so I went ‘under my own steam’. I met the young and most galvanic Prof. of Anaesthesia (Michael Cousins) and the many bright young people whom he has assembled. The clinical anaesthesia is A1 (as I should imagine, altho’ I’ve been divorced from that kind of thing for a quarter-century) & I saw superb monitoring equipment on the largest scale. We dined at my pub, & yarned in the evening. I could contribute nothing but a couple of bound-up sets of computer programmes, one on sound & the other on respiratory valves. The scheme was that, one could type one’s questions into the computer, and the latter would display its answers (& the reasons for them) in each case: still, it struck me as very elementary stuff to take to so highly computerized a place as Flinders University. I didn’t feel justified in tying up the Prof. for the next day, so I accepted an invitation to the McLaren Vale vineyards & spent an agreeably alcoholic day, ending in a sightseeing tour of Adelaide. The latter has grown past all recognition in the past 20 years, so that even my couple of Heysen water-colours of it bear no relation to the present scene.”



## Research Report

# ANZCA Trials Group - Update



**Ornella Clavisi**  
Research Coordinator,  
ANZCA Trials Group

In 2002, the College established an ANZCA Multicentre Trial Secretariat (AMTS) as a way of boosting research in anaesthesia, perioperative medicine and pain medicine through the development of quality multicentre randomized controlled trials.

Since that time, there have been some major developments. The most important is the establishment of an ANZCA Trials Group (formerly known as the Clinical Trials Group); a collaboration of experienced clinical investigators, representing specific areas of interest within anaesthesia and related disciplines. The Trials Group has also recently appointed a research coordinator (Ornella Clavisi), who is experienced in data management, statistical analysis, evidence based practice and systematic review methodology.

### *What does the Trials Group actually do and how can they help you?*

Overall the goals of the Trials Group are to:

- Conduct high quality multicentre randomised controlled trials in anaesthesia, perioperative medicine and pain medicine
- Set research priorities for the College by inviting ideas and draft protocols from ALL College Fellows for the development of multicentre research including randomised controlled trials and surveys
- Provide support for Fellows who wish to acquire funds for research and who need assistance with their ideas and the generation of grant proposals
- Provide research infrastructure support particularly in the areas of database development, data management, study site monitoring, randomisation and statistical analysis
- Develop a network of interested researchers (Fellows and Trainees) for participation in multicentre research as study site investigators
- Provide expertise and advice to College Fellows and Trainees who are interested in developing systematic reviews or evidence based practice guidelines

The Trials Group has also developed a Pilot Grant Scheme which is open to all fellows of ANZCA, JFICM and FPM as a way of assisting researchers in the following areas: pilot phase testing of trials, collection of baseline data using surveys or establishing a network of investigators. The grant scheme is for up to \$5000 with research support from the Trials Group Research Coordinator. So far only one of these grants has been awarded so please feel free to send in your proposal or contact the Trials Group if you are interested in applying.

### *What is the Trials Group currently doing?*

Below is a brief synopsis of the projects that the ANZCA Trials Group are currently working on.

#### **Cardiac Anaesthesia Survey**

The Cardiac Anaesthesia Survey is a prospective survey on current perioperative practice in patients undergoing all types of Cardiac Surgery in Australia, New Zealand and Hong Kong. The overall objectives of this study are to estimate the proportion of patients who are taking antiplatelet and other anticoagulant medication, measure postoperative blood loss, rate of anti-fibrinolytic and blood product usage as well as variability in transfusion practices. Furthermore, the survey also aims to provide up to date morbidity, mortality and length of stay data in contemporary practice. The data collection for this study has been completed and preliminary results were presented at the 2005 ANZCA ASM. An analysis of the final dataset is currently underway.

#### **Aspirin and Tranexamic Acid for Coronary Artery Surgery (ATACAS Trial)**

ATACAS is the first multicentre randomised controlled trial managed by the ANZCA Trials Group. This trial is funded by the National Health and Medical Research Council for \$1.17 million over 3 years. This study is a prospective double blind trial where patient are randomised to one of the following treatment groups: aspirin, tranexamic acid, aspirin plus tranexamic acid and placebo. Overall the aim of this study is to test whether aspirin, tranexamic acid or both can reduce mortality and or major morbidity after coronary artery surgery. This study is currently recruiting sites and is due to start in 2006.

#### **The Australasian Obstetric General Anaesthesia Survey for Caesarean Section**

This survey is funded by the ANZCA Trials Group Pilot Grant Scheme and is designed to collect contemporary perioperative data in women undergoing general anaesthesia for caesarean section in Australasia over a period of 12 months. Overall the aims of this study are to quantify the number of patients which are difficult to intubate and to approximate the incidence of failed intubation. The study will also approximate the incidence of awareness in contemporary practice. Data collection for this study commenced in June 2005. Recruitment of additional sites is currently ongoing.

#### **Cochrane Reviews**

The Trials Group is also involved in the development of two Cochrane reviews "Target Controlled Infusion vs Manually Controlled infusion of propofol" and "Effectiveness and safety of intraoperative transoesophageal echocardiography during cardiac surgery".

#### **Survey Research**

Members of the Trials Group have co-authored a review on survey research in anaesthesia which was recently accepted for publication in *Anaesthesia and Intensive Care Medicine*. Throughout the year the ANZCA Trials Group has assisted Fellows and Trainees wishing to undertake survey research and have specifically been involved in the development and analysis of surveys for the ANZCA Task Forces.

#### **Master Trial**

The Multicentre Australian Study of Epidural Anaesthesia and Analgesia - The Master Trial - (1,2) has been transferred from the University of WA, School of Population Health to ANZCA, in Melbourne. The transfer was initiated by John Rigg, Paul Myles and Konrad Jamrozik to facilitate greater access to the data by interested clinical investigators. The database will be administered by Ornella Clavisi on behalf of the ANZCA Trials Group. Formal applications to access the data should be directed to Ornella. Paul Myles and Philip Peyton will be responsible for approving applications, pending adoption of a policy,



approved by ANZCA council, for securing and managing the database. As fellows will be aware, the Master trial was designed to evaluate the impact of epidural block on outcome in high risk surgery. The database holds clinical and demographic data of all 915 patients, randomised from 1996 to 2001. The database is also a unique high quality data source for clinical data on the pre-operative morbidity characteristics and consequent post operative morbidity of patients undergoing

major surgery. Accordingly, this data has great potential for those investigators who wish to examine the quantitative relationships between preoperative and postoperative morbidity characteristics of patients undergoing major surgery.

If anyone would like any further information on the above projects or pilot grant scheme; would like to participate as a site investigator on any of the above studies or would like to put a

research idea forward please feel free to email or contact the Trials Group. All enquiries should be directed to Ornella Clavisi on: (61 3) 8517 5326 or [oclavis@anzca.edu.au](mailto:oclavis@anzca.edu.au).

#### **References**

1. Rigg J, Jamrozik K, Myles P, Silbert B, Peyton P, Parsons R et al. Design of the Multicentre Australian Study of Epidural Anaesthesia and Analgesia in Major Surgery. *Controlled Clinical Trials* 2000; 21(3): 244-256
2. Rigg J, Jamrozik K, Myles P, Silbert B, Peyton P, Parsons R et al. Epidural anaesthesia and analgesia and outcome of major surgery: a randomised trial. *The Lancet* 2002; 359:1276-82.



# ANZCA Trainee Committee



**Annabel Orr**  
Chair, Trainee Committee

This will be my last report as Chair of the Trainee Committee. It has been an interesting, busy and rewarding time that I have spent in this role over the last twenty or so months and hopefully the Trainee Committee will continue to develop and evolve, ensuring it remains a permanent and important part of the College structure. In the time that the Committee has been in place we have developed and sent out two surveys of

trainees. In addition, we have set up our e-community to improve the ability to communicate between trainees from different regions. (You can access the e-community at <http://online.anzca.edu.au/anzca>.)

A number of members of our Committee have been involved in other areas of the College such as IT, some of the task forces being conducted

*“...even if you feel you are far away, or not in a metropolitan area, you can still be included via teleconferencing, and e-communication....”*

trainees with the goals of improving our understanding of the needs and concerns of all the trainees under the auspices of ANZCA. The results of the surveys have been fed back to the College, and hopefully will have some impact on the future plans of the College in relation to

currently as well as other smaller committees, and as a result continue to provide trainee input at many levels of the College structure. It is a great insight into the workings of the College and an opportunity to meet many talented people.

From November, each of the regional Trainee Committees will be looking for new members as well as a new Chair who will automatically become a member of the Trainee Committee. I would encourage you to get involved – even if you feel you are far away, or not in a metropolitan area, you can still be included via teleconferencing, and e-communication. The more people are involved, the more ideas we have, and the greater number of trainees and their concerns are represented.

I would like to thank all the trainees who have been involved in the last two years as well as Leona Wilson and Russell Jones for their continuing support of these Committees.



## Examinations

# Primary Examination

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

The viva examination was held at College Headquarters, Melbourne.

## Successful Candidates

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

Sudhanshu Agarwal	VIC
Elsbeth Louise Alfredson	NSW
Cassandra Andrews	QLD
Neville Bailey	QLD
Cambell Gill Bennett	NZ
Paul Martin Blundell	NZ
Andrew Reuben Braun	VIC
Liezel Bredenkamp	NZ
Teresa Frances Bulger	NZ
Brendon Eric Buzacott	QLD
Kelly Patrick Anthony Byrne	NZ
James Paul Cameron	NSW
Matthew David James Chacko	NZ
Chin-wern Chan	WA
June Mei Yee Chan	NSW
Kathryn Elizabeth Charlton	QLD
Rui Siang Cheng	SA
Cheong Vicky Gabriel	SGP
Elena Chernova	VIC
Arthur Yin Sau Cheung	VIC
Man Yiu Cheung	VIC
Chia Ling Ling Valerie	SGP
Edwin Kuo Jarng Choong	NSW
Chu Chung Yin	HK
Chung Yu Fai	HK
Matthew William Coghlan	VIC
James Corcoran	SA
John James Peter Dally	SA
Paul Geoffrey Davies	QLD
Yi-Feng Cindy Ding	QLD
Neil Michael Dooney	SA
Daniel Patrick Durack	WA



**Primary Examination July/August 2005 - Court of Examiners**

**Standing:** Dr Andrew Gardner, A/Prof Michael Chan, Dr Ross MacPherson, Dr Peter Krüger, Dr Neil Warwick, A/Prof Geoff Gordon, Dr Craig Noonan, Dr Stephen Barratt, Dr Helen Kolawole, Dr John Copland, Dr Tim Short and Dr Paul Forrest  
**Seated:** Prof James Sleigh, Dr Michael Cleary, A/Prof David Cottee (Chairman), Dr Noel Roberts, Dr Jo Sutherland

Ivana Erac-McKenzie	VIC	Andrew John Kennedy	NSW
Agata Daniela Errera	NZ	Daniel Kennedy	WA
Muhammad Essop	ACT	Sarah Megan Kennedy	VIC
Roy William Fischer	NZ	Nathan James Kershaw	NZ
Alister Ross Ford	VIC	Kay-Lip Khoo	NZ
Nicholas Simon Ford	NSW	Emily Gar-Yee Koo	HK
Craig Laurence Fraser	QLD	Roni Benjamin Krieser	VIC
Martin Willem Frouws	QLD	Jeyanthi Kunadhasan	MAL
Fu Yim Ting	HK	Lam Chi Shan	HK
Richard Galluzzo	ACT	Joshua Ho Pui Lau	WA
Callum Radford Gilchrist	ACT	Li Lin	VIC
Goh Shirley	SGP	Philip Lo	NSW
Amanda Jane Govenlock	QLD	Thanaporn Lorchorchoonkul	SGP
Roderick Kenneth Grant	QLD	Janet Ellen Loughran	NSW
Timothy Christian Gavin Grice	NZ	Kate Suzanne Luscombe	WA
Ali Gur	SA	Cameron Mark Main	SA
James Julian N Hafner	NSW	Man Chi Ning	HK
Amelia Kate Harricks	NSW	Heather Alicia Matthews	NZ
Timothy Peter Haydon	VIC	Shannon James Matzelle	WA
Maryam Horriat	VIC	Kirsten McCullough	SA
Jeffrey David Hoskins	NZ	Heather Rosalie McDonald	QLD
David James Howkee	QLD	Maree Helen Meier	QLD
Jack Shao-Cheng Huang	QLD	Suzanne Edith Miles	QLD
Sarah Hughes	NZ	Kathleen Esther Mistry	NZ
Craig Humphries	VIC	Christopher Hugh Mitchell	WA
David Ip	VIC	Aidin Mohajeri	VIC
Kam Hau Tsz	HK	Simone Mossenson	VIC
Owen Arthur Keet	NZ	Louise Margaret Munro	QLD



Kirstin Larissa A Nguit	NSW
Audrey Siet-Ting Ng	WA
Kheng-Heng Ng	NSW
Mark Darren Gye-Len Ng	VIC
Ng Tze Luen Adrian	SGP
Kim Alexander Nuyen	VIC
Thomas Michael Alexander O'Rourke	NZ
Philip Matthew Owen	NSW
Angela Jade Palumbo	WA
Ling Te Pan	SGP
Shivashan Karan Panchacharavel	NSW
Andrew George Paterson	NSW
Judith Anne Penney	NZ
Darren Pereira	NSW
Senthan Ponniah	ACT
Michael Siew-Foo Poon	NSW
Christopher James Poynter	NZ
Priya Rajendra	VIC
Maivili Mathavi Raveenthiran	QLD
Simon Maximilian Roberts	NSW
Johanna Rose	NZ
Sarah Louise Rylands	QLD
Giles Victor Sampson	NSW
Kishore Kumar Sanghi	NSW
Mir Wais Sekandarzad	NSW
Marianne Bottros Sidhom	QLD
Joanna Louise Sinclair	VIC
Andrew William Smith	NZ
Louisa Marie Smith	QLD
Peter David Smith	NSW
Andrew John Struthers	VIC
Brent Aaron Studd	NSW
Arun Subramanian	VIC
Peter Tam	NSW
Tam Lee Ka	HK
Jennifer Ann Taylor	NZ
Jonathan Michael Tey	NSW
Matthew James Tey	NSW
Bich-Phuong Tieu	SA
Sharon Lii-Anna Tsetong	NSW
Andrew Alexander Udy	NZ
Paloma Gioia Van Zyl	QLD
Paul Xavier Vella	QLD
Stephen Keith Whiting	NZ
Nicola Whittle	NZ
Jerrey Wikarsa	NSW
Chin Ming David Woo	SGP
Tai Lun Paschalis Woo	QLD



*Retiring Primary Examiner Dr Gill Bishop with A/Prof David Cottee (Chairman, Primary Examination Committee)*



*Retiring Primary Examiner Dr Michael Cleary with A/Prof David Cottee (Chairman, Primary Examination Committee)*

John Yang	NSW
Peik Fei Yau	VIC
Amanda Louise Young	VIC
William John Young	NZ
Wanda Wing Zee Yung	NSW
Simon Anthony Zidar	NSW
Benjamin Mark Zugai	QLD

## Renton Prize

The Court of Examiners recommended that the Renton Prize for the half year ended 31 December, 2005 be awarded to:

Dr Shannon James Matzelle	WA
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## Merit Certificates

Merit Certificates were awarded to:

Dr Elspeth Louise Alfredson	NSW
Dr Cambell Gill Bennett	NZ
Dr Matthew David James Chacko	NZ
Dr Chin-Wern Chan	WA
Dr John James Peter Dally	SA
Dr Paul Geoffrey Davies	QLD
Dr Yi-Feng Cindy Ding	QLD
Dr Jack Shao-Cheng Huang	QLD
Dr Nathan James Kershaw	NZ
Dr Kay-Lip Khoo	NZ
Dr Christopher Hugh Mitchell	WA
Dr Louise Margaret Munro	QLD
Dr Angela Jade Palumbo	WA
Dr Andrew Alexander Udy	NZ
Dr Peik Fei Yau	VIC
Dr Benjamin Mark Zugai	QLD





## Examinations

# Final Fellowship Examination

(Anaesthesia) September 2005

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

The viva examination was held at The University of New South Wales, The Prince of Wales Hospital and The Sydney Children's Hospital.

## Successful Candidates

Jane Louise Anderson	VIC
Deborah Natalie Bell	WA
Stephen Mark Berrill	NZ
Thomas Patrick Bookallil	NSW
Liam Joel Broad	VIC
Gerard Sastri Bunes	VIC
Joel Thomas Butler	WA
Jane Frances Calder	NZ
Darren Ross Cathcart	NZ
Olivia Suk Yan Cheung	HK
Michael Fook Yuan Chong	VIC
Nicholas Charles Chrimes	VIC
Alwin Hooi Hock Chuan	NSW
Peter Clapham	NSW
Kathleen Mary Cooke	QLD
Phillip James Cowlshaw	QLD
Alan Gordon Crowther	NZ
Tamara Joan Culnane	WA
Jennifer Fleming Cummings	NSW
Amanda Elizabeth Curo	WA
Rebecca Dabars	VIC
Vincent Johann DaSilva	NSW
Mark James Davie	QLD
Alistair Huw Davies	WA
Steven Dimadis	ACT
Sarah Mary Doneley	QLD
Pamela Alice Eccles	NZ
Victoria Anne Eley	QLD
Adrian Lachlan Feint	QLD
Claire Elizabeth Ann Frost	NZ
Craig Brett Garfinkel	NSW
Susan George	NSW
Iain Charles Stuart Gilmore	NZ
Wendy Goh	NSW
Dale Patrick Greer	NSW
Navneet Gupta	NSW

Rajiv Gupta	NSW
Andrew Phillip Guy	NSW
Robert Hackett	NSW
Simon Alexander Harper	NSW
Sean Stephen Hearn	VIC
Lynn Pei Er Hong	VIC
Anna Mary St Clair Inglis	NZ
Christopher Own Jackson	SA
Anthony Stephen Jenkins	QLD
Delyth Angharad Jones	NSW
Shammi Kabir	NSW
Navkiran Kaur	NSW
Lee-Ann Margaret Kitto	NSW
Paul Lung Sun Kwei	WA
Leonard Chong Lee	WA
Tao Chern Lee	VIC
Khai-Ching Lim	NSW
Kristen Sarah Llewelyn	SA
Lo Chor Kwan	HK
Paul Francis Lockington	NZ
Tai Que Ma	WA
Bojidar Manasiev	NSW
Craig McGrath	VIC
Ian Duncan Henare McKay	NZ
Claire Nichola McTernan	WA
Gavin John Millar	NSW
Martin Alan Minehan	NZ
Martin Peter Misur	NZ
Volker Mitteregger	VIC
David Moore	NZ
Ainslie Elizabeth Murdoch	VIC
Rhyanon Elizabeth Murray	NZ
Taryn Ann Naggs	QLD
Manu Narayanaswamy	NSW
Irene Ng	VIC
Lucia Georgeta Nicolae	QLD
George Fit Fai Pang	QLD
Reshma Pargass	TAS
Linda Stephanie Partridge	SA
Ronald Joseph Pereira	NZ
Hau Pham	NSW
Andrew John Pitcher	NZ
Adam Heath Rehak	VIC
Andrew Leigh Rubinfeld	VIC
Philip Adam Russell	WA
Sanjay Satchi	NSW
Mark Udo Schutze	WA
Katherine Jillian Shelley	WA

Ian Stovin Sherratt	NSW
Jim Greg Shim	NSW
Sharon Smedley	WA
Julian Gary Smith	VIC
Josephine Mei Tan	NSW
Tan Soo See	MAL
Kalai Selvi Tanggaveloo	SA
Jamal A A Tashkandi	NZ
Teoh Chuan Yeong	SA
Meredith Christine Tey	NSW
Thanh Truc Tran	ACT
Evangelos Tziavrangos	WA
Burger van Der Merwe	NZ
Eldon William Ward	NZ
Ian Yee Yan Wong	HK
Caroline Yeoh	NSW

## Cecil Gray Prize

The Court of Examiners recommended that the Cecil Gray Prize for the half year ended 31 December 2005 be awarded to Dr Victoria Eley, Queensland

## Merit List

The following candidates were awarded a Merit Certificate for their performance at the September 2005 Final Examination:

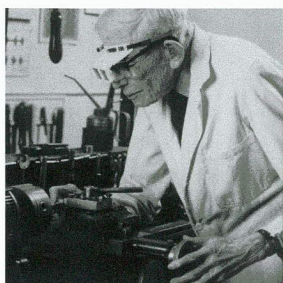
Stephen Berrill	NZ
Tamara Culnane	WA
Bojidar Manasiev	NSW
Manu Narayanaswamy	NSW



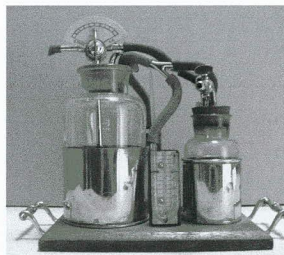
# Geoffrey Kaye Museum of Anaesthetic History

## In the Beginning...

What do the British Museum and the Geoffrey Kaye Museum of Anaesthetic History have in common? Both museums contain an internationally significant core collection which was created as a result of the dedication, research, perseverance and foresight of a highly respected individual.



*Dr Geoffrey Kaye working at his lathe, July 1989  
Dr Kaye—Inventor and Engineer.*



*Simple Blower or Bubble Through Apparatus Made by Dr Geoffrey Kaye in 1929  
Donated by Dr Kaye, 1939*



*Dr Geoffrey Kaye lecturing and demonstrating the principles of anaesthetic apparatus, late 1940s Small Lecture room in the School of Physiology, University of Melbourne. Image courtesy of the Harry Daly Museum, Australian Society of Anaesthetists.*

The British Museum was established in 1753 to house the Sir Hans Sloane Collection which consisted of over 71,000 objects, a library and a herbarium. Sir Hans Sloane, (1660-1753) was a well known physician, naturalist and collector. Although on a much smaller scale, the origin and development of the Geoffrey Kaye Museum of Anaesthetic History has a number of surprising similarities with that of the British Museum.

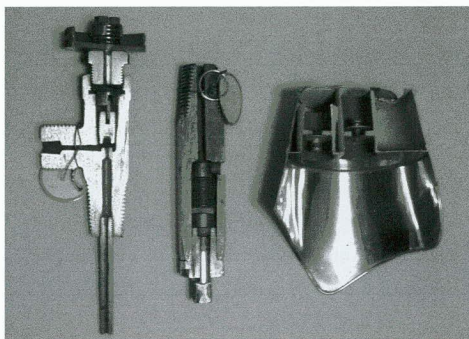
Like Sir Hans Sloane before him, the founder of the Geoffrey Kaye Museum of Anaesthetic History, was a respected physician and avid collector. Dr Geoffrey Kaye (1903-1986), was also a renowned teacher, scientist, inventor, researcher, organizer and resolute correspondent. He was one of

Australia's first full-time practising anaesthetists, a founder of the Australian Society of Anaesthetists and its inaugural Secretary.

The Dr Geoffrey Kaye Collection, which is of international significance, is the core and most significant component of the Geoffrey Kaye Museum of Anaesthetic History. Established in 1935, the original Collection was sourced from hospitals and instrument houses throughout Australia and includes a significant amount of rare 19th Century material. The Collection grew steadily between 1935 and 1955, largely due to donations from medical trade houses and Dr Kaye's collecting activities while overseas during the Second World War.

From the very beginning Dr Kaye had a very clearly defined strategic vision for the Museum which was: *To cultivate an interest in anaesthesia and promote the development of the practice among students, physicians and the general public through the display and use of a wide variety of anaesthetic equipment.*

Dr Kaye was ahead of his time in recognising that the Museum had an important role to play in educating anaesthetists through the use of objects as teaching aids. His lectures and demonstrations relied heavily on the use of sectioned apparatus to illustrate gas pathways and re-breathing channels. As a result, the Museum contains an internationally significant collection of rare sectioned apparatus, valves and flow meters.



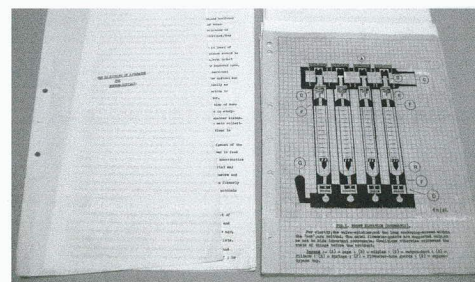
*A Selection of Museum Objects Sectioned by Dr Geoffrey Kaye  
Left to Right: Siebe-Gorman Valve, c. 1940 Donated by Dr J. Watson, 1946, C.I.G. Small Cylinder Valve, 1949 Sectioned by Dr Geoffrey Kaye. Donated by C.I.G., 1950, Dewee's Ether Inhaler, 1902 Sectioned by Dr Geoffrey Kaye*



**Ms Elizabeth Triarico**  
Museum Curator

From its inception displays and demonstrations were considered to be extremely important activities for the Museum, as can be seen from a letter Dr Kaye wrote to the Executive of the Australian Society of Anaesthetists on 7 March 1955, ...*The museum was designed to collect and preserve the apparatus of the past, to display the apparatus of current use, and to provide lecture-demonstrations to postgraduate students and to under-graduates of the University of Melbourne. Surplus material again, was envisaged as the nucleus of branch-museums in other States.* (Wilson, G, and Barry, B., 1987, *Fifty Years The Australian Society of Anaesthetists 1934 – 1984*, p. 308.).

Dr Kaye's foresight and dedication have provided the Geoffrey Kaye Museum of Anaesthetic History



*The Sectioning of Apparatus for Museum Display, 1984  
Original discussion notes prepared by Dr Geoffrey Kaye.  
This document provides an insight into Dr Kaye's views on the importance of using Museum collection items as teaching devices.  
The notes include diagrams of sectioned apparatus.*

with a very solid foundation on which to build. His unrelenting search for anaesthetic apparatus of all kinds and unique educational approach, have ensured that the Museum Collection is one of the largest most comprehensive collections of its kind in the world. Dr Kaye's vision still holds true today and provides a clear direction for the successful future development and management of the Museum.

**Visits to the Museum 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, on: (61 3) 9510 6299 or [etriarico@anzca.edu.au](mailto:etriarico@anzca.edu.au).**



# Recognition of Prior Experience Towards FANZCA Training

FANZCA training comprises five years of which there must be 33 months anaesthesia and three months Intensive Care Medicine. The remaining 24 months may be spent in anaesthesia or related areas (Regulation 15.4.6). Council has sought to give Trainees appropriate recognition of prior learning (Regulation 15.3.2) and training flexibility, balancing this against the need to ensure that sufficient experience is gained in the practice of anaesthesia.

The following is an explanation of the current approach of the College towards recognition of prior experience, whether in anaesthesia or in other specialty areas. The examples given are for the purposes of illustration and are of a general nature. *The case of each Trainee is individually assessed, taking into account all relevant Regulations that apply to the specific situation.*

## **Retrospective accreditation of previous anaesthesia experience**

The Australian Medical Council in its accreditation of the College in October 2002 highlighted the following issue in relation to ANZCA training:

'The Team believes there is still a problem with anaesthetic registrars working in non-accredited positions. There are certainly instances in which hospitals have non-accredited positions where the registrars' experience is identical to that of accredited registrars, including attendance at tutorials and comparable case loads. The Team strongly advocates a mechanism for granting retrospective approval of periods of [anaesthesia] experience to those registrars ultimately selected into a training position who request this and can demonstrate appropriate training experiences.'

and: 'The Team felt it was inconsistent to accredit time in medicine, emergency medicine or intensive care, but not to accredit time spent in a non-accredited [anaesthesia] post where no distinction has been made in the level of the work.'

## **Previously Unaccredited Posts in Hospital Departments with Accredited Posts**

From the beginning of the 2004 training year, the College has accredited Training Organisations, rather than posts; thus, no longer can a registrar (or equivalent) working alongside another registrar who is doing an equivalent job find themselves unable to accredit this time towards training.

However, to ensure that those who did equivalent unaccredited jobs prior to the start of the 2004 training year, Council has decided to recognise such time towards anaesthesia training. Time spent in a non-accredited post in 2003 may be accredited towards the 'core' 33 months of anaesthesia (Regulation 15.3.2.1), and similar experience prior to 2003 may be accredited towards the 24 months of 'other' time (Regulation 15.3.2.2). Accreditation of this time requires a letter of support from the Supervisor of Training or Head of Department who is able to confirm that the experience was 'equivalent to [that obtained in] ANZCA approved posts'.

Although there has been a significant number of recent applications for this recognition, it is likely that the numbers will decline over the next few years as Trainees commencing from the start of the 2004 training year are able to count time in accredited Departments towards their training (provided they are registered as ANZCA Trainees).

## **United Kingdom SHO experience**

A Senior House Officer (SHO) post in the UK occupied after 1st April 1996 may be recognised as contributing to ANZCA Basic Training (Regulation 15.4.4) provided that:

- It is in a hospital which is accredited by the Royal College of Anaesthetists and which has Specialist Registrar posts in Anaesthesia.
- The post is held for a minimum of 3 months and will be recognised by ANZCA for a maximum of 12 months.

- Trainees cannot proceed to Advanced Vocational Training until all the requirements for Basic Vocational Training have been completed.

## **Partial Training in other Anaesthesia Programs**

A Trainee who has completed partial training in another anaesthesia training program, acceptable to Council, may, at the discretion of the Assessor, receive exemption from Basic Training, including the Primary Examination (Regulation 15.4.4.).

*Dr A has completed 24 months training in the UK and has passed the UK Primary and FRCA Examinations. She registers with ANZCA for training and is granted exemption from Basic Training, including the Primary Examination. She is required to complete 36 months of Advanced Vocational Training (which must all be spent in Australia or New Zealand or other areas where the College examines).*

## **Postgraduate anaesthesia qualifications from areas outside Australia and New Zealand where the College examines**

ANZCA has Trainees and conducts examinations in Hong Kong, Singapore and Malaysia. Holders of postgraduate anaesthesia qualifications from these countries (which are accepted by Council as justifying exemption from the Primary Examination) may receive exemption from Basic Training. They may also have retrospective recognition of up to 48 months training time provided this is spent in ANZCA-approved Hospital Departments (Regulation 15.4.10). Modules 4 to 12 must be completed, and may be retrospectively verified with the appropriate documentation.

## **Retrospective accreditation of previous non-anaesthesia experience**

Twenty-four months of training time may be spent in any combination of the following areas: Clinical Anaesthesia, Intensive Care Medicine including Neonatal Intensive Care, Clinical Medicine, Emergency Medicine, Pain Medicine, other disciplines related to Anaesthesia, or a formal research program (Regulation 15.4.6.3).



Up to 24 months may be undertaken in the latter, subject to prospective approval from the Assessor after consultation with the ANZCA Research Committee (Regulation 15.4.6.3.7).

Non-anaesthesia experience has long been recognised retrospectively, the main conditions being that the training is 'recognised by the appropriate College or other relevant training body as appropriate for specialist training purposes', and that the minimum time accredited is three months.

#### **JFICM Fellows**

Fellows of the Joint Faculty of Intensive Care Medicine who have registered for anaesthesia training and are required to complete the Primary Examination may be granted retrospective approval of training time spent in supervised training in Clinical Anaesthesia in Approved Hospital Departments during intensive care training. In addition, they may be granted retrospective recognition of up to 27 months training time in Intensive Care Medicine and other disciplines related to Anaesthesia. Retrospective approval may therefore exceed 24 months; this is one of the few exceptions to the requirement to complete Basic Training before entering Advanced Training.

#### **Approval of 24 months of non-anaesthesia time at the start of Anaesthesia Training**

A specific challenge created by the division of Basic and Advanced Training applies when a registered Trainee seek retrospective accreditation of 12 to 24 months of non-anaesthesia time. For example:

*Dr B registers for anaesthesia training and applies to have 24 months of experience in another specialist training program retrospectively accredited towards training. He provides a letter from his former Head of Department confirming the dates of employment and that this training was recognised towards training by another specialist college.*

If these 24 months were all recognised retrospectively as Basic Training, this Trainee would be in the situation of having completed the time requirement for Basic Training but not having had any anaesthesia experience in which to complete the Modular Requirements of Basic Training (i.e. Modules 1, 2, 3 and one of the clinical Modules 4 to 10). Thus Council has decided to allow, at the discretion of the Assessor, 12 months to be accredited towards Basic and 12 months towards Advanced Training (Regulation 15.3.2.3). *For this Regulation to apply, the application must be made within 12 months of commencing Approved Vocational Training.*

#### **Caveats to retrospective accreditation of experience**

Trainees are unable to commence training until they have completed 24 months prevocational experience; thus experience within this 24 months prevocational training period cannot be accredited towards the five years of FANZCA training.

Training Hospitals (and other organizations) are accredited for six months, or one, two or three years of Approved Vocational Training, according to predetermined criteria (including Modular subspecialty experience available). This limit applies to clinical anaesthesia. Time spent in other specialty areas and/or in a Provisional Fellowship Program may be in addition, up to a maximum of four years in any one Hospital (Regulation 15.11.1.4). These AVT limits are considered when applications for retrospective accreditation of experience are received.

Advanced Training cannot be commenced until the requirements of Basic Training, including the Primary Examination, have been met (Regulation 15.4.5). Trainees who have spent more than 24 months in Basic Training and who have completed all requirements apart from the Primary Examination are eligible to commence Advanced Vocational Training from the day following the passing of the Primary Examination (Regulation 15.4.5). This is considered in relation to

applications for recognition of prior experience.

*Dr C passes his Primary Examination after 28 months of anaesthesia training. He has completed the requisite Modules, but is not eligible to commence Advanced Training until the day after he completes his Primary Examination. His application for recognition of experience prior to the commencement of Approved Training would not be accepted.*

*Dr D passes the Primary Examination after 15 months of anaesthesia training. She applies for recognition of 12 months of time spent as an anaesthesia SHO in the UK (in a RCA accredited Department with Specialist Registrars) prior to the commencement of Approved Training. Nine months of this time is accredited towards her Basic Training and, provided she has completed the appropriate Modules, she is now eligible to enter Advanced Training.*

A maximum of 24 months of training may be spent in areas outside those where the College examines (Regulation 15.4.2). This may include a maximum of 12 months in Basic Training (Regulation 15.7.10). Provided not more than 12 months retrospective approval of prior training in an overseas program has been granted, up to 12 months in Advanced Training may also be spent overseas.

#### **Common issues faced by the Assessor**

Where possible, it is preferable to seek *prospective* approval of experience. This avoids the disappointment of ineligibility for accreditation, and ensures that Trainees receive graded levels of supervision as they progress through training.

It is suggested that Supervisors of Training counsel Trainees regarding the pros and cons of applying for retrospective accreditation of experience. Some Trainees may benefit from not accelerating their progression to Fellowship. Where Trainees decide to apply for retrospective accreditation of prior experience, it is advisable to do this as early as possible during training.



All applications for recognition of prior experience must be supported by relevant documentation. It is usual to require a letter from the Head of Department or Supervisor of Training confirming dates of appointment and that the training was 'recognised by the appropriate College or other

relevant training body as appropriate for specialist training purposes'. In the case of non-accredited posts prior to 2004, confirmation that the post was equivalent to an ANZCA-approved one is required. For UK SHO time, there must be confirmation that the conditions of Regulation 15.4.4 (listed above) are met.

Decisions regarding training, including recognition of prior experience, are made with reference to all Regulations applicable to the specific circumstance. Communications with Trainees include detail of the Regulation(s) upon which decisions are based. A *common situation is that Trainees fail to recognise that more than one Regulation applies to their situation*. Supervisors should encourage Trainees to look closely at all Regulations that may apply to avoid misinterpretation.

For part-time Trainees, all Training determinations are calculated in full-time equivalents.

Any enquiries about training, including retrospective accreditation, should be directed to Ms Elizabeth Woods ([ewoods@anzca.edu.au](mailto:ewoods@anzca.edu.au)).

1. Australian Medical Council. Accreditation Report: The Education and Training Programs of the Australian and New Zealand College of Anaesthetists. October 2002.
2. ANZCA Professional Document TE3 (2003) *Policy on supervision of clinical experience for vocational trainees in anaesthesia*. Available at [www.anzca.edu.au](http://www.anzca.edu.au)

**Lindy Roberts**  
Assessor

*The views expressed are those of the author only. This explanation is for guidance and general discussion, and is not binding on the College. Decisions of the College will be made in accordance with its Regulations.*

## OTS Performance Assessment

### May 2005

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

Katherine Hames	QLD
Upendhar Kandala	NSW
Kaushik Saha	SA

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

Daniel Berge	NSW
Helen Davies	QLD
Michael Duncan	VIC
Dimitri Fedorov	QLD
Usha Gurunathan	NSW
Dominique Hopkins	QLD
Nutan Kumta	QLD
Susan McIlveney	NSW
Eike Pfluger	WA
Claudia Rebmann	WA
Natalie Smith	NSW
Petrus van Den Berg	NSW
Pauline Whyte	SA
Philip Wolstencroft	NZ

### Certificate of Excellence

Dr Katherine Hames, Queensland, was awarded the Certificate of Excellence at the September 2005 Overseas Trained Specialist Performance Assessment.



## Demographic Data

### Gender

According to the 2005 ANZCA Workforce Survey, the gender distribution of ANZCA Fellows internationally is approximately 75% male to 25% female. These results indicate that the proportion of female fellows in the workforce has increased from 20% in 2002 to 25% in 2005. In Australia the percentage of respondents was 77% male and 23% female; New Zealand 73% male and 27% female. Asian Fellows had a noticeably higher proportion of female respondents with 40% female and only 60% male.

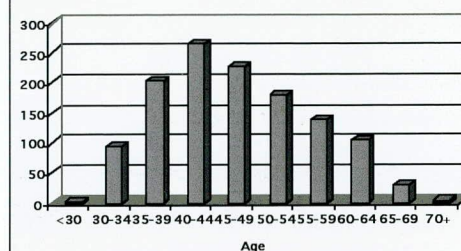
### Age

The average age for all survey respondents was found to be 46.8 years, (compared to 46.2 in 2002). Around 23% of respondents were younger than 40. Only 13% of respondents were older than 60. The average age of Australian Fellows was 47.4, compared to 48.5 for New Zealand Fellows, and only 43.8 for Asian Fellows.

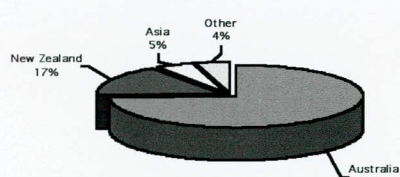
### Region of Practice

The majority of ANZCA Fellows (74%) are based in Australia. Within Australia, the distribution of anaesthetists matches population distribution quite closely.

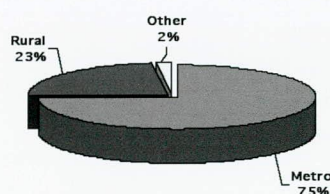
**All Respondents by Age**



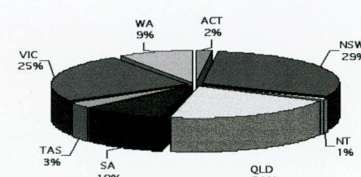
**Respondents by Region**



**Rural vs. Metropolitan Fellows**



**Distribution in Australia**



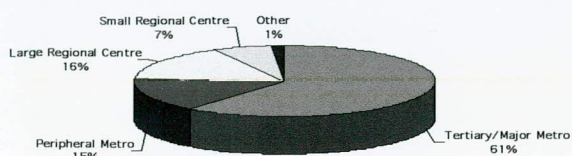
### Hospital Type

The distribution of ANZCA Fellows in terms of hospitals has not changed drastically since 1999.

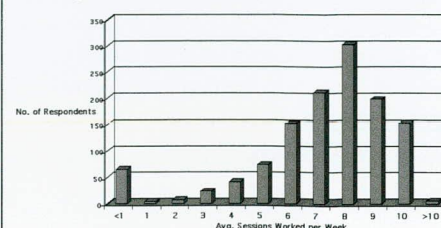
**Table 3 – Hospital Type**

	2005	2002	1999
Tertiary / Major Metro	61 %	60%	62%
Peripheral Metro	15 %	15%	14%
Large Regional Centre	16 %	17%	20%
Small Regional Centre	7 %	5%	2%
Other / Unspecified	1 %	3%	2%

**Hospital Type**



**Average Clinical Session / Week Worked**





## Workforce Data

Clinical anaesthesia is the main area of work for 90% of the 2005 ANZCA respondents, while 8% work mainly in intensive care, and 2% work mainly in pain medicine.

1,043 (81%) of respondents work full time, and 211 (16%) work part time. 30 (3%) of respondents indicated they had retired from practice. The average expected age of retirement for all respondents was 63.9 years.

1,031 (82%) of Fellows work at least one session a week in public anaesthesia.

834 (67%) of all Fellows work at least one session a week in private anaesthesia.

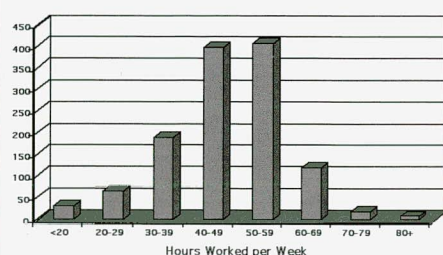
601 (48%) of all Fellows participate in both public and private anaesthesia on a weekly basis.

In a standard working week, full time ANZCA respondents:

- work an average of 48.2 hours.
- are on call an average of 19.4 hours.
- spend an average of 6.8 hours working after hours.
- work an average of 7.5 clinical sessions

ANZCA respondents work an average of 45.7 weeks per year, and are on call an average of 4.9 days per month.

**Average Hours Worked per Week**



According to the 2005 survey, 64% of Fellows were satisfied with their current workload, (compared to 59% in 2002). 30% of respondents would prefer less work, and 6% would prefer more work.

53% of respondents were satisfied with the number of anaesthetists currently in practice. 43% of respondents believed there were not enough anaesthetists in practice. 4% of respondents believed there were too many anaesthetists in practice.

**Table 4 – Work Status by Region**

	Australia	New Zealand	Asia	Other
Full Time	83%	76%	97%	88%
Part Time	17%	24%	3%	12%

**Table 4 – Average Time Working**

	All Fellows	Males	Females	Full Time	Part Time
No. of active respondents	1264	971	319	1043	211
Avg hours worked / week	45.2	46.7	39.3	48.2	30.0
Avg hours on call / week	17.2	18.3	13.2	19.4	11.2
Avg after hours / week	6.3	6.6	5.3	6.8	3.7
Avg weeks worked / year	45.7	45.7	45.2	45.9	44.6
Avg clinical sessions / week	7.1	7.3	6.6	7.5	5.3

**Table 5 – Distribution of Sessions Worked**

Specialized Field	Average No. of Sessions Worked / Fellow / Week	Active Respondents Participating in Field	Proportion of Total ANZCA Respondents
Public Anaesthesia	4.6	960	76 %
Private Anaesthesia	4.6	914	72 %
Intensive Care Unit	4.1	202	16 %
Acute Pain	1.2	144	11 %
Chronic Pain	2.5	82	6 %
Preoperative	1.0	300	24 %
Teaching	1.0	299	24 %
University	2.5	46	4 %
Administration	1.6	439	34 %
QA / Audit	0.7	216	17 %
College / Society	0.9	65	5 %
Research	1.4	104	8 %
Hyperbaric	2.5	15	1 %
Paediatric	2.5	97	8 %
Obstetric	1.5	125	10 %
Simulation Centre	1.3	26	2 %
Other	2.3	65	5 %

**Table 6 – World Distribution of Active ANZCA Fellows**

	Active Respondents	Active ANZCA Fellows	Response Rate
Australia	934	2,759	34 %
New Zealand	202	424	48 %
Africa	3	3	100 %
Canada	8	18	44 %
Europe	2	4	50 %
Hong Kong	46	160	29 %
Malaysia	12	49	24 %
Other Asia	2	2	100 %
Singapore	8	51	16 %
UK	24	57	42 %
USA	13	51	25 %
Other	5	7	71 %
Total	1,259	3,585	35 %



## Summary

There has been a constant decline in the response rate of ANZCA Workforce surveys since 1994. The most recent 2005 response rate of 38% is unacceptably low. In order to obtain a true indication of workforce trends, a response rate of at least 80% should be aimed for in the future.

This study has analyzed a non-random minority (38%) of the total ANZCA workforce. This must be kept in mind if ever the data are to be used for any purposes in the future.

A substantial amount of useful data has been obtained from the 2005 ANZCA Workforce survey. The findings will be added to the database of workforce statistics collected since 1994.

The 2005 ANZCA Workforce Survey has shown us that in general, the anaesthesia workforce is growing and diversifying in order to meet the needs of the Australian and New Zealand populations.

The data can be used by ANZCA and other bodies to address the improvement of the match of supply to demand for specialist anaesthesia services.

Any questions relating to workforce matters should be directed to Dr Diana Khursandi (Chair, ANZCA Workforce Committee) via the College.

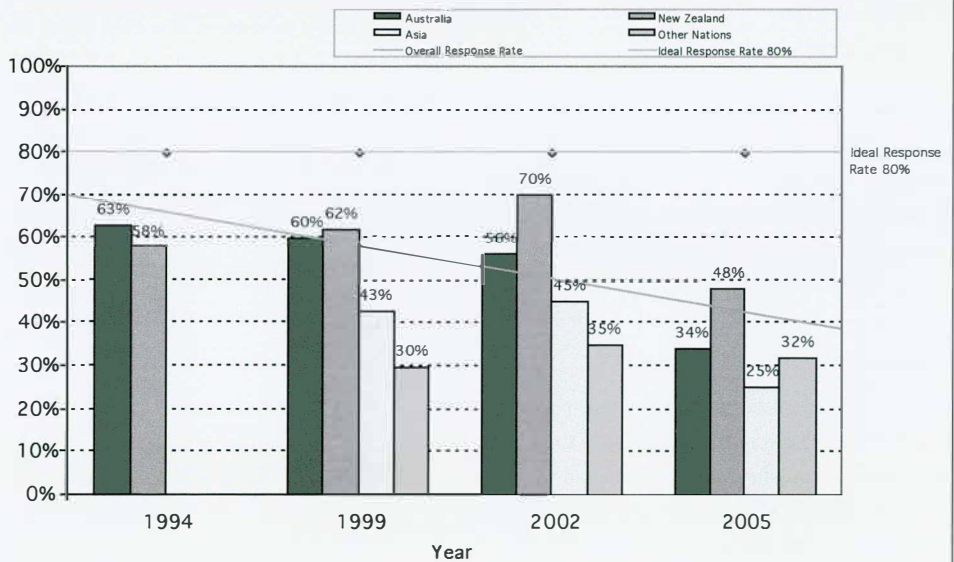
**Table 7 – Australian Population Distribution**

	Population *	ANZCA Fellows	Population per Anaesthetist
NSW	6,731,300	925	7,277
VIC	4,972,800	680	7,313
QLD	3,882,000	498	7,795
SA	1,534,300	269	5,703
WA	1,982,200	254	7,804
TAS	482,100	76	6,343
NT	199,900	12	16,658
ACT	324,000	44	7,364
Australia	20,111,300	2,759	7,289+

\* According to Bureau of Statistics 2004 Figures

+ The recommend population per anaesthetist of 8,500 persons has been proposed for Australia and New Zealand (Baker, 1997).

**1994-2005 Response Rate by Region**







## Special Interest Groups

# Annual Reports

### Acute Pain

#### Executive

The Executive composition is as follows:

Dr Meredith Craigie	SA
Dr Lachlan Doughty	TAS
Dr Richard Halliwell	NSW
Dr Steve Jones (Chair)	NZ
Dr James Sartain	QLD
Prof Stephan Schug	WA
Dr Grant Turner	WA

Our triennial elections are due to be held at our AGM in 2006. This will be in association with the Adelaide ASM. Calls for nominations will be sent to SIG members a couple of months beforehand. It is hoped that there will be a nomination to represent the State of Victoria.

#### Change in Executive Membership

Dr Colin Goodchild resigned from the executive while serving as chairman and Dr Steve Jones (NZ) was asked to stand and duly elected in his place. Dr Martina Meyer-Witting (Qld) has also resigned following a change in work commitments with a reduction in formal commitments to acute pain management. Both are thanked for the work they have done on behalf of the SIG.

#### Continuing Education Activities

##### ANZCA ASM Auckland 2005

The SIG session in Auckland opened with an analysis of two beleaguered analgesic modalities: Prof Schug reviewing the advantages of epidurals and Dr Jones examining the adverse but also beneficial cardiovascular effects of NSAIDs and selective COX-2 inhibitors. Dr Brian Anderson, despite his responsibilities as conference co-convenor, allowed himself to be prevailed upon to re-present his excellent paper on paracetamol.

Dr Meredith Craigie conducted a PBLD on behalf of the SIG.

#### Rural Advanced Specialist Training Scheme

Dr James Sartain contributed a lecture on pain management on behalf of the SIG

##### ANZCA ASM Adelaide 2006

The SIG has expressed a desire to present a session at the Adelaide meeting.

#### Issues Arising

The Executive is concerned about the effect that publicity of the adverse cardiovascular effects of the COX-2 inhibitors and indeed also traditional NSAIDs will have on our perioperative practice. Dr Jones has published a defensive position in the September edition of the British Journal of Anaesthesia and has corresponded with regulatory authorities over the issue.

**Steve Jones**  
Chairman

### Anaesthetists in Management

#### Executive

The SIG Executive composition is as follows

Dr Vanessa Beavis (Chair)	NZ
Dr Martin Lum	NSW
Dr Patricia Goonetilleke	VIC
Professor John Rigg	WA
Dr Darcy Williams	VIC

#### Administration

The second Annual General Meeting was held on 10th May 2005 during the ANZCA ASM in Auckland.

The minutes have been circulated to the members of the SIG.

The key points discussed were:

- Results of the needs analysis survey
- E-community
- Future activities

The membership is now 136.

#### Finances

The finances for the SIG in 2004 were as follows:

Balance 31/12/03	– (\$330.94)
Income in 2004	– \$1,758.86
Expenses in 2004	– (\$367.59)
Balance 31/12/04	– \$1,060.33

( ) donates a negative amount.

#### Continuing Education

The SIG contributed to the ASM in a dedicated lecture session on management as well as a very successful half day workshop.

Both sessions were well attended and feedback was positive.

We will be contributing to the SIG Meeting in Noosa in October 2005. This is the Combined Education Welfare of Anaesthetists, Management and Simulation Special Interest Group Meeting.

The e-community has been activated and has a broad range of topics posted, which should have a broad appeal.

#### Achievements this year

- Increase in membership
- Successful session and workshop with the ASM
- Establishment of the e-community
- Formal election of the Executive completed

#### Plans for 2006

- Continued development of educational resources
- Contribution to the ASM in Adelaide
- Contribution to the combined SIG Meeting in Noosa
- Continue to provide a support network for members and fellows of ANZCA

I would like to thank Juliette Mullumby of ANZCA for her invaluable help with administration matters. The Executive would welcome feedback and suggestions from members as to the future needs and direction of the SIG.

**Vanessa Beavis**  
Chair



## Cardiothoracic, Vascular and Perfusion

### Introduction

The role of the Cardiothoracic, Vascular And Perfusion Special Interest Group (CVP SIG) continues to evolve and represents a broad based forum for those with specific interests within our specialty. Apart from contributing to the major national continuing education meetings and conducting a biennial meeting, the CVP SIG group provides a forum for the exchange of ideas to ultimately improve the management of the patients under our care. This includes patients undergoing cardiac, thoracic and vascular procedures, and patients with significant cardio-respiratory disease undergoing other procedures. We now have 549 members.

### The CVP SIG Website

([www.anzca.edu.au/ceqa/sig\\_general/cvp/index.htm](http://www.anzca.edu.au/ceqa/sig_general/cvp/index.htm)) is located under the CE & QA section of the College Website ([www.anzca.edu.au](http://www.anzca.edu.au)). There are links to the website from the ASA (Australian Society of Anaesthetists) website and the NZSA (New Zealand Society of Anaesthetists) website. The College, ASA and NZSA are the three parent organizations of the CVP SIG. The CVP SIG website is also readily accessible from the ACECC (Anaesthesia Continuing Education Coordinating Committee) website ([www.acecc.org.au/](http://www.acecc.org.au/)).

### CVP SIG Executive

I would like to thank the departing members of the executive (Drs Andrew McKee and David Whish) for their valuable contributions and welcome the 3 new members (Drs Alastair McGeorge, Ross Wallace and Monique Wells). Dr Roman Kluger has completed his 3-year term as Chairman and a new Chairman – Dr Chris Cokis, was elected unanimously by the Executive in August 2005.

The current membership of the CVP SIG Executive (ratified at the CVP SIG Annual General Meeting held in July 2005 at the 8th Biennial

Meeting in Broome, WA) is -

Dr Guy Christie-Taylor	SA
Dr Chris Cokis (Chair)	WA
Dr Brad Fawkes	NSW
Dr Mario Kalpokas	VIC
Dr Roman Kluger	VIC
Dr Alastair McGeorge	NZ
Dr John Murray	QLD
Dr Ross Wallace	NSW
Dr Monique Wells	QLD

It is important that state members of the Special Interest Group use their Executive representatives as spokespersons. The Executive conducts teleconferences throughout the year to plan continuing education activities, discuss issues pertaining to cardiovascular and vascular anaesthesia and perfusion, and to discuss future initiatives of the CVP SIG.

Our next AGM will be held during the ANZCA ASM in May 2006 (Adelaide).

### Continuing Education Meetings During 2004-5

Our major CME event in 2005 was the CVP SIG 8th Biennial Conference. This was held at the Cable Beach Club Resort, Broome, Western Australia on 3-5th July 2005 and was followed by an advanced transoesophageal echocardiography (TOE) workshop on 6th July.

The CVP SIG and NAMPA (National Association of Medical Perfusionists) also held their AGMs during this meeting.

The meeting was very successful – with 108 registrants for the main meeting, 65 registrants for the TOE workshop and an excellent standard and variety of scientific presentations. Registrants came from all areas including 7 from New Zealand. Overall feedback from delegates was very positive, reflecting the high standard of the presentations, the opportunity to meet and exchange ideas with colleagues from all over Australasia and the popularity of the conference location (see attached conference report).

The CVP SIG contributed sessions to both major national anaesthesia meetings in 2004 –

1. Perth Annual Scientific Meeting (ANZCA ASM) – May 2004

*Carotid Surgery and Anaesthesia*

**Professor M James**

*Anaesthesia and Ventricular Assist Devices*

**Dr C Cokis**

*Risk in Cardiac Anaesthesia*

**Dr W Weightman**

2. Sydney National Scientific Congress (ASA NSC) – September 2004

*Pathophysiology of perioperative myocardial infarction*

**Dr G Landesberg**

*Silent Myocardial Ischaemia – Implications for surgical patients*

**Prof P Foex**

*Anaesthesia for Cardiac Surgery – Can we influence the outcome in 2004*

**Assoc Prof D Scott**

*Insulin Therapy for Improvement of LV Function*

**Dr M Priestley**

The CVP SIG will contribute sessions to the ANZCA ASM in May 2006 (Adelaide) and the ASA NSC in October 2006 (Sunshine Coast).

### Medical Perfusion

This is a complex area where there is a large variation in practice across Australia and New Zealand. The management of total body perfusion continues to be an area of major medical management during cardiac surgery, encompassing not only the heart-lung machine itself and the extracorporeal circuit, but also the management of anaesthetised patients and their coagulation status. We shall continue to emphasize this area in our educational activities.



After much discussion and wide consultation a revision of Professional Document PS27 – Guidelines for Fellows Who Practice Major Extracorporeal Perfusion – was produced in February 2004, and a further significant revision of this document is being considered at this time.

In March 2004 the ANZCA Certificates Committee raised the issue of the development of a Certification Process for Medical Perfusion. The CVP SIG felt it was premature to pursue establishment of a Certificate in Medical Perfusion at this time because of the wide range of views on this issue amongst the membership. Many felt that Professional Document PS27 (especially with recent revisions) was providing a suitable guideline for ensuring a high standard of practice in Medical Perfusion. Furthermore a letter (endorsed by the College, ASA and NAMPA [National Association of Medical Perfusionists]) was circulated to all private hospitals drawing attention to the College guidelines and suggesting that they be considered when providing medical perfusion services and when accrediting medical practitioners for perfusion privileges at the hospital.

#### **Transoesophageal Echocardiography (TOE)**

ANZCA Professional Documents – “PS 46 - Recommendations for Training and Practice of Diagnostic Perioperative Transoesophageal Echocardiography in Adults”, was revised in February 2004 to include reference to the Postgraduate Diploma in Perioperative and Critical Care Echocardiography (University of Melbourne) as one training option.

#### **Drug withdrawals**

Over the last few years there have been a number of drug withdrawals (intravenous atenolol, epsilon-aminocaproic acid) and temporary shortages (metaraminol, protamine), which had a significant impact on our practice. The CVP SIG has liaised with all involved parties to minimise the inconvenience caused by these supply interruptions. The need to advise all doctors, medical organizations (e.g. ANZCA) and hospital pharmacies impacted by such decisions, well in advance (so that suitable alternative arrangements may be made), was emphasised to the drug companies.

#### **e-Communities**

A CVP SIG Members e-Community and CVP SIG Executive e-Community were established by Dr Brad Fawkes in December 2004. e-Communities is a section within ANZCA Online (<http://online.anzca.edu.au/anzca/source/security/member-logon.cfm?Section=Home&CFID=13897&CFTOKEN=48427675>) that allows Fellows to subscribe to communities of interest and participate in discussion forums, read news items and post (or download) documents (including full-text journal articles and web-links) within those areas.

I would encourage all members to join and contribute to the relevant e-Community (clear directions online).

#### **Future initiatives**

The CVP SIG is in a strong position with a good balance and a large membership. These attributes will be used to foster research and education activities in the area of cardiothoracic and vascular anaesthesia and perfusion. Options that will be considered include research grants, data collection, simulator workshops and prizes for projects or posters.

#### **Administration**

In December 2004 Helen Morris (Administrative Officer, Continuing Education) who has provided superb support over the years to all the SIGs, was promoted to Executive Officer, Faculty of Pain Medicine. We would like to take this opportunity to formally congratulate Helen on her promotion and express our gratitude for her absolutely outstanding work for the CVP SIG over the past ten years. Although she will be sadly missed, we wish her great success in her new appointment.

Juliette Mullumby was promoted to the role of Administrative Officer, Continuing Education. Juliette has performed superbly in her new role and we would like to thank Juliette for her vital contribution to this SIG. Her expertise, efficiency and enthusiasm are pivotal in all of our endeavours and communications.

**Roman Kluger**

*Past Chairman*

## **Diving and Hyperbaric Medicine**

#### **Executive**

Dr Chris Acott	SA
Dr Mike Bennett	NSW
Dr Alistair Gibson	NZ
Dr Bob Webb	QLD
Dr Simon Mitchell	NZ
<i>South Pacific Underwater Medicine Society</i>	
Dr David Smart	TAS
<i>ANZ Hyperbaric Medicine Group</i>	
Dr Brian Spain	NT
Dr Margaret Walker (Chair)	TAS
Dr David Wilkinson	SA
Dr Robert Wong	WA
Dr Mike Davis	NZ

#### **Membership**

There are currently 171 registered members of the Diving and Hyperbaric Medicine SIG, from Australia, New Zealand and overseas, including 10 associate members.

#### **Honours Obtained**

At the recent Annual Scientific Meeting of the Undersea Hyperbaric Medicine Society in June 2005 at Las Vegas, Nevada, two members of the SIG received awards for significant contributions to diving and hyperbaric medicine. Dr Mike Davis received the Charles W Schilling Award for contributions of an outstanding nature to teaching, to the support of the goals of the Undersea and Hyperbaric Medical Society in educating the diving community and the public with communications about science and practice of diving medicine and related fields. Dr David Smart received the Craig Hoffman Award for significant contributions to Diving safety. We heartily congratulate them for their efforts.

Dr Chris Acott has been Elected President of the South Pacific Underwater Medicine Society.

#### **ANZCA Citations**

Drs Carl Edmonds, Peter McCartney and John Williamson have been awarded ANZCA Citations for their contributions to Diving and Hyperbaric Medicine.

#### **ANZCA Certificate**

Following the hard work of a dedicated



committee, the ANZCA now endorses a certificate in Diving and Hyperbaric Medicine. Details of the training programme can be found on the ANZCA website, including objectives of training and those Hospitals with hyperbaric units accredited for training. Foundation certificates were awarded to 17 people.

#### **Accreditation of Units**

The SIG has provided inspectors to visit those hospitals whose Hyperbaric Units have applied for accreditation for training for the ANZCA Certificate in DHM. Currently, Royal Hobart Hospital (TAS), Prince of Wales Hospital (NSW), and Fremantle Hospital (WA) are accredited for training for the ANZCA Certificate in Diving and Hyperbaric Medicine. The Certificates committee is awaiting applications from other hospitals who wish to be accredited for training.

#### **Examinations**

The first examinations for the ANZCA Certificate in Diving and Hyperbaric Medicine were held in October 2004. The examination consisted of a written paper and viva. Four candidates presented, and three were successful. It is anticipated that the examination will be an annual event, depending on demand.

#### **Examiners are**

Dr Mike Bennett	NSW
Dr David Smart	TAS
Dr David Wilkinson	SA
Dr Robert Wong	WA
Dr Barbara Trytko	NSW
Dr Margaret Walker	TAS

Dr Robert Wong has been appointed as Chair of the Examination Committee in Diving and Hyperbaric Medicine, and Dr Mike Bennett has been appointed as deputy Chair. The examiners have risen to the challenge of establishing the first ever examination in Diving and Hyperbaric Medicine in Australia, and in doing so, endorsing diving and hyperbaric medicine as a credible scientific discipline.

#### **Introductory Course in Diving and Hyperbaric Medicine**

The ANZHM course is an annual event, held this year in March at the Prince of Wales Hospital

under the supervision of Dr Mike Bennett, and attended by candidates from Australia, Asia, Europe, South America and the Pacific islands. Attendance at this course is one of the requirements for the ANZCA Certificate, as it covers a wide range of subjects in Diving and Hyperbaric Medicine, with lectures, tutorials and discussions contributed by faculty from around the country. It will be held next in March 2006.

#### **Expert Supporting Committee in Hyperbaric Medicine of the Medicare Services Advisory Committee (MSAC)**

There has been ongoing assistance from members of the SIG Executive to MSAC in presenting scientific evidence in hyperbaric medicine to determine the medical conditions acceptable for public funding for hyperbaric oxygen therapy. As a result of these consultations, there has been a list of indications adopted by Medicare for which there is level one scientific evidence to support the use of hyperbaric oxygen, with a further shorter list of conditions for which further evidence is required, but which have interim funding for 3 years.

#### **Scientific Meetings**

Members of the SIG have been active in attending scientific meetings and presented papers at national and international conferences, including the meetings of the South Pacific Underwater Medicine Society (SPUMS), European Underwater & Baromedical Society (EUBS), Undersea & Hyperbaric Medical Society (UHMS), as well as the Australian Diving & Hyperbaric Medicine Meeting hosted by the Hyperbaric Technicians & Nurses Association (HTNA).

A highly successful UHMS Meeting was held in Sydney in May 2004, organised primarily by Dr Mike Bennett, and attracted registrants from around the world. It was the first time the UHMS had been held in Australia, and with 393 registrants, was the third largest UHMS meeting ever. Dr Bennett is to be congratulated on an exceptional meeting.

The SIG will hold its next scientific session at the Adelaide ANZCA ASM in 2006, aiming to concentrate disseminating information on

medical conditions other than diving related diseases which can be treated with hyperbaric oxygen therapy.

#### **Finance**

Balance 31/12/03	(3,808.47)
Income to 31/12/04	0
Expenses to 31/12/04	(964.71)
Balance 26/10/04	(4,773.18)

#### **NSW Health Protocol for Management of DCI**

The SIG was approached to provide an opinion on the NSW Health Protocol for Management of DCI. A document drafted by the Prince of Wales Hospital was sent to the SIG at the request of Dr Mike Bennett for endorsement by an official educational body. It was agreed that the proposed protocol was reasonable for diving emergencies in NSW. It was highlighted that protocols would be state determined, depending on the facilities of each state.

#### **Observer at European Diving Technology Committee**

Dr Ian Miller was nominated to represent the SIG on this Committee and the formal approval process is currently being undertaken.

#### **Nationwide standard database**

Dr Robert Webb has been working for some time on behalf of the SIG in developing a nationwide standard database for statistics collected from Australian and New Zealand hyperbaric units. He now has the database structures from Fremantle, Royal Adelaide, the Alfred, Townsville, Prince of Wales and the Royal Hobart Hospitals. It is hoped that a standardised database will facilitate collation of information from multiple centres, and allow regular publication of data within the field.

**Margaret Walker**  
Chair



## Medical Education

The Med Ed SIG has been involved in a range of activities over the past year. The group has run sessions at the ASA NSC in Sydney in September 2004 and the ANZCA ASM in Auckland in May 2005.

The combined Medical Education, Simulation and Skills Training, Welfare of Anaesthetists and Anaesthetists in Management Special Interest Groups held a combined meeting at the Marriott Hotel Surfers Paradise from the 1st – 3rd October. The 95 registrants were able to attend a broad range of workshops and interactive lectures from a total of 19 presenters. The Overseas Guest Lecturer was Dr David Greaves from the UK who presented on The UK Non-Medical Anaesthetist Program, The UK Certificate in Anaesthesia Education, Anaesthesia Non Technical Skills (ANTS), and The Trainee / Specialist with Difficulties. The Australasian Guest Lecturer was Dr David Barton who presented on Relationships and Professional Life. The evaluation of the meeting by the participants was highly positive. Planning is well advanced for this year's meeting in Noosa Heads in October.

The executive would like to acknowledge and thank Helen Morris and more recently Juliette Mullumby at the SIG Secretariat for their assistance and expertise in facilitating SIG activities.

**Rod Tayler**  
Chairman

## Simulation and Skills

### Membership of Executive

A/Prof Jennifer Weller (Chair)	NZ
Dr Brendan Flanagan	VIC
Dr Richard Morris	NSW
Dr Richard Riley	WA
Prof Harry Owen	SA
Dr Brian Robinson	NZ
Dr Sandy Garden	NZ
Dr TW Lee	HK

### The role of the Simulation and Skills SIG

The primary role of the SIG is to advise the College, ASA and NZSA on matters related to simulation, to educate the anaesthetic community on matters related to simulation, and to provide a platform for sharing information among members. The SIG should run a yearly meeting for its members.

### Election of New Chair and Meeting Convenor

A/ Prof Jennifer Weller was elected Chair of the Simulation SIG at a teleconference on 4 November 2004. Dr Flanagan was given a vote of thanks for his hard work in establishing the Simulation and Skills SIG.

### The "Human Factors" combined SIG meeting September 2004

This was a successful meeting with very positive feedback. A few suggestions for improvements were made by attendees. These included increased number of simulation sessions, avoiding concurrent education and simulation sessions, clarifying whether a session was a simulation or an education topic, increased number of workshops.

These suggestions were taken into account when planning the 2005 meeting as far as was possible within the constraints of a shared programme.

### Auckland ASM

The SIG participated in the May 2005 ANZCA ASM in Auckland. SIG members ran a number of simulation workshops at the new Auckland Simulation and Post Graduate Skills Centre, as well as a 90 minute Simulation SIG session within the conference on "Breaking Bad News".

The Simulation SIG ASM was held at the Auckland ASM

The E-community was launched by Dr Morris. The main topic of discussion was planning for the upcoming Noosa SIG meeting.

### Combined SIG meeting, NOOSA

The Simulation and Skills SIG has worked closely with the Education and other SIGs planning of the Combined meeting in Noosa in October 2005. It will be hosting a number of panel discussions presentations, and workshops, with input from a number of Simulation SIG members. A major theme will be the use of simulation in assessment for certification, accreditation and remediation.

### SIG e-community

Richard Morris has set up a framework for a Simulation and Skills SIG e-community on ANZCA on-line. To date this has been little used, partly due to access difficulties, a situation which should improve shortly. The SIG plans to post dates of meetings, minutes of meetings, discussion documents, conference abstracts and other news on this site.

### Simulation Centre Instructor Training

The SIG has a brief to advise the College on matters related to simulation education. Instructor training is an area of concern for a number of centres. A lack of uniformity, no standard process, and variable resources available to train and support new instructors, there is potential for variable standards of instruction, which has the potential to affect the quality of courses. A number of instructors' courses exist, serving different groups. The SIG Executive will prepare a discussion document for consideration by the Courses Subcommittee on the issue.

### Teleconferences

The Simulation SIG held two teleconferences in the last year.

**Jennifer Weller**  
Chair



## Obstetric Anaesthesia

### *SIG Executive*

The current SIG Executive comprises:

Dr Genevieve Goulding	QLD
Dr Steven Katz	NSW
Prof Warwick Ngan Kee	HK
Dr Christopher Orlikowski	TAS
A/Prof Michael Paech	WA
Dr Andrew Ross	VIC
Dr Graham Sharpe	NZ
Dr Scott Simmons (Chair)	SA
Dr Elizabeth Ward	NSW

### *Co-opted Members*

Dr John Crowhurst	VIC
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### *Administration*

The Executive's three-year term of office expired in 2004 and a new Executive was elected through due process, with membership as above. Dr Scott Simmons was appointed Chair during the year. The outstanding work of Assoc Prof Michael Paech as Chair during the period of 'rebirth' of the Group is acknowledged and greatly appreciated. The contribution of departing Executive members and co-opted members is also noted with sincere thanks. It should be noted that currently the ACT and NT do not have representation on the Executive, but we were pleased to welcome a representative from Tasmania.

The Annual General Meeting for 2005 will be held during the Australian Society of Anaesthetists National Scientific Congress on the Gold Coast in September. It is hoped that a draft strategic plan for the activities of the Group during the next three years will be discussed and developed from this meeting.

The SIG Membership continues to increase and currently stands at 667. The financial position is a little stronger, with a balance of at 26th October 2004 of \$13,333.79.

### *Quality Improvement Activities*

The work of Executive members during last year to facilitate the creation of a joint (RANZCOG/ANZCA/RACGP/ACRRM) position statement on the provision of obstetric

anaesthesia services is ongoing. Ratification is anticipated during the forthcoming year.

The Clinical Indicators specific to obstetric anaesthesia developed by the working party during the past year have now been included in the joint ANZCA and Australian Council on Healthcare Standards indicator set Version 4 for use in 2005. This set includes four measures pertaining to occurrence of postdural puncture headache, use of general anaesthesia for caesarean section, timely delivery of care for emergency caesarean section and documentation of informed consent for labour analgesia. These are obtainable via the College website.

A working group was formed to develop a position statement on "Aseptic technique for the insertion of epidural catheters". A draft document will be available for consideration at the AGM and it is anticipated that this will be completed during the forthcoming year.

A major quality initiative was commenced during the year under the direction of Michael Paech involving a multicentre survey on various aspects of the use of general anaesthesia for caesarean section. It is anticipated that results of the survey will be available during 2006.

### *Continuing Education*

The SIG has continued to support the major national meetings, the ANZCA ASM and ASA NSC. The SIG session at the ASM focused on maternal safety and welfare with presentations covering diverse topics of amniotic fluid embolism, neuralgia and pulmonary embolism. A breakfast session at the same meeting by Dr John Crowhurst provided an update on combined spinal epidural usage in obstetrics.

The SIG single-theme scientific conference in Blenheim, NZ in November 2004, convened by Graham Sharpe, was extremely well attended and proved to be an outstanding success. This meeting had an impressive faculty, including Dr David Bogod from the UK and many well-known speakers from Australasia and Hong Kong.

What is quickly becoming a significant annual event in the form of the Victorian SIG meeting was once again held during June 2004. Maggie Wong and the other organizers are to be

congratulated on a very successful meeting with an array of prominent speakers including Dr Geraldine O'Sullivan of Guy's and St Thomas Hospital, UK.

### *Acknowledgements*

I would like to acknowledge the efforts of Juliette Mullumby in getting me up to speed upon assuming the chair of the SIG. Following in the footsteps of Michael Paech will be a hard act to follow but I look forward to contributing to the growth of the group upon the very solid foundations that Mike has created.

**Scott Simmons**  
Chairman



## Awards

# 2006 Research Grant Awards

The following *Research Grants for 2006*, recommended by the Research Committee, were awarded by Council at the September Council Meeting:



**Dr Rinaldo Bellomo (VIC)**

**\$40,860** A study of the nature and mechanisms of tubular injury in experimental septic acute renal failure

**\$9,000** A pilot randomized open label pilot study of the efficacy of dexmedetomidine and haloperidol in ventilated patients with ICU-associated agitation and delirium



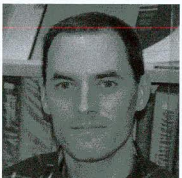
**Professor Andrew Bersten (SA)**

**\$50,000** Prevention of ventilator-induced lung injury: could dynamic factors also play a role?



**Dr Jeremy Cohen (QLD)**

**\$24,000** Unraveling the metabolic syndrome in critical illness: Role of tissue cortisol and 11-beta hydroxysteroid dehydrogenase



**Dr D A Cowie (VIC)**

**\$40,000** The IMASH trial: Does intravenous magnesium sulphate improve outcome after aneurismal subarachnoid haemorrhage?

**Dr Andrew Davidson (VIC)**

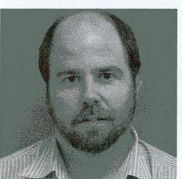
**\$8,500** MAC-awake in children

**\$8,500** The influence of age on Bispectral Index as a predictor of anaesthetic depth in infants and children



**Dr P M Finch (WA)**

**\$40,000** Mechanism and treatment for pain evoked by touch in patients with chronic pain after traumatic limb injury



**Dr P S Kruger (QLD)**

**\$30,000** The biology of HMG CoA Reductase Inhibitors in patients with sepsis



**Assoc Prof Kate Leslie (VIC)**

**\$50,000** B-Aware Trial long-term follow-up study



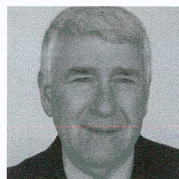
**Professor Jeffrey Lipman (QLD)**

**\$30,000** Pharmacokinetic modelling of various B-lactam antibiotics in critically-ill patients using micro dialysis



**Dr Pamela E Macintyre (SA)**

**\$45,000** Efflux transporter activity in the blood brain barrier in vivo - a method of application to opioids



**Professor Laurence E Mather (NSW)**

**\$50,000** Pharmacological consequences of general anaesthesia on local anaesthetic cardiovascular effect and pharmacokinetics



**Dr P R McCall (VIC)**

**\$18,000** "Salvage Use" of recombinant activated factor VII after inadequate haemostatic response to conventional therapy in complex cardiac surgery - a randomized placebo controlled trial



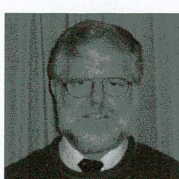
**Assoc Prof J A Myburgh (NSW)**

**\$20,000** A comparison of the effects of noradrenaline and adrenaline in critically ill patients



**A/Professor Michael J Paech (WA)**

**\$5,585** The Australasian survey on obstetric general anaesthesia for caesarean section



**Assoc Prof Anthony Quail (NSW)**

**\$43,000** The effect of propofol on cardiovascular and respiratory control mechanisms during severe arterial hypoxia in the rabbit.



**A/Professor Carlos Scheinkestel (VIC)**

**\$16,860** *An analysis of temporally distributed medical and nursing team coordination in the intensive care unit*



**Professor S A Schug (WA)**

**\$17,000** *Psychological factors that predict patient satisfaction and response to multidisciplinary treatment for chronic pain*

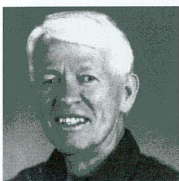
**Dr C L Thompson (NSW)**

**\$22,000** *Anaesthesia auditory alarm design and evaluation recommendation for alarm standards*



**Dr E Russell Vickers (NSW)**

**\$50,000** *Analysis of dental pulp from extracted teeth to identify dental pain mechanisms*



**Dr John A Williamson (SA)**

**\$35,000** *Comparing the latest 2000 incidents with the first 2000 to track progress and devise safety strategies for new problems*

The **Harry Daly Research Award** was awarded to **Dr Rinaldo Bellomo** for his project "A study of the nature and mechanisms of tubular injury in experimental septic acute renal failure."

The **Organon Research Award** was awarded to **Professor Laurie Mather** for his project "Pharmacological consequences of general anaesthesia on local anaesthetic cardiovascular effect and pharmacokinetics."

The **John Boyd Craig Bursary** was awarded to **Dr Phillip Finch** for his project "Mechanism and treatment for pain evoked by touch in patients with chronic pain after traumatic limb injury."

## 2005 Academic Enhancement Grant



The 2005 Academic Enhancement grant of \$61,000 was awarded to **Professor Rinaldo Bellomo**, Department of Intensive Care, Austin Hospital, Melbourne.

## 2006 Simulation/Education Grant Awards

The following Simulation/Education Grant award for 2006, recommended by the Research Committee, was awarded by Council at the September Council Meeting:



**Dr Reny Segal (VIC)**

**\$34,852** *Endoscopic performance on a mannequin predicts clinical performance on a first attempt*





## Obituary

# Dr Archibald Stewart Lamont –TAS

*5th February 1926 – 27th August 2005*

**FFARACS 1979, FANZCA 1992**

Stewart came to Hobart in 1977 as Director of Anaesthetics at the Royal Hobart Hospital, having initially graduated in medicine in Glasgow and then obtained his anaesthetic qualifications in London. He subsequently spent a number of years in Leeds where he was involved in setting up one of the early Intensive Care Units.

It was my impression that Stewart had some difficulty in adapting to the change in work style from the very hierarchical British National Health Service hospital system to the less rigid Australian system, with its ready exchange of staff between the public and private hospitals, especially as in 1977 we were only 3 years beyond the point where all the surgical staff and most of the anaesthetists were honorary, and the relaxed work style of the honorary days was the way the hospital functioned.

Nevertheless, Stewart adapted and survived, bringing his own particular talents of meticulous preparation and unhurried execution to the ethos of the Department of Anaesthesia. He made a special contribution to the teaching of anaesthetics, and during his time as Director the standard of teaching for the registrars received significant attention, and this was reflected in the examination results attained during this period.

From my viewpoint as a surgeon we had our ups and downs in the early years. On occasions Stewart could be infuriatingly slow in the preparation of the patient, but this was counterbalanced by the confidence that one felt that, when Stewart said the patient was ready for operation, then the patient was ready for operation, and furthermore, would receive his undivided attention during the procedure. Undivided, that is if one excludes the occasional dead-pan remark about the vagaries of surgeons, when one occasionally caught the twinkle in his eye above the mask. I must say that if I had not previously worked in Scotland and learned to cope with the dry lugubrious wit that passes for humour in that part of the world, it would sometimes have been easy to take these remarks the wrong way, and perhaps this happened with

Stewart and some people from time to time.

Stewart had infinite patience in the setting up of his work and in planning for the procedure. During several years of his period at the Royal I was involved in carrying out a series of operations on very obese patients which required a clear exposure of the lower end of the oesophagus where it enters the abdomen from the chest, an area which is difficult to visualize, especially in the obese, and where it is very easy to impede respiratory movements during the operation. This makes it an area of unpopularity with anaesthetists, but we developed some special retractors to reduce the hazard, which, however, had the drawback from the surgeons' viewpoint, that it required fixation and adjustment of the retractor attachment by the anaesthetist. It was at this time, with this operation, that I particularly came to appreciate Stewart's qualities of careful preparation, unruffled calm and cooperation.

These qualities came to the fore also with his love of sailing, a love which we share. Hannah has told me of their time in Leeds, where, with the boat in Scotland and work in Yorkshire, it was a five hour drive to get started on a sailing weekend. What heaven it was for Stewart to be only a few minutes from the yacht, and to be able easily to spend even a little segment of spare time doing the little fiddly jobs on the boat, an opportunity so beloved of all yachties, and which are part of the pleasure of sailing. In typical thorough fashion Stewart undertook a Yachtmasters training course to add to his competence and contribute to the safety of his crew. It was a sad day when his failing health caused him to give up the wonderful pleasure of sailing, which Hannah was able to share with him.

When Stewart retired from the Royal in 1991 he took pleasure in having more time with Hannah and more time on the boat, but he did not abandon the use of his very considerable talents, continuing on with anaesthetics in private practice. At this time he joined us in our rooms in Macquarie Street where our secretaries looked

after his bookings. He was more relaxed and almost jovial at this time and was very popular with our staff because of his readiness to undertake cases without complaint and often at considerable inconvenience. His consideration for his supporting staff was always a feature of Stewart's professional life. At this time he undertook some overseas locums in Wales and elsewhere as he was winding down, but increasing ill health finally called a halt to his considerable contribution to the profession and science of anaesthesia.

We now say goodbye to Stewart and take comfort in the fact that, while our loss is keenly felt, there is honour and reward in reflecting on a professional life lived to the highest standards, and as a service to his fellow man.

**Emeritus Professor John Hunn**

*2nd September 2005*



## Report

# ANZCA New Fellows' Conference

*Tongariro, 4th-5th May 2005*

## "Towards Better Leadership, Teamwork and Communication"

The theme for this year's New Fellows' Conference was "Towards Better Leadership, Teamwork and Communication". It was held in Tongariro, Central North Island, NZ, on 4th and 5th May 2005, immediately prior to this year's joint ANZCA/NZ Regional ANZICS ASM. The Convenor was Alastair McGeorge from the Cardio-Thoracic Centre in Auckland Hospital.

*There were 22 delegates from Australia and New Zealand, comprising:*

- 2 Convenors (one for 2005 and the future Convenor for 2006)
- 2 Board Members (one each from ANZCA and JFICM)
- 12 ANZCA Delegates: 2 each from New Zealand, Victoria, Western Australia, South Australia/Northern Territories, Queensland and one from New South Wales and Hong Kong respectively
- 5 JFICM Delegates: 2 each from New Zealand and Queensland, and 1 from Victoria
- 1 FPM delegate
- There were also guest appearances from the President of the College (Professor Michael Cousins) and the Dean of Joint Faculty (Dr Jack Havill)

*There were 3 distinct sections to the Conference:*

- An introduction session, involving each delegate giving a short presentation setting out their aims for the Conference and personal examples where leadership, teamwork or communication could be improved.
- A day spent at the Sir Edmund Hillary Outdoor Pursuits Centre, where the delegates were divided into small groups and exposed to problem solving situations and evolving group dynamics.



- A summing-up session, which initially involved all the delegates, and subsequently Anaesthetists and Intensivists separating to discuss individual and shared issues.

### *Introduction Session*

The delegates met at Auckland airport and flew to Taupo. As with any group, there was some initial hesitancy and politeness, but the team-building soon started as the bus taking the group to the Chateau broke down with smoke billowing from the bonnet. During the time spent by the side of the road, conversation became more open and relaxed.

Upon eventual arrival at the hotel, the bonding approach became more pronounced as the first formal session of the day started. Each delegate had prepared a presentation about themselves, their aims for the Conference and examples from their experiences where better teamwork, leadership and communication might have resulted in a better outcome for all concerned. Examples ranged from individual clinical situations, inter-personal issues, managerial problems and ability to "step up" from a Senior Registrar to Specialist role.

*The major issues can be summarised under the headings:*

- **Conflict resolution**
  - Difficulty in dealing with anger management issues: both when anger is directed at the individual, but also when a feeling of loss of control persists (particularly in clinical situations), which occur when Clinicians are "out of their comfort zone". This loss of control is all-too-frequently manifested by anger, which decreases the ability to work efficiently. Several examples of anger in the operating theatre were used to illustrate this by Anaesthetists.
  - The ability to performance-manage both Specialist colleagues and Registrars was highlighted as an issue, both to enhance working environments, but also to ensure better teamwork.
- **Knowledge of boundaries** – Clinicians are more secure when the boundaries are clear, but areas where responsibility is unclear can lead to adverse outcomes. Examples included the difficult trauma patient in ED, where there may be a blurring of care and prioritisation between ED and ICU / Anaesthesia.
- **Teamwork outside the comfort zone** – effective teamwork outside the ICU/OR was



highlighted as an area for improvement. This is a difficult area both for effective teamwork within the ICU team but also between ICU and referring teams.

- **Family vs. work** – New Fellows' in both specialities highlighted the difficulties that starting work as a Specialist had on the home environment, and this had taken several of the delegates by surprise. Whilst probably obvious to more experienced Fellows, this difficulty had not been mentioned by older colleagues or the College as a potential issue.
- **Effective communication** - this was a recurring theme throughout the entire Conference: how important it was, but also how easily it was not to achieve this. The difference between hearing and listening was also highlighted, both with Specialist colleagues, but also with Registrars.

#### ***Sir Edmund Hillary Outdoor Pursuits Centre (OPC)***

The day spent at the OPC was designed to take individuals out of their "Comfort Zone", to put them into their "Stretch Zone", but not to over-stress them into their "Panic Zone".

The delegates were divided into groups of 7-8, and a guide was assigned per group who selected exercises that highlighted:

- Problem-solving
- Team-building
- Communication

These included leading each other blind-folded around the bush, helping each other over high walls and down flying foxes, and exercises involving making rope squares blindfolded. The difference in personalities and leadership amongst individuals was pronounced, but rapidly different styles and modes of problem solving were utilised. Recognition that each individual had certain skills to bring to each situation and team was highlighted and discussed after each exercise. The importance of concise, clear communication was emphasised over and over again.



The afternoon was spent in either: the high ropes, a gorge or a canyon or using each other as well as the guides to foster trust and teamwork. In-between the formal exercises, there was plenty of time to discuss issues and how an appreciation of so-called "simple" exercise and problem-solving could be utilised in the hospital setting.

### Summary Session

This session involved both the entire Conference involvement, but also small group discussion.

There were some points and suggestions that both Intensivists and Anaesthetists agreed upon. These included:

- The format of the New Fellows' Conference was excellent and participation should be encouraged. In particular, the emphasis on non-clinical issues was highly commended. The small numbers of delegates making up the Conference were appreciated and the possibility of extending the Conference by half a day was discussed.
- In addition, the possibility of convening a regional New Fellow's Day for Intensivists, Anaesthetists and Surgeons was discussed, to enhance inter-departmental discussion and communication.

However, there were also some marked differences in stressors and practice between Intensivists and Anaesthetists, and arguably the most useful part of the Conference occurred when these 2 groups separated for further discussion.



### Recommendations from the Intensivists at the New Fellows' Conference were:

1. The New Fellows recognise the College's role in creating the Senior Registrar position. They would like to endorse their support for this position as a means to allow and accept further responsibility before taking up a Specialist role. This role should also involve the Senior Registrar in business meetings, budgetary meetings, Registrar assessments and the day-to-day running of ICU's.
2. The establishment of a New Fellows' Conference for new Intensivists is recommended. This would be open to all JFICM New Fellows within 3 to 4 years post Fellowship, and not just regional representatives. Different stressors were highlighted between Intensivists and Anaesthetists (Intensivists identified bed shortages, nursing shortages, triaging and managerial issues as major Intensive Care problems. These issues were not discussed at all in the group forum but were highlighted as major problems amongst New Fellow Intensivists). Discussing these stressors and problems with New Fellows who had more understanding of these issues was helpful and should be encouraged. This would not supersede the joint New Fellows' Conference, since inter-departmental collegiality is vital, but would run at a different time since the "brainstorming" by JFICM New Fellows was most useful. It could possibly run just prior to the JFICM meeting.
3. The New Fellows understand that the Training Committee set up by JFICM to look at all

aspects of Intensive Care training currently has no New Fellow representative. The presence of a New Fellow on this committee is recommended, to give a recent perspective to training issues and problems.

4. The establishment of a New Fellow's "Frequently Asked Questions" web site in the College web page is recommended. This could look at issues frequently affecting New Fellow's in their position, with ideas and possible solutions. Issues that could be posted on the website could be as wide-ranging as: How to write a business case / How to write an Ethics application / How to cope with difficult Registrars or difficult Clinical Directors / How to job-share in ICU / Families and being an Intensivist etc. The possibility of having a New Fellows chat-site for JFICM New Fellows to informally approach and discuss issues on-line was also discussed.

In summary, the New Fellows' Conference was excellently organised and run by Alastair. The setting was spectacular, the weather amazing and the OPC was superb. This was a great environment and opportunity to meet new people, and discuss issues amongst peers in similar situations and experience as oneself. I wish next years' Conference as much success as this one.

**Pete Dzendorowskyj**

*NZ Representative, NFC, June 2005*



## Special Interest Group Report

# Innovations and Initiatives in Education, Simulation, Welfare and Management



The second combined meeting of the Medical Education, Simulation and Skills Training, Welfare of Anaesthetists and Anaesthetists in Management SIGs was held at the Sheraton Noosa Resort and Spa on 7th -9th October. Over a lovely warm weekend 125 delegates participated in a range of lectures, workshops



and for the early birds breakfast sessions. Laerdal, LMA PacMed, Abbott Australasia and AstraZeneca were all generous sponsors of the meeting and participated in a trade display.



Professor Brian Jolly from Centre for Medical Health Science Education, Faculty of Medicine, Monash University and Associate Professor Fiona Lake from the Faculty of Medicine and Dentistry, University of Western Australia were the two

invited speakers to this meeting. A further 25 local speakers also contributed greatly to the success of the meeting.



## Report

# 29th Annual ANZCA/ASA Combined CME Meeting of Queensland

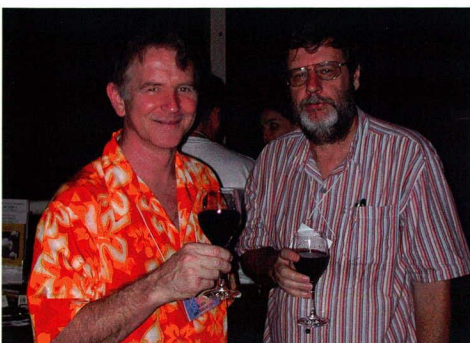
### Port Douglas 2nd and 3rd July 2005

On July the 1st around 57 delegates arrived in Port Douglas, Far North Queensland for the 29th Annual ANZCA/ASA Combined CME Meeting. The meeting theme was 'Tropical Anaesthesia', a chance for the anaesthetists from 'up north' to present some of their areas of interest.

The weather was picture perfect, with delegates from as far as Adelaide, Melbourne, New Zealand and Canberra welcoming the warm sunshine. Our venue was the recently refurbished Radisson Treetops Resort and Spa, which provided an ideal location for a midsized meeting. The resort is nestled in amongst a rainforest and wraps around the pool and water features.

The meeting unofficially opened Friday night with the health care industry cocktail party, always an ideal way to kick things off! The meeting was very well represented with 14 Health Care Companies exhibiting on the Jacana Deck surrounded by the resort rainforest. On Saturday morning the program proper began, with the official opening by Dr Genevieve Goulding, Chair of the Qld Combined CME Committee. The first speakers took the audience out of their comfort zones with presentations on pharmacological crocodile restraint and the toxicology of our local jellyfish. After morning tea the topics moved on to anaesthetic implications of valve disease in pregnancy, anaesthesia record keeping and appropriate use of antiemetics.

Saturday afternoon saw the delegates enjoying many of the tourist attractions on offer in the



*Dr John Archdeacon and Dr Bob Web enjoying the Friday night cocktail party*



*Morning Tea on the Jacana Deck overlooking the rainforest with the Health Care Industry display.*

region including; Four mile beach, the Daintree and Cape Tribulation or simply walking through Port Douglas sampling the shopping and cafes. About seventy delegates and partners reconvened at the Wharf Restaurant for the conference dinner. The venue was ideal as we had just enough room, making it quite an intimate evening. Our guest speaker was Professor John Campbell, an Oxford graduate, expert on Space Archaeology and member of SETI. His presentation looked at the importance of preserving the history of space exploration right from the onset, as well as touching on the implications of extra-terrestrial intelligence. This sparked some animated discussion that kept us going into the small hours.

Sunday morning saw a few late comers to the morning program, no doubt relaxing in the tropical atmosphere. The presentations included a detailed account of the hyperbaric chamber in Townsville, an engaging account of an anaesthetist's involvement in the birth of a new medical school in North Queensland and finally an account of the history of extra glottic airways devices. During the morning the ASA representatives updated delegates on the latest issues facing our profession.

Finally the meeting closed at around 1pm Sunday, with a few lucky individuals staying on to enjoy the resort, while the rest of us prepared to return home and face work on Monday. Many thanks to the Convenor Dr Sean McManus for putting together an interesting and topical program. Also thanks to the College Staff Ms Sharon Miethke and Ms Anne Strasburg for their many hours of work in preparation and ensuring the meeting ran smoothly.



*Catching up at the cocktail party were Drs Buff Maycock, Genevieve Goulding, Martin Culwick, Patricia Goonitilleke and Tim Wong.*



## MOPS

# New MOPS Program for 2006

It is clear from feedback to date to articles in the Bulletin, input from some of the Taskforces, and comments following the MOPS session at the ASA ASC on the Gold Coast, that a substantial effort is needed to revise and upgrade the ANZCA MOPS Program.

To date, the MOPS Committee has reviewed the development of MOPS to its current format, and considered the following documents:

- World Federation for Medical Education Continuing Professional Development for Medical Doctors. WFME Global Standards for Quality Improvement 2003.
- Australian Medical Council Standards and Procedures for Accreditation of Specialist Medical Education and Training and Professional Development Programs.

- Medical Council of New Zealand Policy on Recertification.
- Royal College of Physicians and Surgeons of Canada Maintenance of Certification Program.
- Good Practice Guides of the General Medical Council, and adaptations by the New Zealand Medical Council and Australian State and Territory Medical Boards.
- CPMC/RANZCOG Learning, Education and Professional (LEAP) Project.

The next step is to develop a revised MOPS Program, with input from Fellows, from the relevant taskforces, from Regional and National Committees, and from the CE&QA Committee, ACECC and the Medical Education SIG, as well as from the Education and Training Committee (to ensure there is follow through on the new ANZCA training program.)

In addition, a reference group will be utilized to provide input into drafting the new program.

Getting the revised MOPS Program right is a balancing act – it has to be credible to the community and regulatory bodies, achieve its objectives, currently set out as: “to foster continuing scholarship in order to maintain a high standard of clinical practice. Thus the principal role is educational and the Program validates continuous medical education (CME), quality assurance (QA), and other self-improvement educational activities”, and be flexible, accessible, and achievable by Fellows and other participants.

#### Websites of interest:

<a href="http://www.amc.org.au">www.amc.org.au</a>	<a href="http://www.surgeons.org">www.surgeons.org</a>
<a href="http://www.mcnz.org.nz">www.mcnz.org.nz</a>	<a href="http://www.gmc-uk.org">www.gmc-uk.org</a>
<a href="http://www.racgp.org.au">www.racgp.org.au</a>	<a href="http://www.racp.edu.au">www.racp.edu.au</a>
<a href="http://www.rcpsc.medical.org">www.rcpsc.medical.org</a>	<a href="http://www.ranzcog.edu.au">www.ranzcog.edu.au</a>
<a href="http://www.sund.ku.dk/wfme">www.sund.ku.dk/wfme</a>	<a href="http://www.ranzcp.org">www.ranzcp.org</a>

## Verification of MOPS participation in New Zealand

The MCNZ requires vocationally registered medical practitioners in New Zealand to participate in a continuing professional development (CPD) program, and asks them to indicate such on their application for an annual practising certificate (APC). ANZCA's MOPS Program has been approved as a suitable CPD Program for anaesthetists in New Zealand. The MCNZ audits 10% of medical practitioners applying for APCs for compliance with the CPD requirements, and as part of that audit asks the relevant body (for anaesthetists, ANZCA) to validate the practitioner's assertion that they have met the requirements of the CPD Program.

To assist New Zealand MOPS participants to meet the MCNZ requirements a recommendation was passed at the recent Annual General Meeting of New Zealand Fellows, held during the New Zealand Annual Scientific Meeting.

#### *The recommendation was:*

*That the College verifies successful participation in ANZCA MOPS Program for those Fellows who have given permission to both ANZCA and MCNZ.*

Accordingly permission is being sought from all New Zealand MOPS participants for information that is contained in their Statement of Participation to be released to the MCNZ upon request, providing that the participant has also given permission to the MCNZ.

**G D Phillips**

*For the MOPS Committee*



## Faculty of Pain Medicine

# Dean's Message

The *raison d'être* of the Faculty is its training and education function. Recently the Australian Medical Council requested a report from the Faculty on developments in its training program since the accreditation process in 2002. I am pleased to present this "good-news" story to Fellows and trainees.

The 2002 AMC Accreditation Report identified three areas of the Faculty's program for future comment: (i) development of "more realistic requirements" for accredited training positions; (ii) possible modification of the assessment process; and (iii) provision of opportunities for overseas trained specialists. The report went on to state that the Faculty had met the standards for accreditation of its training program but that formal recommendation was contingent upon recognition of pain medicine as a medical specialty. At this time of writing, we are awaiting the Minister's decision regarding recognition.

### 1. Accreditation of training units

In responding to the challenge of providing more opportunities for training in Pain Medicine, including taking advantage of potential opportunities in the private sector, the Faculty has modified its approach to accreditation of training units. Faculty document PM2, *Guidelines for Units Offering Training in Multidisciplinary Pain Medicine* has been extensively revised.

Rather than requiring strict conformity with a set of structural criteria, training units are now accredited on the basis of what they can offer to trainees in terms of variety of pain medicine experience, supervision, teaching and learning. In a complementary way, the programs of individual trainees can be tailored according to required and desired exposure. This is particularly important as pain medicine trainees come from diverse backgrounds. It is possible therefore that the training program of an individual trainee may occur in more than one training unit. This change in emphasis should facilitate also reciprocal opportunities for trainees in other disciplines such as palliative medicine, addiction medicine and liaison psychiatry, especially when such services are physically co-located with pain units.

The Faculty has now accredited 16 training units in Australia and New Zealand, including a private clinic in Brisbane. Three new applications are in progress, facilitated by these changes. The review and re-accreditation process has been tightened, again focussed on the programs actually pursued by trainees. Funding of trainee positions remains a challenge.

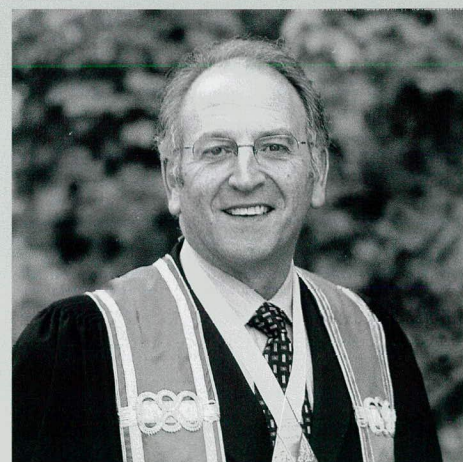
### 2. Assessment

The rigour of the examination process attracted the attention of the 2002 AMC Accreditation Report. Review of this process has been intensive, at Examination Committee, Court of Examiners and Board levels, over the course of the seven annual examinations held to date. The emphasis of the examination is on clinical performance, where possible, in addition to competence and knowledge. The components of the examination have remained unchanged: a written paper of ten fifteen-minute questions, five of which are compulsory; an observed "long case"; a series of "short cases" in acute, chronic and cancer pain, and a communications station; and a series of structured viva voce examination scenarios in acute, chronic and cancer pain and in investigations. The examination questions and scenarios are set under strict reference to the Objectives of Training. Within this framework the content and style of questions and scenarios are under constant review. The Faculty continues to believe that this format is the most appropriate for an "add-on" Fellowship in a complex discipline. A New Fellow now sits on the Examination Committee and was an observer at the most recent examination. Representatives from other parent Colleges have also been observers.

Over this seven-year period, 107 candidates have presented for examination, 92 being successful (86% overall). This sustained (79-100%) pass rate is considered to be very satisfactory, considering the demands of the specialty.

### 3. Supervision of training and in-training assessment

With the change in accreditation emphasis towards trainees' programs plus the increasing



focus in assessment on trainee performance in addition to knowledge, skills, attitudes and competence, the Faculty has revised its approach to In-Training Assessment. Specifically, under "roles and competencies", knowledge, history-taking, physical examination, patient/staff interaction, communication with the patient, diagnostic and treatment formulation and therapeutic skills are assessed.

In turn this has required that the needs of Supervisors of Training (SoTs) be addressed. The Faculty has held SoT meetings at its last three Annual Scientific Meetings, has appointed a Supervisor of SoTs and will be convening a pain medicine-specific SoT workshop early in 2006. To this end, in collaboration with the Education Division of ANZCA, the Faculty has produced a Supervisor of Training Support Kit.

With respect to overseas trained specialists, the Faculty applies the same formula (prior Qualification, adequate Training and Examination success) as is applied to "home-grown" trainees, acknowledging that establishing equivalence of qualifications and quality of prior training and experience can be difficult.

I believe that Fellows can be proud of this progress. Not only have pathways and process for training in Pain Medicine been broadened but also much support material for trainees and supervisors has been developed. Our profile and funding should be boosted by specialty recognition but already, with these developments, Fellows may well see potential for creating training opportunities in new contexts.

**Milton Cohen**  
Dean





## Professional Document: Review PM2 (2005)

### Faculty of Pain Medicine

Australian and New Zealand College of Anaesthetists ABN 82 055 042 852

# Guidelines for Units Offering Training in Multidisciplinary Pain Medicine

## 1. Introduction:

- 1.1 These guidelines establish the recommended standards for Units offering training in Multidisciplinary Pain Medicine for Fellowship of the Faculty of Pain Medicine of the Australian and New Zealand College of Anaesthetists.
- 1.2 The term Unit is the Faculty's preferred designation for the personnel and facilities that together may constitute all or part of the training program of a trainee.
- 1.3 The term "program" refers to the experience and exposure devised for a trainee. A Trainee's program may be pursued through more than one Unit.
- 1.4 A Multidisciplinary Pain Medicine Unit must include practitioners from at least three relevant medical specialties and from relevant allied health professions. These health professionals specialise in diagnosis and management of patients with chronic pain, acute pain and cancer pain, referred to generically as "patients with pain". They should have experience working together in an interdisciplinary context.
- 1.5 The Multidisciplinary Pain Medicine Unit must have access to rehabilitation services, cancer/palliative care services, psychological and psychiatric services and an Acute Pain Service. Coordination between these services is highly desirable.
- 1.6 The Multidisciplinary Pain Medicine Unit must be approved prospectively by the Board of the Faculty of Pain Medicine for training purposes.
- 1.7 Trainees are expected to spend 0.9 FTE in Pain Medicine. The trainee may work in their primary specialty outside normal hours.

## 2. Administrative Structure and Staffing

- 2.1 Funding for a training position(s) is required and remains the responsibility of the Unit(s) involved.
- 2.2 All medical practitioners involved in the Unit must be accredited by their institutions for the duties and procedures they perform.
- 2.3 The Director of a Multidisciplinary Pain Unit must be a Fellow of the Faculty of Pain Medicine.
- 2.4 The Supervisor of Training must be a Fellow of the Faculty of Pain Medicine. The Supervisor of Training has the responsibility for coordination and oversight of the trainee's program, including where that program is pursued in more than one unit.
- 2.5 A session in Pain Medicine is a notional period of 3.5 hours devoted exclusively to the specialty.
- 2.6 There must be a minimum of eight (8) scheduled medical specialist sessions provided in the Unit(s) and available to the trainee each week. A maximum of 2 sessions allocated to the Acute Pain Service can be counted. At least four (4) sessions per week should be conducted by medical practitioners holding Fellowship of the Faculty of Pain Medicine.
- 2.7 Regularly scheduled specialist sessions are essential. These sessions can be provided by:
- 2.7.1 Anaesthetists, Neurologists, Neurosurgeons, Palliative Medicine Physicians, Psychiatrists, Rehabilitation Physicians, Rheumatologists, and other relevant specialties.
- 2.8 Specialist supervision appropriate to the level of clinical experience of the trainee must be available.

2.9 The following disciplines should be available:

- 2.9.1 Nursing: a senior registered nurse should be available as appropriate. (Nursing staff for a procedural service see 3.2 and for an Acute Pain Service: see 2.20).
- 2.9.2 Clinical Psychology: a minimum of five (5) sessions weekly.
- 2.9.3 Physiotherapy: a minimum of five (5) sessions weekly.

2.10 Clinical input is desirable from:

- 2.10.1 Occupational Therapy
- 2.10.2 Social Work
- 2.10.3 Other Allied Health disciplines such as Rehabilitation Counselling and Dietetics.

2.11 Units must be able to offer training and or experience in the following areas:

- 2.11.1 Review of medical records.
- 2.11.2 History taking and physical examination relevant to Pain Medicine.
- 2.11.3 Psychological assessment and treatment including cognitive behavioural approaches.
- 2.11.4 Diagnosis and formulation of a management plan.
- 2.11.5 Consultative input from other medical specialties.
- 2.11.6 Medical and pharmacological management.
- 2.11.7 Physical therapy.



- 2.11.8 Interdisciplinary meetings.
- 2.11.9 Communication with the patient's general practitioner.
- 2.12 Regularly scheduled educational sessions for all staff are essential.
- 2.13 Involvement in undergraduate and postgraduate medical, nursing and allied health education is essential.
- 2.14 Regularly scheduled quality improvement and peer review activities are essential.
- 2.15 A comprehensive patient record system is essential.
- 2.16 Documentation of treatment protocols and procedures for patients together with a statement of their rights and responsibilities is essential.
- 2.17 Secretarial assistance to the Unit(s) is essential.
- 2.18 An active research program related to Pain Medicine is highly desirable.
- 2.19 A computerised data review system for both diagnosis and treatment is highly desirable.
- 2.20 The Acute Pain Service associated with the Multidisciplinary Pain Medicine Unit must have:
- 2.20.1 at least one (1) specialist anaesthetist session allocated each weekday.
- 2.20.2 a specialist anaesthetist should be available for consultation 24 hours a day.
- 2.20.3 at least one (1) registered nursing session allocated each weekday.

### 3 Physical Components of the Facilities

- 3.1 Appropriate consulting and examination rooms are essential.
- 3.2 Appropriate procedure rooms with adequate equipment and staffed by nurses, technicians and radiographers as required are highly desirable.
- 3.2.1 Anaesthesia and resuscitation equipment must comply with ANZCA

College Professional Document T1 (2000) Recommendations on Minimum Facilities for Safe Anaesthesia Practice in Operating Suites.

- 3.2.2 Recovery facilities and procedures must comply with ANZCA College Professional Document PS4 (2000) Recommendations for the Post-Anaesthesia Recovery Room.

3.3 Suitable office space for permanent staff and trainees is essential. See ANZCA Professional Document TE1 (2003) Recommendations for Hospitals seeking College Approval for Vocational Training in Anaesthesia.

3.4 Access to in-patient beds is essential.

3.5 Access to a library is essential.

### 4 Clinical Workload and Standards for A Multidisciplinary Pain Medicine Training Unit

- 4.1 There must be sufficient numbers of new patients per annum to provide the trainee with exposure to:
- 4.1.1 Acute perioperative, medical and trauma related pain
- 4.1.2 Persistent non-cancer pain
- 4.1.3 Cancer pain.
- 4.2 Formal interdisciplinary case conferences should be held at least once per week. Inclusion of more than one medical discipline in discussions is highly desirable.
- 4.3 Procedural sessions: (eg: diagnostic and therapeutic nerve blocks) are required to provide adequate exposure for trainees.
- 4.4 In-patient rounds: There must be regular scheduled attendances to inpatients under the care of the Unit(s). There must be medical specialist input to the rounds.
- 4.5 Medical specialist cover: must be available 24 hours per day throughout the year.
- 4.6 Radiology: There should be regular review sessions.
- 4.7 Psychiatry and Psychology therapy sessions: Trainees should gain adequate exposure.

4.8 Audit and clinical review sessions: should be held at least monthly, and be minuted.

4.9 Compliance with all current Faculty Professional Documents is essential.

4.10 Recommended numbers of patients treated in the Unit per trainee per year should approximate: acute 500, chronic non-cancer 250 and cancer 50.

### Faculty of Pain Medicine Professional Documents

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

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

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

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

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

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

*Promulgated: November 2001*

*Date of current document: October 2005*

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Faculty Website: [www.fpm.anzca.edu.au](http://www.fpm.anzca.edu.au)



Faculty of Pain Medicine

# Professional Documents

**P = Professional PS = Professional Standards**

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

## *College Professional Documents Adopted by the Faculty:*

- PS4 (2000) Recommendations for the Post-Anaesthesia Recovery Room (Adopted February 2001)
- PS7 (2003) Recommendations on the Pre-Anaesthesia Consultation (Adopted November 2003)
- PS8 (2003) Guidelines on the Assistant for the Anaesthetist (Adopted November 2003)
- PS9 (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),

The activities of the Joint Faculty seem to be increasing rapidly with over 500 Fellows, many more trainees, more sitting examinations, and more Scientific Meetings. As a result, Carol Cunningham-Browne and our other staff, have been under constant pressure. Fortunately we have been joined by Laura Fernandez, who has taken on the responsibilities of the Hospital Accreditation Committee, Education and Trainee Committees, administration of Formal Projects and assisting with the Journal. Laura has already showed her worth and we look forward to a long association.

Fellows with their FJFICM have once again done well from excellent support from the ANZCA Foundation Research Grant distribution this year. In addition, Dr Rinaldo Bellomo received a significant academic enhancement grant. The Board conducted some re-negotiation with ANZCA Council and has decided to keep contributing 10% of subscriptions to the ANZCA Foundation Research Fund. Intensive Care

*“The activities of the Joint Faculty seem to be increasing rapidly with over 500 Fellows, many more trainees, more sitting examinations, and more Scientific Meetings...”*

Fellows have benefited well from this Fund over a number of years because the standard of their applications has been high. Congratulations to those who received grants.

The Board expressed concern at an unusually low pass rate in the August sitting of the Written

Fellowship Examination. The process and results have been carefully scrutinised and we are happy that the process is excellent. There are many factors involved in a low pass rate and the reasons are not immediately clear. Changes to the structure of the Fellowship Examination to

*“Some of our trainees and Supervisors of Training have reported difficulty in getting anaesthesia posts for ICM trainees.”*

improve reliability, such as removing the Essays in the Written Section, and incorporating the cold cases into the OSCE Section, as well as requiring candidates to pass the Written Section before being eligible to enter the Oral Sections are the major changes implemented in 2005. Greater numbers of candidates are also presenting, with the increase in trainees. It is possible that some candidates are focusing their studies on the Written Section. It is possible that with shorter working hours, some trainees are not getting enough experience, especially as many of the questions were very clinically based. One of the things we are going to do, is to look carefully at how increased internal calibration of the Examiners can be achieved, to be certain we are not increasing the standards expected. The Examination Committee and especially its Chairman, Peter Morley, have worked very hard at the issue, and at the moment it looks as though the unusually low pass rate may be a “blip on the system”. It behoves Supervisors of Training and other Fellows, to try to have trainees in a reasonably prepared state before examination attempts are made.

The ACCC (Australian Competition and Consumer Commission) has now reported back to the various College bodies. I am glad to say that along with ANZCA, JFICM meets most of the requirements. There are some anomalies in

their conclusions, particularly with regard to trainee selection processes, to avoid restriction of competition. In intensive care, the hospital employing bodies control the selection process, with JFICM Fellows assisting. An important requirement which will affect the Joint Faculty, is

a requirement for jurisdictional representation on some internal committees e.g. Overseas Specialist Committee, Hospital Accreditation Committee. The “jurisdictions” e.g. AMC, employing authorities, state governments, now find themselves in the position of having to supply members to a myriad of College Committees. Some rationalisation will need to take place.

The Australian Government's Productivity Commission has also produced their paper for discussion. Their recommendations will not affect the Colleges much at this stage, but will have major ramifications for various Government bodies. Suggestions include: allocating the funding available for university based education of health workers to the Department of Health and Ageing; the establishment of a single national accreditation agency for all university and postgraduate training; states and territories should take steps to improve the operation of mutual recognition in relation to health workforce; and the Australian Medical Workforce Advisory Committee and the Australian Health Workforce Advisory Committee should disappear, and report to another body. There are many other high level recommendations. It will be interesting to observe their progress.

Some of our trainees and Supervisors of Training have reported difficulty in getting

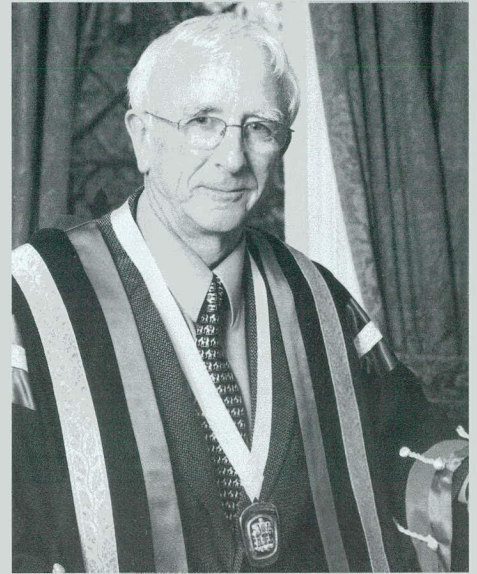


anaesthesia posts for ICM trainees. This matter is being discussed at Education Committees of both JFICM and ANZCA. It is actually quite a difficult issue to help with as it requires local goodwill. Obviously directors of anaesthesia departments want the best candidates they can get. If the situation is persistent, it may force more trainees out to a rural environment for their anaesthesia experience, which actually may give more and better general experience. ANZCA has asked the Joint Faculty to define what is required in the year of mandated anaesthesia.

By the time you have read this, the Board will have had a Planning Meeting at which we will have discussed a raft of issues including relationships with our parent Colleges, Board constitution and delegated powers, CPD and re-certification issues, educational curriculum and a new look at ways we assess trainees. The world doesn't seem to stop still for long!

**Jack Havill**

*September 2005*





## Report

# Report of the October 2005 Board Meeting

### Honours

The Board was very pleased to note the award of the Robert Orton Medal to Professor Garry Phillips, the ANZCA Council representative to Board. Congratulations were also passed on to Mrs Joan Sheales, CEO ANZCA, who was awarded Honorary Fellowship by ANZCA Council.

## Examinations

### Fellowship Examination

A number of initiatives relating to the Fellowship Examination were endorsed by the Board. These included:

1. A pilot one day course to be held in December 2005 which is targeted at teaching trainees the fundamentals of studying and preparing for and coping with exams. The exam will be aimed at Trainees in the early stages of their training, those who experience difficulty passing exams, and Overseas Trained Specialist candidates who are unfamiliar with our Examination system.
2. Following the introduction of the requirement for the Written Component of the Fellowship Examination to be passed before being invited to the Oral Sections, the mark for eligibility to sit the Oral component has been revised to 45%. Candidates receiving  $\geq 45\%$  but  $< 50\%$  for the written exam will be notified that they had received sufficient marks to be eligible to sit the Oral component of the current exam. If the candidate does not pass the exam overall, that candidate will be notified that they did not pass the Written section and that this would not entitle them to an exemption from the Written component of the Examination. Candidates receiving 50% for the Written component will be notified that they have received sufficient marks to sit the Oral component of the current exam. If the candidate does not pass the exam overall, that candidate will be exempted from the Written component of the next 2 timetabled exams.

### A JFICM Primary Examination

A working group continues to develop a syllabus for the Primary Examination in several workshops, and it is expected that the first examination will be held in May 2007. The content of the Examination will be promulgated early in 2006 to allow time for candidates to prepare.

### The G.A. (Don) Harrison Medal Winner, 2005

The Board is pleased to announce the winner of the G.A. (Don) Harrison Medal for 2005 is Dr Timothy Stanley, of Newcastle NSW.

## Education

### Supervisors of Training

The Board considered the pilot program of workshops conducted during 2005. The Board resolved:

1. As from 2006, in order to enhance their education and training, Supervisors of Training (SOT) are required to attend a JFICM, ANZCA or RACP SOT workshop within 12 months of their appointment.
2. All SOT are required to attend a Workshop every two years.

This is in line with RACP requirements.

### Curriculum and Assessments

The Education Officer has convened working groups to reconsider the whole curriculum area. This is being accompanied by a review of assessment of Trainees. The philosophy is shifting from the "big hurdle at the end" to more formative and smaller summative hurdles during training. This may include specific courses eg. simulation, and more emphasis on in-training assessment.

The In-Training Assessment processes will include forms which pertain to each individual component of the training program.

### Training in Hong Kong

The Board is working with Fellows in Hong Kong to establish a Training Committee in Hong Kong to assist with communications between Fellows there and the Joint Faculty.

### Accreditation of Units for Basic Training

An application form has been developed for Units applying for Basic Training to enable consideration of whether they meet the requirements as outlined in the statement 'Minimum Criteria for Accreditation of Units for Basic Training'.

## Finance

### Fees for 2006

Following extensive review, the Board has resolved to increase some fees to cover costs related to additional staffing and other related administrative costs, such as distribution of the Journal and OTS. This follows a marked increase in the number of trainees and Fellows in recent years. The fees are:

- Registration Fee for 2006 \$500
- Training Assessment Fee A\$300  
This will be introduced for doctors not registered but seeking an assessment of training requirements.
- Basic Training Fee \$500
- Advanced Training Fee \$1000
- Annual Mailing Fee for Trainees for 2006 will be increased to A\$300
- Fellowship Examination Entry Fee for 2006 will be increased to A\$2300
- Non-Fellows' Fee for MOPS for 2006 will be reduced to A\$300 +GST (where applicable)
- Annual Subscription for Fellows for 2006, due and payable on 1st January 2006, will be increased to A\$1140 +GST where applicable
- Overseas Trained Specialist Assessment Fee for 2006 will remain at A\$1300 plus GST



- A new OTS Registration Fee will be imposed for 2006 of \$500 + GST
- OTS Administration Fee for 2006 will be increased to \$1000 + GST
- Occupational Training Visa processing fee for 2006 will remain at \$150 + GST
- Area of Need Assessment fee for 2006 will remain at \$250 plus GST
- AON Site Visit for 2006 will remain at \$1500 + GST plus reasonable travel and accommodation costs when there is a requirement for a reviewer to attend an on-site review

## Internal Affairs

### *New Fellows Conference, 2006*

Drs Celia Bradford, NSW, Dr Mike Gillham, NZ and Dr Paul Goldrick, NT were endorsed as JFICM representatives to the New Fellows Conference in 2006.

### *Director of Professional Affairs*

The Board resolved to appoint a Director of Professional Affairs, modeled on the current position held by Professor Garry Phillips for ANZCA. It was considered this person, a Fellow with experience in Board affairs, would be employed on a part time basis to assist the Dean and the Board as a whole in representation to government and other organisations, preparation of professional statements, data and reports to such bodies, assist in the development of strategies and to develop a network of relationships with external bodies. The position will be advertised.

### *Planning Day*

The Board held a planning day to allow free and frank discussion and brainstorming on various issues. The day was facilitated by Dr Richard Lee and Ms Carol Cunningham-Browne. A number of issues were examined, relating to governance, relationships with parent colleges, CPD and

recertification issues, educational modules including courses and use of simulation, plus a lengthy review of our assessment procedures. It was very beneficial for Board members to spend more time on some of these issues considering the growing business covered at Board meetings.

## Visitors

### *ANZICS Foundation*

The Board welcomed Dr George Skowronski, Chairman of the ANZICS Foundation. Discussions took place around the relationship between the Foundation and the JFICM. The Board was very supportive and will consider ways in which the JFICM might offer support to the Foundation.

### *Visit from Chairman of Education Committee of European Society of Intensive Care*

The Board also received a visit from Dr Dermot Phelan. He provided a briefing of the ESIC and its various activities across Europe. This included examinations and syllabi tailored to many countries, an online collection of intensive care topics called PACS which is very developed, European Scientific Meetings, and a study group known as CoBaTrICE to which the Joint Faculty contributes. Useful discussion was held and the contact should prove useful for future discussions.

### *Report of the New Fellows Conference*

Dr Peter Dzendrowskyj delivered a presentation following this year's New Fellows' Conference held in Tongariro, New Zealand.

Recommendations and comments included:

1. Endorsement of the Faculty's establishment of the Senior Registrar position.
2. Establishment of a New Fellows' Conference for new Intensivists is recommended. This will be considered in association with JFICM's ASM in 2006.

3. That a New Fellow representative be appointed to the Training Committee. The Board is considering the issue of a Trainee/New Fellow representative at present.
4. The establishment of a New Fellows' "Frequently Asked Questions" web site in the Faculty web site is recommended.

### *RACS Trauma Committee*

Dr Arthas Flabouris, the JFICM representative on this Committee reported on activities. In discussion of the Trauma Verification Group which inspects hospitals on request for accreditation, it was agreed that the Joint Faculty would:

- a) Upgrade the list of Intensivists available to assist with site visits
- b) Nominate a representative for the Rural Trauma Subcommittee
- c) Support the exploration of an intensive care trauma education module
- d) Promote disaster preparedness and look for particular Intensivists with an interest in this area



## Report

# The Burnie Meeting

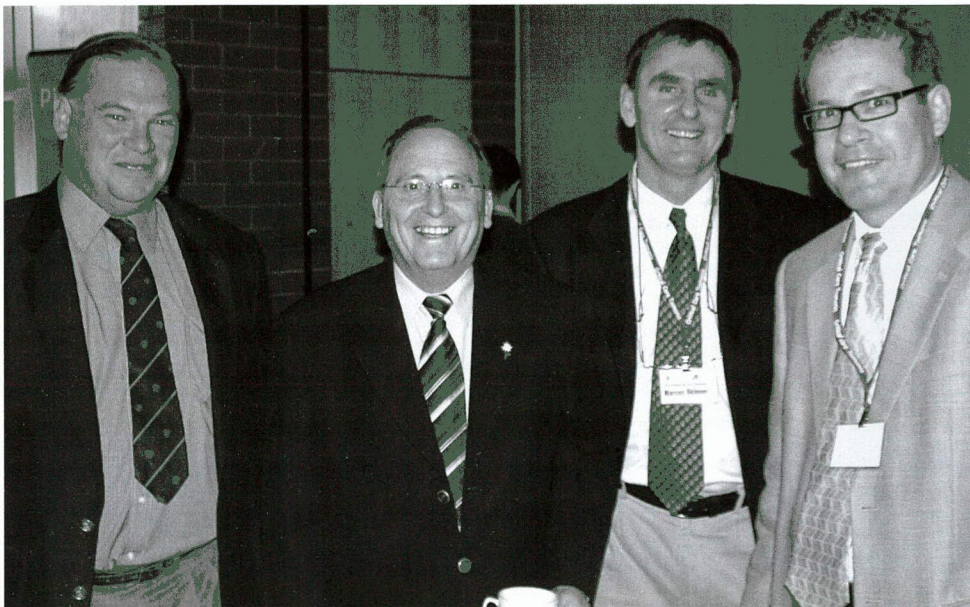
13th August 2005

In small states such as Tasmania, close co-operation exists between the JFICM and ANZICS as many members/Fellows are conjoint. The newly formed Tasmanian Regional Committee of the JFICM has to date held several meetings in conjunction with local ANZICS educational meetings, a system that works well. The recent 11th ANZICS/Australian College of Critical Care Nurses Continuing Educating Meeting held recently in Burnie, Northern Tasmania, was well supported by ANZICS members and JFICM Fellows alike.

The theme this year was Prescription for Disaster. The meeting was opened by the Minister of Health, The Honourable David Llewellyn. Unfortunately Dr Jack Havill, Dean JFICM, was unable to attend at short notice. The Organising Committee attempted to compile a program that was innovative, covering areas that broadly encompassed risk management in areas where we are exposed and vulnerable. Dr Michael Buist presented a range of extremely interesting and educational topics including The Epidemiology of Unexpected Death in Hospital and MET and Patient Safety. We had legal input from the Senior Crown Law Solicitor Mr Paul Turner on the Legal Interpretation of Error, followed by clarification of the Coronial Requirements in ICU by Suzanne Greenaway. Associate Professor Tracy Bucknell gave an insightful talk on Decision Making in ICU followed by Drug Error and Prevention in ICU by Suzette Seaton. The whole session was finalised with an excellent talk from Donna Golsmith on Risk Management – Where To in the Future.

This year's meeting was very well attended with one of the highest registrations for many years, including visitors from Victoria! In addition, the critique/feedback from the attendees has been very positive. The formal dinner at the Burnie Club provided a warm, friendly and relaxed environment to enjoy the intensive care camaraderie and all had a good time.

We are deeply indebted to the many people who participated in the process of making the



At the 11th ANZICS / ACCCN Meeting (Left to Right): Associate Professor Tony Bell; Hon David Llewellyn MHA, Minister for Health and Human Services; Dr Marcus Skinner and Dr Michael Buist

Conference a success. The reality is that without such support by guest speakers, we would have difficulty getting such a high attendance. In addition we had excellent support and sponsorship from partners in the health industry and without this assistance, such a meeting would not be possible. The Organising Committee would like to thank all of our sponsors for their valued and ongoing support. In particular we wish to acknowledge our major sponsor PHILIPS and thank them for their generous support.

We look forward to seeing many again as Tasmania hosts the National ANZICS Meeting in 2006 in Hobart.

**Dr Marcus Skinner**  
**Ms Trudy Segger**

*Convenors 11th ANZICS/ACCCN Combined  
Scientific Meeting Tasmania 2005*

**Dr John Gowardman**  
*Chair*

*Tasmanian Regional Committee JFICM*





## Report

# Trainee Committee

The JFICM Trainee Committee continues to meet at regular intervals to discuss issues pertinent to training in the field of intensive care. The Trainee Committee acts as a conduit between Registrars and College bodies such as the Education Committee. There has also been a suggestion that a trainee representative or new fellow would be a valuable addition to the Joint Faculty Board. The Committee has one representative per state and one from New Zealand.

The pertinent issues discussed included:

### *The Role of a Primary Examination for Intensive Care*

A comprehensive survey of trainees has suggested that this is wanted, but not to the exclusion of other primary exams. The Committee discussed the potential content of the exam.

### *Workforce Issues*

In particular the legislation to allow part-time training in intensive care. There is still a marked discrepancy in the representation of women in intensive care - (Men:Women Fellows = 10:1). There may be perceived limitations to flexibility in our profession, which discourage women from embracing intensive care as a serious prospect.

### *The Syllabus for the Fellowship Exam*

There is a call from some camps for the curriculum to be more focused and directive.

Dr Mathew Piercy from Victoria will take the position of Chair of the Trainee Committee from the next meeting.

**Dr Celia Bradford**  
*Outgoing Chair  
 Trainee Committee JFICM*

## Admission to Fellowship

*The following were admitted to Fellowship by Examination.*

Pi Ang Seet	VIC
Patrick Liston	NSW
Carole Louise Foot	QLD
Nicole Anne Margaret Blackwell	QLD
Matthew Jerome Maiden	VIC
Himangsu Gangopadhyay	VIC
Ivana Kliman	NSW
Alan Paul Davey-Quinn	NSW
Roberto Citroni	VIC



## The G.A. (Don) Harrison Medal 2005

Congratulations to **Dr Timothy Stanley**, winner of this award for 2005, based on his performance at the Fellowship Examination.



# Supervisors of Training in Intensive Care

## **Australia Capital Territory**

Dr I A Leditschke, FJFICM  
*The Canberra Hospital*

## **New South Wales**

Dr J R Awad, FANZCA, FJFICM  
*Sydney Children's Hospital*

Dr P L Byth, FANZCA, FJFICM  
*John Hunter Hospital*

Dr R K Choong, FJFICM  
*Hornsby Ku-Ring-Gai Hospital*

Dr J E Gallagher, FJFICM  
*Westmead Hospital*

Dr J Gillis, FJFICM  
*The Children's Hospital at Westmead*

Dr R P Lee, FANZCA, FJFICM  
*Royal North Shore Hospital*

Dr A J McDonogh, FJFICM  
*Gosford Hospital*

Dr D M Milliss, FANZCA, FJFICM  
*Concord Repatriation General Hospital*

Dr P Nair, FJFICM  
*St Vincent's Hospital*

Dr S R Nolan, FJFICM, FRACP  
*Blacktown Mt. Druitt Health - Blacktown Campus*

Dr M J O'Leary, FJFICM  
*The St George Hospital*

Dr P R Phipps, FJFICM  
*Royal Prince Alfred Hospital*

Dr K S Rachakonda, FJFICM  
*Wollongong Hospital*

Dr R F Raper, FJFICM  
*North Shore Private Hospital*

Dr I M Seppelt, FANZCA, FJFICM  
*Nepean Hospital*

Dr A H Stewart, FANZCA, FJFICM  
*Liverpool Hospital*

Dr B E Trytko, FANZCA, FJFICM  
*Prince of Wales Hospital*

## **Northern Territory**

Dr P B Goldrick, FANZCA, FJFICM  
*Royal Darwin Hospital*

## **Queensland**

Dr J S Evans, FANZCA, FJFICM  
*The Townsville Hospital*

Dr R M Hegde, FJFICM  
*Logan Hospital*

Dr P S Kruger, FANZCA, FJFICM  
*Princess Alexandra Hospital*

Dr J A McEniery, FJFICM  
*Royal Children's Hospital, Brisbane*

Dr R W Quinn, FANZCA, FJFICM  
*Gold Coast Hospital*

Dr P H Sargent, FJFICM  
*Mater Children's Public Hospital*

Dr C B Scott, FANZCA, FJFICM  
*Nambour General Hospital*

Dr P H Scott, FANZCA, FJFICM  
*Mater Adult Hospital (Mater Health Services)*

Dr D C Wenck, FANZCA, FJFICM  
*Cairns Base Hospital*

Dr R F Whiting, FANZCA, FJFICM  
*Greenslopes Private Hospital*

Dr N J Widdicombe, FJFICM  
*Royal Brisbane Hospital*

Dr M D Ziegenfuss, FJFICM  
*The Prince Charles Hospital*

## **South Australia**

Dr D J Evans, FANZCA, FJFICM  
*Royal Adelaide Hospital*

Dr A W Holt, FANZCA, FJFICM  
*Flinders Medical Centre*

Dr S R Keeley, FJFICM  
*Women's and Children's Hospital*

Dr S L Peake, FANZCA, FJFICM  
*The Queen Elizabeth Hospital*

## **Tasmania**

Dr P D Cooper, FANZCA, FJFICM  
*Royal Hobart Hospital*

Dr J R Gowardman, FJFICM  
*Launceston General Hospital*

## **Victoria**

Dr D T Green, FJFICM  
*Geelong Hospital*

Dr J V Green, FANZCA, FJFICM  
*The Northern Hospital*

Assoc Prof G K Hart, FANZCA, FJFICM  
*Austin Health*

Dr A K Hilton, FANZCA, FJFICM  
*Alfred Hospital*

Dr B U Ihle, FJFICM  
*Epworth Hospital*

Dr K J Millar, FJFICM  
*Royal Children's Hospital Campus*

Dr O A Monteiro, FJFICM  
*Dandenong Hospital*

Dr P T Morley, FANZCA, FJFICM  
*Melbourne Private Hospital*

Dr R Nagappan, FJFICM  
*Box Hill Hospital*



Professor W G Parkin, FANZCA, FJFICM  
*Monash Medical Centre*

Dr M S Robertson, FANZCA, FJFICM  
*Royal Melbourne Hospital*

Dr S Velandy Koottayi, FJFICM  
*Western Hospital*

Dr D Y Williams, FANZCA, FJFICM  
*St Vincent's Hospital*

#### **Western Australia**

Dr A W Duncan, FANZCA, FJFICM  
*Princess Margaret Hospital for Children*

Dr S A Edlin, FJFICM  
*Royal Perth Hospital*

Dr M Pinder, FJFICM  
*Sir Charles Gairdner Hospital*

Dr D C Simes, FANZCA, FJFICM  
*Fremantle Hospital*

#### **Canada**

Dr P W Skippen, FANZCA, FJFICM  
*British Columbia Children's Hospital*

#### **Hong Kong**

Dr K W Au Yeung, FANZCA, FJFICM  
*Queen Elizabeth Hospital*

Dr C D Gomersall, FJFICM  
*Prince of Wales Hospital*

Dr K A Leung, FANZCA, FJFICM  
*Pamela Youde Nethersole Eastern Hospital*

Dr H So, FANZCA, FJFICM  
*North District Hospital*

Dr P Tan  
*Tuen Mun Hospital*

Dr K K Young, FANZCA, FJFICM  
*Queen Mary Hospital*

Assoc Prof T A Buckley, FANZCA, FJFICM  
*Princess Margaret Hospital*

#### **New Zealand**

Dr D H Buckley, FANZCA, FJFICM  
*Starship Children's Hospital*

Dr L H Galler, FANZCA, FJFICM  
*Auckland City Hospital and  
Green Lane Clinical Centre*

Dr S J Henderson, FJFICM  
*Christchurch Hospital*

Dr P R Hicks, FANZCA, FJFICM  
*Wellington Hospital*

Dr W G Howard, FJFICM  
*Waikato Hospital*

Dr M P Ramsay, FJFICM  
*Dunedin Hospital*

Dr A P Rankin, FJFICM  
*Middlemore Hospital*

Dr M J Gillham, FANZCA, FJFICM  
*Green Lane Hospital*

## **Supervisors of Training in Intensive Care**

*The following appointments were ratified by the Board of Faculty:*

Dr Grant Howard  
*Waikato Hospital, NZ*

Dr Phil Byth  
*John Hunter Hospital, NSW*

Dr Ramesh Nagappan  
*Box Hill Hospital, VIC*

Dr Johnny Millar  
*Royal Children's Hospital, VIC*



# Terrorism, Bali and Tropical Paradise

The phone ringing was persistent and with reluctance I got out of bed to answer it. It was Saturday 1st October at 2300 and the call was to put me on standby in my RAAF Specialist Reserve capacity to go up to Bali to evacuate the victims of a series of bombs that had exploded 2 hours ago. My first reaction was one of overwhelming sadness that this could happen again. My first thoughts were of the last time this happened mingled with my more recent experiences on deployment in Iraq. My first action was to make lots of phone calls and to activate our ICU disaster response plan. I packed up my kit for the trip and then tried to get a few hours of sleep – the wheels were in motion and the next step was many hours away.

On Sunday morning another call woke me at 0600 to update the situation and further sleep was then impossible. I got up and got ready and went in to the hospital to check our preparedness and attend the first hospital command and control meeting at 0900. We organised to discharge those patients in ICU/HDU who were ready to go to the ward, expedite planned discharges from the wards, send patients to the private hospital where able and cancel Monday's elective surgery and outpatients. I handed over the ICU Disaster Commander role to Dr Paul Goldrick at 1130, put on my RAAF uniform and headed over to the RAAF base for our first briefing at 1400. In the hours between 1400 and

1900, the logistics of the AME were worked out, teams were planned and intelligence gathered – particularly from the RAAF medical assessment team who arrived in Bali and commenced the AME process. There was one AME team from RAAF Base Darwin and two AME teams and equipment were flown up to Darwin from Sydney, and by 1900 we were on our way in two Hercules C130Js to Denpasar. The AME teams were augmented by Specialist Reserves – Mr David Read and Dr Malcolm Johnston-Leek from Darwin, and reservists flown from interstate – Dr Trevor Gardiner and Dr Bill Griggs. The AME teams have permanent RAAF doctors, nurses and medics and they are the ones that know the system and ensure it all runs like clockwork – the specialist reserves augment the medical expertise but the AME teams are the ones who ensure the AME runs effectively and efficiently.

The trip in the Hercules is 3.5 hours from Darwin to Denpasar and given that the noise levels require earplugs for hearing protection, we spent most of this time trying to get some rest. The AME teams spent some of the time preparing and planning so we were ready to hit the ground running when we arrived and that is exactly what we did! The medical assessment team in Bali had worked hard in the hours before we arrived. The stretcher patients, walking wounded and families were at the airport ready to load. Most of the AME teams and specialist

Dr Stephens



reserves stayed at the airport to perform the task of assessment and loading. Dr Steve Cook was running the assessment team and he took myself, a senior AME nursing officer Steve Crimston and Bill Griggs out to Sanglah Hospital to assess and transfer three ICU patients. The trip in the back of an Indonesian ambulance with lights and sirens, and going as fast as the driver could was, to say the least, a little scary. The atmosphere at Sanglah Hospital was very sombre. There were families scattered around, quietly watching and waiting as we walked around the outdoor corridors to the private ICU. We removed our boots and entered the ICU to assess two Japanese patients. Both patients were not ventilated but one was tachycardic and had a low PaO<sub>2</sub>/FiO<sub>2</sub> ratio that both Bill and I thought would require intervention once we got him out to the airport. The other patient looked very stable and we left Bill with the English doctor who worked in the ICU to organise an ambulance out to the airport as we went off to assess and transfer the ventilated patient from the public ICU. As we walked past the ambulance with our kit in it, we signalled for the driver to follow so he was closer to the entrance we would come out of. We were then informed by the Indonesian officials with us that they had a different ambulance for us so we sent one of our team to transfer the kit – this was to happen a second time when we came out with the patient – the ambulance we ended up with was obviously the best ambulance they could find for us. The Indonesian officials, doctors and nurses were very helpful and trusting of us – Steve Cook had done an excellent job of establishing a good rapport with the staff and the whole transfer went very smoothly. We were quite busy the whole time at Sanglah Hospital and it was dark outside so I didn't get a good feel for the whole hospital. The intensive care units had quite basic equipment but the set up was fairly standard and the unit was clean. The atmosphere was calm and the patient transfer very efficiently managed. We needed to give additional sedation and put a dressing on a large open wound and left other management issues until we got to the aircraft. We asked the driver to go slowly back to the airport but he still managed to hit a speed bump at high speed throwing patient and staff into the air, so it was a relief when we finally got there. There were





15 evacuees on our plane with just the one ventilated patient. The ICU patients are loaded last onto the plane so once we were on and had done what patient care was immediately required, we strapped in and took off. The trip back went quite quickly as we had lots to do. Steve Crimston and I just looked after our ventilated patient for the trip. Most of the patients and passengers slept through the trip. We landed at 0510 on Monday morning and were met by the RDH Airport Assessment team led by Dr Brian Spain. We were loaded onto an ambulance and made the short trip to RDH. We took the patient straight to ICU and I handed over to Paul Goldrick. The RDH ICU was well organised and humming – we ended up with 6 patients in ICU from the event but could have comfortably received many more.

The patients this time had blast injuries. There were no burns as the blasts occurred in the open and no buildings caught fire. The bombs contained ball bearings and other bits of metal and the injuries were very reminiscent of the blast injuries we had seen all too often during my 3 months in Iraq. The injuries can look very innocent and conceal a projectile path of destruction that only becomes apparent as imaging and operative intervention defines the full extent of the injuries. There were eye injuries, lung injuries, abdominal injuries and multiple soft tissue injuries. RDH received 6 ICU patients and 7 ward patients from the event. These patients required 52 hours of surgery in the first 2 days. The interventions included repeated washouts of wounds, re-laparotomies, surgery for cardiac tamponade, tracheostomy for airway compromise and removal of shrapnel.

All ten Australian patients were from Newcastle. One ventilated patient was sent by a retrieval jet to Sydney for urgent intervention for complex eye injuries. The other nine patients were stabilised over the first two days. All the clinicians involved in the patient's care met on Tuesday morning and agreed that transfer of the Newcastle patients to John Hunter on Wednesday would be appropriate. The clinicians at RDH were very keen for me to be on the



transfer, so once again I put on my uniform and was part of the RAAF AME team. The opportunity to follow the process through from beginning to end was fantastic. It was an exhausting 5 days but a very rewarding experience. The trip to Williamstown was 5.5 hours and the patients on this flight were less critically ill so I had an opportunity to look around and get a good feel for the whole AME set up. There were two patients from our HDU area, 6 stretcher patients and one seated patient. We also had the rest of the teams going home to Sydney as passengers so there was a big sigh of relief when we finally touched down. We escorted the patients into John Hunter Hospital and handed over their care to a large enthusiastic and skilled medical reception team. Three international patients remain in RDH ICU as I write this story.

It is now 6 days after the event and I am looking forward to the weekend. Time to reflect on what has happened and move on with normal life. I spent the first 3 months of this year in Iraq seeing this scale of mass casualty event from suicide bombings on an almost daily basis. The clinical care is now routine, the horrific nature of the injuries expected, the impact of the trauma less acute. The disaster plan of the Royal Darwin Hospital has been tested and shown to work a number of times now. We are constantly refining our plan and we will once again have lessons learned. Royal Darwin Hospital is at the frontline of the response to events in South East Asia. We have Commonwealth funding to become the National Trauma and Disaster Centre and with this funding will continue to improve our response capability over the next 4 years. Darwin may be a long way

from the population centres of Australia but in our own small way we have a big role to play.

*“The injuries can look very innocent and conceal a projectile path of destruction...”*

It is an unfortunate state of affairs that as Intensivists we need to be expert in the planning of the response to a terrorist attack as well as natural disasters. We also need to be skilled at dealing with the aftermath. The emotional impact of these events on staff is enormous. I would encourage ICUs across Australia to review their plans. This threat is not going away and if an event occurs in one of the more populous cities in Australia we need to be able to minimise the damage by having efficient and effective systems in place.

**Dr Dianne Stephens, FANZCA, FJFICM**

*Director of Intensive Care  
Royal Darwin Hospital*



## Joint Faculty of Intensive Care Medicine

# Policy Documents

- IC-1 (2003) Minimum Standards for Intensive Care Units
- IC-2 (2005) Intensive Care Specialist Practice in Hospitals Accredited for Training in Intensive Care Medicine
- IC-3 (2003) Guidelines for Intensive Care Units seeking Accreditation for Training in Intensive Care Medicine
- IC-4 (2000) The Supervision of Vocational Trainees in Intensive Care
- IC-5 (1995) Withdrawn
- IC-6 (2002) The Role of Supervisors of Training in Intensive Care Medicine
- IC-7 (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 TE-1 (2005)

Australian and New Zealand College of Anaesthetists ABN 82 055 042 852

# Recommendations for Hospitals Seeking College Approval for Vocational Training in Anaesthesia

### 1. General

- 1.1 An Approved Hospital Department is one that has been accredited by the College for the purpose of providing trainees with supervised training experience in anaesthesia.
- 1.2 Approved Hospital Departments will be recognised by the College for training only if they are part of one or more Approved Training Programs. (see College Professional Document TE 10 - Recommendations for Vocational Training Programs)

### 2. The Approved Hospital Department

- 2.1 Hospital Departments that request accreditation for ANZCA training will be assessed by College representatives with approval being granted by Council.
- 2.2 Approved Hospital Departments must agree to re-inspection by College representatives when requested by Council.
- 2.3 Job descriptions for the specialist anaesthesia staff, anaesthesia trainees and other anaesthesia providers must be acceptable to the College (see College Professional Document TE6 Guidelines on the Duties of an Anaesthetist).
- 2.4 When specialist anaesthesia staff are appointed, the advice of a properly constituted committee capable of evaluating the applicants must be sought. See College Professional Document PS44 - Guidelines to Fellows Acting on Appointments Committees for Senior Staff in Anaesthesia.
- 2.5 Positions in Departments approved for training in anaesthesia by the College must be advertised with that approval noted.

- 2.6 An Approved Hospital Department of Anaesthesia must be under the direction of a suitably qualified anaesthetist who is responsible for the organisation, teaching and service requirements of that Department.
- 2.7 A Supervisor of Training in Anaesthesia must be nominated by the Department of Anaesthesia and notified to College Council. It is not permissible for the Supervisor of Training to be the Director of the Department of Anaesthesia. This appointment requires ratification by Council. The duties of the Supervisor of Training are specified in College Professional Document TE5 Policy for Supervisors of Training in Anaesthesia.
- 2.8 There must be adequate supervision of trainees by specialist anaesthesia staff who hold the FANZCA or another qualification acceptable to Council (see College Professional Document TE3 Policy on Supervision of Clinical Experience for Vocational Trainees in Anaesthesia). Specialist anaesthesia staff must be familiar with the College's training program.
- 2.9 Trainees may be employed full or part-time. Their duties must include normal, emergency and out-of-hours supervised work. Part-time training is subject to the requirements of the relevant College Regulations.
- 2.10 The hospital must agree to notify Council via the Supervisor of Training and the Regional Education Officer of any changes that might affect training. Importance is placed on changes such as alterations in work-load and increases or decreases in the number of senior staff and trainees working in the Department.

### 2.11 The Department of Anaesthesia must have:

- 2.11.1 A minimum of one specialist anaesthetist who holds the FANZCA.
- 2.11.2 A minimum of two full time equivalent (FTE) specialist anaesthesia staff with qualifications acceptable to Council.
- 2.11.3 Sufficient FTE anaesthesia specialists to provide supervision for all trainees in accordance with College Professional Document TE3 Policy on Supervision of Clinical Experience for Vocational Trainees in Anaesthesia.
- 2.11.4 Adequate secretarial staff. Most departments will require at least one full-time secretary with several being needed in larger hospitals (see College Professional Document TE7 Recommendations on Secretarial and Support Services to Departments of Anaesthesia).
- 2.11.5 Adequate office space for the specialist staff.
- 2.11.6 Suitable study facilities for trainees.
- 2.11.7 Access to a suitable conference room for quality assurance, clinical review and educational activities.
- 2.11.8 Regular programs of quality assurance and teaching appropriate to the size of the department (see College Professional Document TE9 Quality Assurance)
- 2.11.9 Adequate library facilities with information sources appropriate to anaesthesia and its sub-specialities.



2.11.10 Ready access to appropriate computer facilities for specialists and trainees.

2.11.11 Access to clinical support services appropriate to the role of the hospital.

2.11.12 Anaesthesia specialists participating in the College's Maintenance of Professional Standards Program or its equivalent.

This Professional Document should be interpreted with regard to the following Documents:

PS4 *Recommendations for the Post-Anaesthesia Recovery Room*

PS6 *Recommendations on Minimum Requirements for the Anaesthesia Record*

PS7 *Recommendations on the Pre-Anaesthetic Consultation*

PS8 *Guidelines on the Assistant for the Anaesthetist*

PS18 *Recommendations on Monitoring During Anaesthesia*

T1 *Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations*

TE2 *Policy on Vocational Training Modules and Module Supervision*

TE3 *Policy on Supervision of Clinical Experience for Vocational Trainees in Anaesthesia*

TE4 *Policy on Duties of Regional Education Officers in Anaesthesia*

TE5 *Policy for Supervisors of Training in Anaesthesia*

TE6 *Guidelines on the Duties of an Anaesthetist*

TE7 *Guidelines for Secretarial and Support Services to Departments of Anaesthesia*

TE9 *Guidelines on Quality Assurance in Anaesthesia*

TE10 *Recommendations for Vocational Training Programs*

TE13 *Guidelines for the Provisional Fellowship Program*

TE17 *Policy on Advisors of Candidates for Anaesthesia Training*

PS44 *Guidelines to Fellows Acting on Appointments Committees for Senior Staff in Anaesthesia*

### **College Professional Documents**

College Professional Documents are progressively being coded as follows:

**TE** Training and Educational

**EX** Examinations

**PS** Professional Standards

**T** Technical

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

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

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

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

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

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

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

Promulgated (as E1): 1985  
Reviewed: 1991, 1996, 2003, 2005  
Date of current document: Sept 2005

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## **Policy Documents – Under Review**

In line with College policy, the following Policy Documents are due for review in 2006:

TE14 *Guidelines for the In-Training Assessment of Trainees in Anaesthesia*

EX1 *Examination Candidates Suffering from Illness, Accident or Disability*

PS2 *Statement on Credentialling in Anaesthesia*

PS6 *Recommendations on Minimum Requirements for the Anaesthesia Record*

PS12 *Statement on Smoking as Related to the Perioperative Period*

PS16 *Statement on the Standards of Practice of a Specialist Anaesthetist*

PS19 *Recommendations on Monitored Care by an Anaesthetist*

PS20 *Recommendations for Responsibilities of the Anaesthetist in the Post-Operative Period*

PS43 *Statement on Fatigue and the Anaesthetist*

PS44 *Guidelines to Fellows Acting on Appointments Committees for Senior Staff in Anaesthesia*

PS45 *Statement on Patients' Rights to Pain Management*

Council will welcome any input or suggestions relating to these documents which will be considered during the review.





## Professional Document: Review PS40 (2005)

**Australian and New Zealand College of Anaesthetists** ABN 82 055 042 852  
**Joint Faculty of Intensive Care Medicine and Faculty of Pain Medicine**

# Guidelines for the Relationship Between Fellows, Trainees, and the Healthcare Industry

These guidelines are intended to assist Fellows and Trainees of the College with professional and ethical matters which can arise from their involvement with the healthcare industry. It must always be remembered that while the healthcare industry generally makes its approaches to doctors, healthcare facilities or professional organisations, the ultimate beneficiary of the approach must be the patient

### 1. General Principles

- 1.1 There should be formal and open acknowledgement by the Fellow or group if they are in receipt of financial or material support from the healthcare industry for any professional activity.
- 1.2 An association between the College and the healthcare industry does not imply endorsement of the product or service being promoted by the industry. A specific disclaimer to this effect should be included with any associated publication.
- 1.3 Patient benefit should be the ultimate basis for any association with the healthcare industry.
- 1.4 During the negotiation of any agreement with which the College is directly or indirectly involved, all correspondence must refer to the College status of the negotiator. The final agreement must be subject to College approval. When negotiations are conducted in a personal capacity, no mention of a College affiliation can be made.

### 2. CME Meetings, Organised by the College and Sponsored by the Healthcare Industry

- 2.1 The meeting must be under the control of a College based organising Committee which may include appropriate

representation from the healthcare industry.

- 2.2 The support by the healthcare industry must be fully and formally acknowledged by the organising Committee.
- 2.3 There must be a disclaimer to separate that support from endorsement (by the College) of any service and/or products being promoted by the healthcare industry.
- 2.4 Any profit resulting directly or indirectly from support by the healthcare industry must be devoted to further educational or research activities.
- 2.5 Normal College guidelines for control of the meeting or any session of the meeting must be observed. It is not permissible for primary control of the meeting or any session of the meeting to be assumed by a member of the healthcare industry.

### 3. CME Meetings, Organised by the Healthcare Industry

- 3.1 When a member of the healthcare industry takes responsibility for a meeting, the College should not be associated with that meeting and specifically should not endorse any service or product being promoted by the meeting.
- 3.2 The decision whether to attend commercially organised meetings as in 3.1 (often with an associated social activity), should be made having regard to the General Principles.
- 3.3 Fellows and trainees speaking at commercially organised meetings should

consider the General Principles. They should be aware that they are not representing the College, and should not purport to represent the College.

### 4. Research Projects

- 4.1 It is accepted that the healthcare industry is a major sponsor of research. It is essential that a written contract be established between all parties involved. The contract should involve a neutral third party such as a University, a hospital or a Research Foundation. The contract should be subject to the rules of the third party with all financial arrangements being channeled through them.
- 4.2 Normal Ethical Committee procedures must be followed and must include full prospective disclosure of the proposed commercial association. This will also apply when seeking patient consent for their participation in any such study.
- 4.3 If a prize is offered for work performed by a Fellow or trainee, the selection of the prizewinner must be entirely under the control of an appropriately constituted and independent Committee.

### 5. Industry Sponsored Employment

- 5.1 Where funding is provided in whole or in part for an employed or training position, it is essential that this be paid through a neutral third party such as the Hospital or University responsible for employment of the Fellow or trainee. All matters related to employment must be subject to the normal rules of the employer.

### 6. Travel

- 6.1 Funds offered on a personal basis to



facilitate attendance at an educational activity should be carefully considered having regard to the General Principles noted above. Funding should always be acknowledged in any presentation or report. A letter of thanks may be useful and should be copied to the organisers of the educational activity.

- 6.2 Travel and tour expenses for a commercially sponsored educational visit to other centres should be considered in terms of the likely professional benefit to all involved. It is essential that talks or lectures are presented in an unbiased manner while acknowledging the support given. A specific disclaimer in respect of the sponsor's services or product may be appropriate.

#### **College Professional Documents**

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# Australian and New Zealand College of Anaesthetists

## Professional Documents

**NOTE: All Professional Documents are on the College website at [www.anzca.edu.au](http://www.anzca.edu.au)**

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

- TE1 (2005) Recommendations for Hospitals Seeking College Approval for Vocational Training in Anaesthesia Bulletin November 2005, Page 77
- TE2 (2003) Policy on Vocational Training Modules and Module Supervision 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
- PS2 (2001) Statement on Credentialling in Anaesthesia Bulletin March 2002, Page 65
- PS3 (2003) Guidelines for the Management of Major Regional Analgesia Bulletin March 2003 , pg 70
- PS4 (2000) Recommendations for the Post-Anaesthesia Recovery Room Bulletin November 2000, pg 72
- PS6 (2001) Recommendations on the Recording of an Episode of Anaesthesia Care (the Anaesthesia Record) Bulletin November 2001, pg 77
- PS7 (2003) Recommendations on the Pre-Anaesthesia Consultation Bulletin November 2003, pg 87
- PS8 (2003) Guidelines on the Assistant for the Anaesthetist Bulletin November 2003, pg 89
- PS9 (2001) Guidelines on Conscious Sedation for Diagnostic, Interventional Medical and Surgical Procedures Bulletin June 2001, pg 88



- PS10 (2004) Guidelines on the Handover of Responsibility During an Anaesthetic Bulletin November 2004, pg 79
- PS12 (2001) Statement on Smoking as Related to the Perioperative Period Bulletin November 2001, pg 79
- 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
- PS16 (2001) Statement on the Standards of Practice of a Specialist Anaesthetist Bulletin November 2001, pg 81
- PS18 (2000) Recommendations on Monitoring During Anaesthesia Bulletin November 2000, pg 78
- PS19 (2001) Recommendations on Monitored Care by an Anaesthetist Bulletin November 2001, pg 82
- PS20 (2001) Recommendations for Responsibilities of the Anaesthetist in the Post-Operative Period Bulletin November 2001, pg 83
- PS21 (2003) Guidelines on Conscious Sedation for Dental Procedures Bulletin June 2003, pg 93
- PS24 (2004) Guidelines on Sedation for Gastrointestinal Endoscopic Procedures Bulletin August 2004, pg 66
- PS26 (2005) Guidelines on Consent for Anaesthesia or Sedation Bulletin June 2005, pg 102
- PS27 (2004) Guidelines for Fellows who Practice Major Extracorporeal Perfusion Bulletin February 2004, pg 66
- PS28 (2005) Guidelines on Infection Control in Anaesthesia Bulletin February 2005, pg 59
- PS29 (2002) Statement on Anaesthesia Care of Children in Healthcare Facilities without Dedicated Paediatric Facilities Bulletin November 2002, pg 80
- PS31 (2003) Recommendations on Checking Anaesthesia Delivery Systems Bulletin August 2003, pg 85
- PS37 (2004) Statement on Local Anaesthesia and Allied Health Practitioners Bulletin February 2004, pg 69
- PS38 (2004) Statement Relating to the Relief of Pain and Suffering and End of Life Decisions Bulletin November 2004, pg 80
- PS39 (2003) Minimum Standards for Intrahospital Transport of Critically Ill Patients Bulletin June 2003, pg 90
- PS40 (2005) Guidelines for the Relationship Between Fellows, Trainees and the Healthcare Industry Bulletin November 2005, pg 79
- PS41 (2000) Guidelines on Acute Pain Management Bulletin November 2000, pg 80
- PS42 (2000) Recommendations for Staffing of Departments of Anaesthesia Bulletin March 2001, pg 63
- PS43 (2001) Statement on Fatigue and the Anaesthetist Bulletin March 2002, pg 69
- PS44 (2001) Guidelines to Fellows Acting on Appointments Committees for Senior Staff in Anaesthesia Bulletin March 2002, pg 71
- PS45 (2001) Statement on Patients' Rights to Pain Management Bulletin March 2002, pg 72
- PS46 (2004) Recommendations for Training and Practice of Diagnostic Perioperative Transoesophageal Echocardiography in Adults Bulletin February 2004, pg 70
- PS47 (2002) Guidelines for Hospitals Seeking College Approval of Posts for Vocational Training in Diving and Hyperbaric Medicine Bulletin November 2002, pg 82
- PS48 (2003) Statement on Clinical Principles for Procedural Sedation Bulletin June 2003, pg 97
- PS49 (2003) Guidelines on the Health of Specialists and Trainees Bulletin August 2003, pg 89
- PS50 (2004) Recommendations on Practice Re-entry for a Specialist Anaesthetist Bulletin February 2004, pg 73