Australian and New Zealand College of Anaesthetists

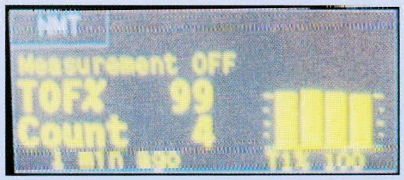
ABN 82 055 042 852

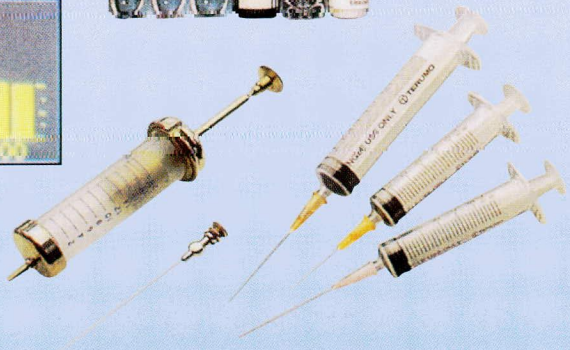
Joint Faculty of Intensive Care Medicine
Faculty of Pain Medicine

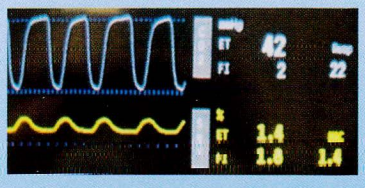
Bulletin

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

Inside ....







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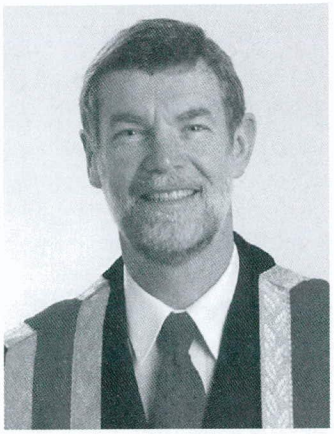


President's Message

Richard J Willis, ANZCA

The major challenge facing ANZCA in 2003 is the preparation and implementation of the first major revision of the training program since the introduction of the Objectives of Training in 1976. The aims of this revision include the following: to better define the learning objectives; to develop a structured but flexible program; to use the techniques of self-assessment, adult-learning and web-based learning and assessment; to include new topics such as communication, ethics, management, personal and community health and health infrastructure; to increase trainee 'ownership' of their training program with a greater focus on discussion with supervisors and on in-training assessment; to fulfill the Australian Medical Council's requirements for accreditation of medical specialty education and training programs.

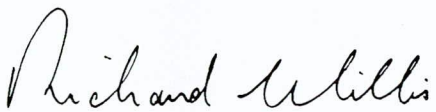
Most Fellows working in hospitals that currently have accredited posts for ANZCA trainees will be aware of the details of this revised program. Full details of the revised curriculum are available on the ANZCA website but esssential elements are as follows:

- The five year training period will be divided into two years of basic training (BTY 1 and 2) and three years of advanced training (ATY 1, 2 and 3).
- The curriculum consists of 12 modules that cover all aspects of required knowledge, skills and attitudes.
- The 12 modules include basic anaesthesia and peri-operative care, professional attributes, professional practice, evidence based medicine and formal project, as well as all the clinical subspecialties including intensive care and pain medicine.
- Modules do not necessarily involve a committed continuous block period of time, although that may be desirable where possible. Hence some modules may involve experience gained at different hospitals. The aim is to maintain flexibility rather than be overly prescriptive.
- The process for completion of most modules will involve trainee self-assessment in association with discussion with module supervisors. A more complex process would impose an unacceptable load on supervisors.
- There will be web-based assessments for the two professional issues modules, and the formal project assessment will be similar to the present process.
- The Primary and Final examinations will continue. Some proposed changes to the Primary will not be implemented until at least 12 months have passed from the time of notification of the changes.
- Trainees will maintain their own 'Learning Portfolio' that will contain a record of all their training details as well as a record of their learning objectives and achievements.
- The implementation date for all trainees will be the commencement of the 2004 hospital year with the important proviso that no current trainees will be disadvantaged.
- A Provisional Fellowship program will be available for those in ATY 3 who have completed all clinical modules and passed the final examination. Other trainees may use part or all of ATY 3 to complete these requirements.

The above details are only a broad outline of the revision to the training program. Recently, our main effort has been directed at finalizing the necessary changes to the College Regulations to ensure the details of the revision and the implementation process are clear. This has now been completed and will be circulated soon to trainees and supervisors.

Coincident with the introduction of the revised training program has been the necessity to ensure that potential trainees (not filling accredited training posts) are not working alongside ANZCA trainees with similar duties differing in name only, unless there are sound educational reasons for doing so. Such reasons could include availability of sufficient educational opportunities and adequacy of supervision. It is important to note that any proposed changes to the current accreditation process are quite separate from the introduction of the revised FANZCA training program as this has caused confusion in some areas. Further details and guidelines for trainee selection will be available in the near future when specific potential problems in some areas have been worked through.

I continue to be impressed by the huge amount of work done gratis by Fellows for the benefit of others in the profession. Fellows' contributions are made to many aspects of our profession, but each year the Annual Scientific Meeting provides obvious evidence of one aspect of this work. The immensely successful ASM held recently in Hobart was, in all respects, an outstanding achievement from the Australian state with the smallest number of Fellows. On behalf of all College Fellows, I thank the Convenors and the Organising Committee for their organization of a wonderful four days of science, education and fellowship.



Richard Willis
President

ALERT!!!

Operating Room Fire

The College has become aware of a number of fires in operating rooms over the last 12 months in Australia and New Zealand. Details are often not available until an inquiry has been held or an article published.

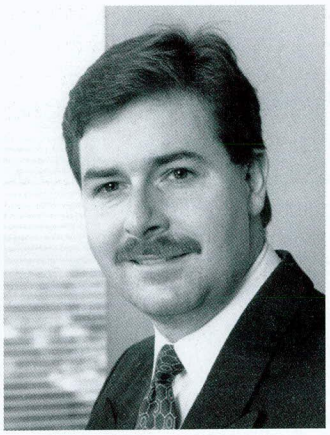
The most common cause of fire in the operating room relates to an ***ignition source***, usually in the hands of the surgeon, an ***oxidiser***, which may include air, nitrous oxide or oxygen, and ***fuel***, which may include almost any material in contact with patient and staff, volatile chemicals (especially alcohol based solutions) and the body.

While the principles of fire prevention and management are well understood, it is of concern that accidents continue to happen.

Prevention and management of fires in the operating room are discussed in:

- Health Devices, January 2003, "Focus on Surgical Fire Safety".
- New Zealand Fire Service, Fire Service Report (www.fire.org.nz/news/media/2002)

It is recommended that all anaesthetists should participate in a review of their role in fire prevention and management in any location where anaesthesia is provided.



Law Report

Michael Gorton LLB., B.Comm, FRACS (Hon), FANZCA (Hon)
College Honorary Solicitor
Partner – Russell Kennedy, Solicitors

Governance and Legal Risk Management

Issues of governance, clinical governance, legal risk and related terms are much bandied about.

The concepts have different meanings to different people, including:

- **Minimising Liability** – particularly steps to reduce liability and exposure.
- **Accountability** – improving accountability and transparency within organisations, particularly decision making.
- **Risk management** – dealing with legal risk, financial risk and business risk within an enterprise.
- **Compliance** – meeting statutory, regulatory and other requirements.

In the usual context it relates to how Boards of Management can be satisfied that risks and liabilities within an enterprise are being addressed. Boards, with personal liability as directors of the company, want to be satisfied that any issues which may give rise to personal liability have been adequately addressed within the enterprise.

Moving towards better governance includes addressing such issues as organisational culture, staff knowledge and values, system design, resources and appropriate management models. There is a need to identify and comply with appropriate standards within the enterprise, depending on the nature of its activities. There should be a culture which recognises the opportunity cost to the organisation of doing it wrong, and the benefits to the organisation of getting it right.

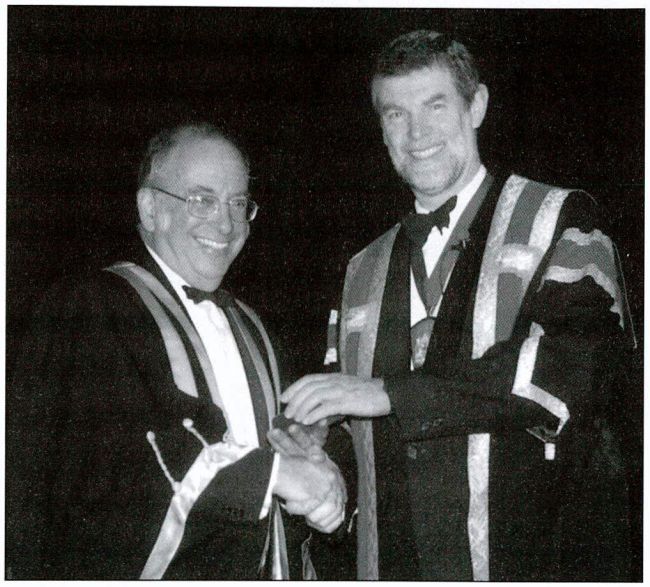
Key governance issues for organisations, particularly in health and aged care, can involve an **audit** of current processes and structures including:

- Reviewing levels of **delegation**, to ensure that the appropriate people in the organisation only have sufficient authority to bind the organisation commensurate with their tasks and duties.
- A system of **accountability** and **reporting** regimes – to ensure that urgent issues are raised through appropriate channels and that regular reporting proceeds up the line to the CEO, and ultimately the Board.
- Appropriate **policies** and procedures – the raft of issues which a modern enterprise must cover including OH&S,EO, privacy, care and safety, statutory compliance.
- **Education** and **training** – it is not sufficient to merely have appropriate policies. Staff must be properly trained and educated.
- Notice requirements, **compliance** checklist and sign off – a system by which management at various levels of the organisation 'sign off' in relation to compliance within their area and notification of any breach or incident.
- **Complaint handling** – a system to deal with instances which arise and complaints received.

For many organisations, a 'legal risk audit' can help to identify those areas where systems may be lacking or inadequate. A legal risk audit would concentrate on those areas which can expose an organisation to the most liability. A review will also identify whether the organisation, as a whole, has appropriate systems and processes in place to deal with these key governance issues.

A compliance checklist can be developed for an enterprise which assists both identification of risk, identification of inadequacies within the organisation and provide assurance to management and the Board that statutory and regulatory compliance has occurred.

Legal advisers can assist in the development of compliance manuals, carrying out 'legal risk audits' and the development of appropriate checklists and reporting processes, in order to minimise exposure to legal risk, and enhance compliance with legal obligations.



Australian and New Zealand College of Anaesthetists' Medal

Citation – Ian Rechtman

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

Mr President, it is my privilege to present to you Ian Rechtman for the award of the Australian and New Zealand College of Anaesthetists' Medal.

Ian Rechtman was born in Melbourne and attended Princes Hill Primary School and then Northcote High School. He was accepted into the Faculty of Medicine at The University of Melbourne and graduated in 1962. Two years earlier he married Mary, a fellow student. Bravely their first son Philip was born just prior to the final MBBS examination and later Andrew arrived immediately following the Final Fellowship Examination. Philip and his wife Dina have produced the two little "chickens" Rachelle and Marilyn for their doting grandparents.

Ian first worked as a Junior Resident Medical Officer at what was formerly the Footscray and District Hospital. He was then accepted into a training position at the Austin Hospital and subsequently moved to The Alfred Hospital to complete his training. He was awarded Fellowship of the Faculty of Anaesthetists, RACS in 1967.

After a year as a Staff Anaesthetist at The Alfred Hospital he was appointed a sessional anaesthetist at Western General and Box Hill Hospitals. He established the Intensive Care Unit at Western General Hospital where he was the inaugural Director. One can only wonder how he managed to cover the city from Box Hill in the east to Footscray in the west with interests in both anaesthesia and intensive care. He later joined the Victorian Anaesthetic Group and continued his appointment at The Alfred as a Visiting Anaesthetist.

Ian first joined the Victorian Regional Committee in 1975. He held the positions of Honorary Secretary, Continuing Medical Education Officer and was Chairman from 1987-1990. During his years as Chairman he was an enthusiastic member of the Victorian Chairs of Anaesthesia Appeal to which he gave enormous support.

1991 was a particularly busy year for Ian with his appointment to the Panel of Examiners and election to the Board of the Faculty of Anaesthetists, RACS, and later the College Council. As an Examiner, he was a contributor with his characteristic enthusiasm and generosity. As a member of College Council he held the position of Assessor, Library Officer and Chairman of the Hospital Accreditation Committee. One of Ian's highlights was to identify "Ulimaroa" as a suitable home for our new College. He is immensely proud of "Ulimaroa" and was excited at the development and building of ANZCA House.

Ian joined the RAAF Reserve where he served giving anaesthetics at Butterworth in Malaysia and Laverton Base Hospital. He gained the rank of Wing Commander.

When Ian retired from Council, the Victorian Regional Committee held a reception at "Ulimaroa" to mark his contributions to the Faculty and College which spanned over 25 years. He has been remarkable as a faithful and dedicated servant of the College. On the nomination of the Victorian Regional Committee, Council awarded Ian a College Citation recognising his enormous personal and professional contributions over the years.

Ian's outstanding characteristics are his generosity and his enthusiasm. They are reflected in his personal and professional life. His generosity is demonstrated in his professional life through his relationships, his teaching of trainees in the operating room, his preparation of candidates for the Final Fellowship Examination and his commitment to the College. Literally generations of us have enjoyed Rechtman hospitality as dinner guests, our inclusion in celebrations and following hours of examination practice, rewarded with delicious refreshments.

A significant contribution to the College which is more difficult to measure and yet, perhaps, most important, has been his role in developing and maintaining our relationships in Asia, especially in Hong Kong. Ian's warmth, generosity and enthusiasm have been invaluable.

Tonight it is my great personal pleasure on behalf of the Australian and New Zealand College of Anaesthetists to recognise Ian Rechtman's contribution to the College and our profession.

Mr President, I present to you Ian Rechtman for the award of the Australian and New Zealand College of Anaesthetists' Medal.

Australian and New Zealand College of Anaesthetists' Medal

Citation – Margaret Stuart Smith, OBE QJM

Mr President, it is my privilege to present to you Margaret Stuart Smith for the award of the Australian and New Zealand College of Anaesthetists' Medal.

Margaret Riddell was born and educated in Wellington, attended Victoria and Otago Universities, and graduated with her medical degree in 1936. After completing her two house-surgeon years in Wellington Hospital, Dr Riddell travelled to Britain for anaesthetic training, working at Great Ormond Street and Leicester Royal Infirmary. She gained her Diploma of Anaesthetics of the Royal College of Surgeons and the Royal College of Physicians in 1939, being the first New Zealand woman to do so. This was to be a continuing theme in her career, as she became an example and a leader to New Zealand medical women. Dr Riddell remained in Britain during the Second World War, where she provided valuable service to wounded servicemen, although her particular interest was paediatric anaesthesia. During her time in Britain she was responsible for setting up the anaesthetic department in the EMS Hospital attached to Edinburgh Royal Infirmary.

After the war she returned to New Zealand to commence work in Christchurch, and in the same year married Carl Smith. Dr Smith, as she then became, took up a position as consultant specialist anaesthetist at Christchurch Hospital, again being the first woman to do so. She continued to work in public and private anaesthetic practice in Christchurch until her retirement in 1982. Her special interest was paediatric anaesthesia, and she was an active teacher of many future anaesthetists. As well she undertook the daunting task of providing anaesthesia in the radiology department for patients undergoing pneumo-encephalography. In 1952 Dr Smith was made a Foundation Fellow of the new Faculty of Anaesthetists, Royal Australasian College of Surgeons, one of only six New Zealanders, and the only New Zealand woman.

Dr Smith was very active in the New Zealand medical and anaesthetic community. She was the first female President of the New Zealand Society of Anaesthetists in 1976 - 77, and was the only female President until our current President.

Her contributions to the medical community were not limited to anaesthesia; she was involved in the Medical Association of New Zealand, and the New Zealand Medical Women's Association. She was the Chair of the Christchurch Branch in the 1960s, and the Medical Archivist of the Canterbury Branch for an extended period.

Dr Smith served the community in many ways, and was recognised by Her Majesty the Queen for that work with a Queen's Silver Jubilee Medal (QJM) in 1977, and an Order of the British Empire (OBE) in 1990. She is a life member of the National Council of Women, was the President of the Christchurch Branch in the 1970s, and their representative on the Canterbury Medical Research Foundation. She was a committee member of the International Women's Year in 1975, and of the Regional Women's Decade, and is a charter member of the women's service organisation Zonta. She was also a member of the Social Development Council in the1970s. Dr Smith was a lector in Christchurch Cathedral.

As well as Dr Smith's service to anaesthesia and to the community, she raised three children, two of whom are now medically qualified. With the support of her husband, and very good organisation, she was able to combine medical and family life, so that from her qualification in 1936 until her retirement in 1982, she had no breaks from medical practice.

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

Mr President, I present to you Margaret Stuart Smith, OBE QJM for the award of the Australian and New Zealand College of Anaesthetists' Medal.

Honours and Appointments:

Dr Patricia Mackay (Vic) – Centenary Medal
Dr James Wilkinson (NSW) – Master of Health Law, University of Sydney
Professor Tess Cramond (Qld) – Centenary Medal
Dr Brian Pollard (NSW) – Centenary Medal
A/Professor Richard Walsh (NSW) – Centenary Medal
Professor Teik Oh (WA) – Fellowship of the College of Anaesthetists, Colleges of Medicine of South Africa

Assoc. Prof. Paul Myles, recipient of the 2003 Organon Research Award with Mr Erik de Nooij, Associate Product Manager, Organon Australia.

Erratum

Joint Consultative Committee on Anaesthesia – Paediatric Anaesthesia Policy

The incorrect version of the amended JCCA Policy on Paediatric Anaesthesia was published in the June 2003 Bulletin (Council Highlights pg. 8). The correct version follows:

Council endorsed the JCCA policy:
That endorsement for elective paediatric anaesthetics down to age 12 months may be granted on an individual practitioner basis after demonstration of the need for such endorsement and assessment/accreditation by regional representatives of the JCCA. Such endorsement to be related to the area of need, the individual's documented training in paediatric anaesthesia to the age of 12 months, and be dependent on the maintenance of professional standards.

Australian and New Zealand College of Anaesthetists

Workforce Survey 2002

All Fellows

In November 2001, a workforce questionnaire was sent out with annual subscription notices to all active Fellows of the Australian and New Zealand College of Anaesthetists (ANZCA).

Of the 3137 practicing ANZCA Fellows, 1748 returned questionnaires, with a response rate of 56%. Six of the respondents indicated that they had now retired from practice. Analysis of the remaining 1742 questionnaires from active fellows gives the following results. (Not all respondents answered all questions).

The following report includes all respondents to the Workforce 2002 survey in active practice.

	Number of Active Respondents	Number of Active ANZCA Fellows	Response Rate
All ANZCA Fellows	1742	3137	56%
Australia	1329	2364	56%
New Zealand	252	359	70%
Asian	104	230	45%
Other Nations	56	162	35%

DEMOGRAPHIC DATA

- **Gender**

  According to the 2002 ANZCA Workforce Survey, the gender distribution of ANZCA Fellows internationally is approximately 80% male to 20% female. This distribution is consistent with the last workforce survey in 1999, and with the ANZCA database. In Australia the percentage of male respondents was 81.1% and female 18.9%. New Zealand (252 respondents) had 78.3% male and 21.7% female. However it was found that Asia (104 respondents) had a noticeably lower proportion of male respondents with 66.3% male and 33.7% female.

- **Age**

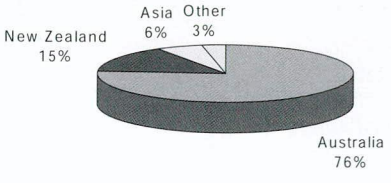
  The average age for all survey respondents was found to be 46.2 years, (compared to 47.4 in 1999). There were no respondents younger than 30, and very few older than 70. The majority of respondents were aged between 40-49 years. The average age of Australian Fellows was 46.2, compared to 46.6 for New Zealand Fellows and 44.1 for Asian Fellows.

  The average age for all Fellows according to the ANZCA database is 48.6 years.

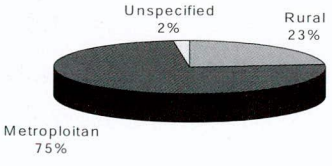
- **Region of Practice**

  The majority of ANZCA Fellows (76%) are based in Australia. Within Australia, the distribution of anaesthetists matches population distribution quite closely.

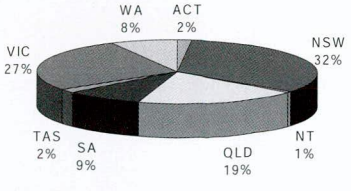
Respondents by Region



Rural vs. Metropolitan Fellows



Distribution in Australia

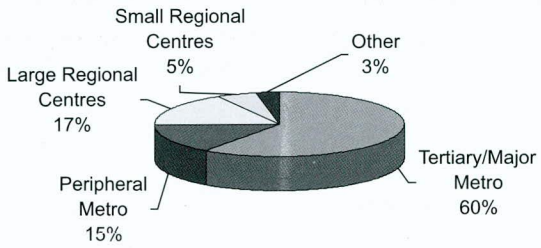


- **Hospital Type**

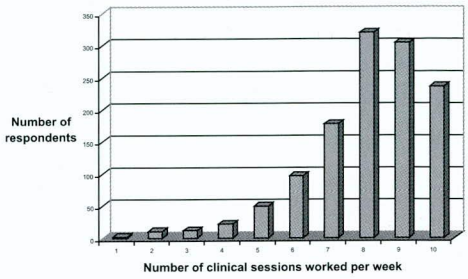
The distribution of ANZCA Fellows in terms of hospitals has not changed significantly since 1999.

	2002 Respondents	2002	1999
Tertiary / Major Metro	1048	60%	62%
Peripheral Metro	254	15%	14%
Large Regional Centre	298	17%	20%
Small Regional Centre	83	5%	2%
Other / Unspecified	59	3%	2%

Hospital Type



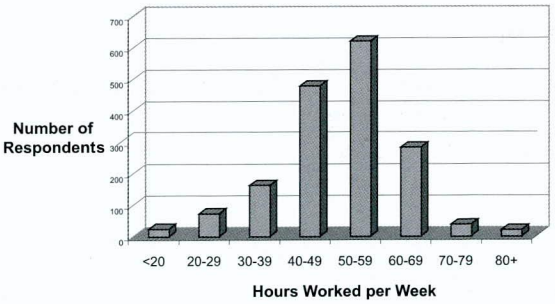
Average Clinical Session / Week Worked



WORKFORCE DATA

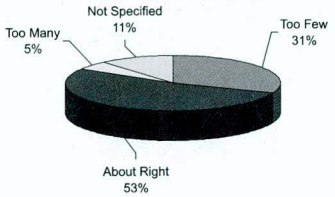
- Clinical anaesthesia is the main area of work for 86% of the 2002 ANZCA Workforce, while 9% work mainly in intensive care, and 5% work mainly in pain medicine.
- 1551 (89%) of respondents work full time, and 191 (11%) work part time. The average expected age of retirement for ANZCA Fellows is 65.5 years.
- 1464 (84%) of Fellows work at least one session a week in public anaesthesia.
- 1281 (74%) of all Fellows work at least one session a week in private anaesthesia.
- 1003 (58%) of all Fellows participate in both public and private anaesthesia on a weekly basis.

- In a standard working week, full time ANZCA Fellows:
  - work an average of 50.9 hours.
  - are on call an average of 23.1 hours.
  - spend an average of 8.8 hours working after hours.
  - work an average of 8.3 clinical sessions



- ANZCA Fellows work an average of 46 weeks per year, and are on call an average of 6.5 days per month.
- In 2002, only 59% of Fellows were satisfied with their current workload, (compared to 68% in 1999.) 36% of respondents would prefer less work, and 4% would prefer more work.
- 53% of respondents were satisfied with the number of anaesthetists currently in practice. 31% of respondents believed there were not enough anaesthetists in practice (compared to only 20% in 1999).

Opinion on Number of Anaesthetists in Practice



SUMMARY

Although there are some indicators to suggest an undersupply of active anesthetists in Australia, the 2002 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 population.

Furthermore, the Australian and New Zealand College of Anaesthetists has adjusted both its intake levels, and its number of graduates per year in order to meet future projections.

The data obtained by this study can be used by both ANZCA and government bodies to improve the match of supply to demand for specialist anaesthesia services.

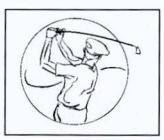
The response rate for ANZCA Workforce surveys has been on the decline since 1994. The response rates for ANZCA Surveys in the past have been 63% in 1994 and 60% in 1999. The 2002 response rate was only 56%.

We strongly recommend all Fellows to return their surveys and help increase this response rate in years to come. A higher response rate not only improves the statistical accuracy of reports such as this, but also helps us shape a better picture of the anaesthesia workforce in general.

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

Irish Delegation

The Irish Department of Health recently organised a fact finding trip to South Africa, Australia and New Zealand. Representatives (Dr Ian Surgeon, Postgraduate Dean, College of Anaesthetists, RCSI; Professor Oscar Traynor, Dean, Postgraduate Studies, Royal College of Surgeons Ireland; Dr Tony Peirce, Royal College of Physicians Ireland; Mr John Cregan, Irish Department of Health and Dr Ray Power, CEO, Locumotion) met with the College President, Dr Richard Willis to discuss a range of issues with regard to training.

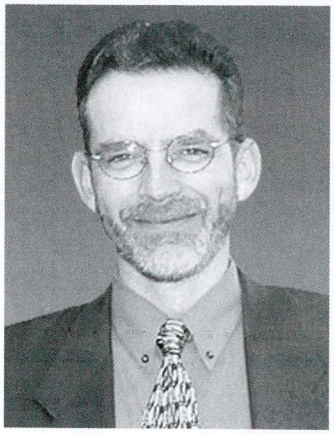


ASM 2003

Hobart Golf Tournament

The Golf Tournament for the ANZCA ASM Meeting took place at the Royal Hobart Golf Club. This was a magnificent course in very good condition and the day was perfect for Golf. Michael Davies and the conference secretariat organised a great day, which was appreciated by 38 players who played for the various competitions. Dr Tim Costello with a handicap of 18 was the winner of the ANZCA Golf Trophy with a score of +5, Roger Barker was runner up on +2. We all look forward to the ANZCA golf at the ASM in Perth where John Rigg will assist the local organisers in arranging the tournament.

Dr Tim Costello with Assoc. Professor Michael Davies



Education Report

RUSSELL W. JONES, Director of Education, ANZCA

Use of a variety of assessments is essential for the accurate evaluation of the complex knowledge, skills and attitudes that combine to make a Specialist Anaesthetist. An important contributor to the success of the FANZCA Training Program has been its reliance on multiple methods of assessment. These methods each have their own strengths and weaknesses and, together, aid in building an accurate picture of a Trainee's abilities. The methods include feedback from Supervisors of Training (SOTs) and other Specialists (eg, via in-training assessments), multiple-choice questions (MCQs), short-answer questions (SAQs) and viva questions (as part of the Primary and Final Examinations), and the Formal Project. Diagrammatically they are represented in Figure 1. Introduction of the revised FANZCA allows for the addition of Trainee self-assessment to aid in the training process. It is important to emphasise that incorporation of Trainee self-assessment into the FANZCA Training Program will not supplant any existing assessment procedures. Rather the use of Trainee self-assessment will provide additional evaluative information.

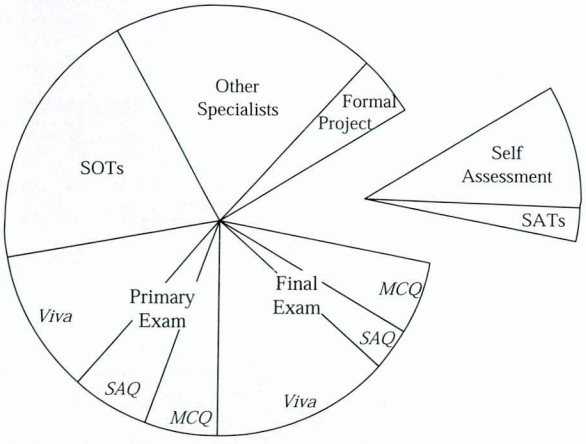


Figure 1. Model showing how a variety of assessment techniques contribute to a complete picture of a Trainee's abilities.

Self-Assessment Tests

Modules 2 (Professional Attributes) and 12 (Professional Practice) of the Revised FANZCA Training Program will include Self Assessment Tests (SATs). Each SAT will comprise 40 multiple-choice questions. Trainees will apply to sit SATs after they have mastered the objectives in modules 2 and 12. SATs are web-based and will require Trainees to log onto the ANZCA website. They are similar to normal examinations except Trainees are able to work through the questions at their own pace and at their convenience. Use of the web will allow immediate feedback of results to the Trainee and College.

Trainee Self-Assessment

It is the nature of the profession that, once qualified, an individual practitioner conducts his or her practice with little regulation from bodies external to the profession[1]. Thus it falls to the individual Specialist to decide what, when and how they update their abilities. Effectiveness of this updating is very much dependent on self-directed and lifelong learning capabilities[2]. Furthermore, although Specialists may be subject to informal peer review from colleagues, many, particularly those in small to moderate practices may have little opportunity to assess (or be assessed by) others. Consequently assessing oneself becomes a central skill in maintaining professional competence[1].

In order for Trainees "to acquire lifelong learning skills, they must develop the ability to critically evaluate themselves"[3]. One of the key aims of the FANZCA Training Program is to ensure the Trainee undergoes a transition from a largely teacher-directed experience to self-directed learning in everyday practice[4] that they can apply throughout their post training professional practice.

Accepting that self-assessment is an essential skill for a Specialist to develop as part of their training, how good are Trainees at self-assessment? Several studies[3,5,6,7] reveal

Trainees to be poor at self-assessment. Trainees tend to be poor at self-assessment because they are not taught self-assessment skills during their training. Like any other skill, Trainees first need to be introduced to the concept and then practiced in the skill before they become sufficiently professionally proficient to incorporate it into their own behaviours[3]. This is summarised in the Skill Spiral shown in Figure 2.

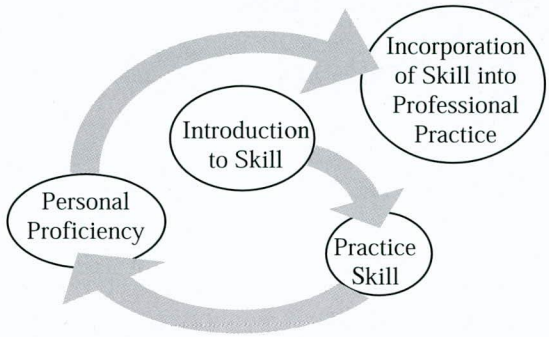


Figure 2. The Skill Spiral.

Thus the question becomes, does Trainee self-assessment improve with practice? Numerous studies[8,9,10,11,12] reveal it does. It has also been shown that Trainees' self-assessment abilities are consistent over different types of skills and tasks[2]. That is, once Trainees understand how to self-assess they can apply that self-assessment across the varied aspects of their professional practice.

Benefits of Self-Assessment

Having established that self-assessment is an essential skill for Trainees to master prior to leaving the formal training program, and that it is not going to take responsibility away from Supervisors and other Specialists who have traditionally been involved in the assessment process, how will it help Supervisors and other Instructors? Self-assessment offers the following advantages:

- Places greater responsibility for learning on the Trainee
- Motivates the Trainee to improve knowledge and skills[13]
- Gives participants greater ownership over the evaluation process[14]
- Offers Supervisors and other Instructors an additional device to study and interpret Trainee behaviour[3]
- Can influence the Trainee's behaviour so as to increase their compliance with standards[15,16]
- Can improve communication between Supervisors and Trainees[17]
- Clarifies areas for improvement[18]

Furthermore, the research literature tells us self-assessment:

- Serves as an aid in professional development[14]
- Enhances self-esteem[18]
- Develops self-awareness[18]
- Is of paramount importance for:
    - o Continuing professional competence[1,11,19]
    - o Life long learning[3,20,21]
    - o Problem-based learning activities[1]
    - o Adult learning[1]
- Has merit as a measure of non-cognitive abilities associated with clinical performance[22]

In summary, "one aim of ... medical education is to produce competent [Specialists] who can judge the quality of their work, recognise deficiencies, and improve future performance"[19]. As self-assessment "skills are important in the development of lifelong learning habits, then it should be a goal of our curricula to foster and develop these skills in our [Trainees]. Like any other skills, self-assessment skills must be practiced in order for them to improve."[3]. It is best that they be introduced and practiced during FANZCA training so they can be effectively applied throughout the potentially long professional life of our Trainees and Specialists.

1 Reiter HI, Eva KW, Hatala RM & Norman GR. Self and peer assessment in tutorials: application of a relative-ranking model. *Acad Med* 2002; 77(11): 1134-9.

2 Fitzgerald JT, Gruppen LD & White CB. The influence of task formats on the accuracy of medical students' self-assessments. *Acad Med* 2000; 75(7): 737-41.

3 Sullivan ME, Hitchcock MA & Dunnington GL. Peer and self assessment during problem-based tutorials. *Am J Surg* 1999; 177: 266-9.

4 Gruppen LD, White C, Fitzgerald JT, Grum CM & Woolliscroft JO. Medical students' self-assessments and their allocations of learning time. *Acad Med* 2000; 75(4): 374-9.

5 Ginsburg S, Regehr G, Hatala R et al. Context, conflict, and resolution: a conceptual framework for evaluating professionalism. *Acad Med* 2000; 75: S6-11.

6 Jankowski J, Crombie I, Block R et al. Self-assessment of medical knowledge: do physicians overestimate or underestimate? *J R Coll Phys* 1991; 25: 306-8.

7 Risucci DA, Tortolani AJ & Ward RJ. Ratings of surgical residents by self, supervisors and peers. *Surg Gynecol Obstet* 1989; 169: 519-26.

8 MacDonald J, Williams RG & Rogers DA. Self-assessment in simulation-based surgical skills training. *Am J Surg* 2003; 185: 319-22.

9 Smith CD, Farrell TM, McNatt SS & Metreveli RE. Assessing laparoscopic manipulative skills. *Am J Surg* 2001; 181: 547-50.

10 Woolliscroft JO, TenHaken J, Smith J & Calhoun JG. Medical Students' clinical self-assessments: comparisons with external measures of performance and the students' self-assessments of overall performance and effort. *Acad Med* 1993; 68(4): 285-94.

11 Gordon MJ. A review of the validity and accuracy of self-assessments in health professions training. *Acad Med* 1991; 66(12): 762-9.

12 Calhoun JG, Ten Haken JD & Woolliscroft JO. Medical students' development of self- and peer-assessment skills: a longitudinal study. *Teach Learn Med* 1990; 2:25-9.

13 Zabarenko R & Zabarenko L. *The Doctor Tree*. Pittsburgh: University of Pittsburgh; 1978.

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16 Love KG & Hughes FV. Relationship of self-assessment ratings and written test score: implications for law enforcement promotional systems. *Pub Pers Man* 1994; 23(1): 19-29.

17 Harris MM & Schaubroeck J. A meta-analysis of self-supervisor, self-peer, and peer-supervisor ratings. *Pers Psych* 1988; 41: 43-62.

18 Best M, Carswell RJB & Abott SD. Self-evaluation for nursing students. *Nurs Outlook* 1990; 38(4): 172-7.

19 Murdoch-Eaton D. Reflective practice skills in undergraduates. *Acad Med* 2002; 77(7): 734.

20 Barrows HS & Tamblyn RM. Self-assessment units. *J Med Educ* 1976; 51: 334-6.

21 Keck JW, Arnold L, Willoughby L & Calkins V. Efficacy of cognitive/non-cognitive measures in predicting resident-physician performance. *J Med Educ* 1979; 54: 759-65.

22 Arnold L, Willoughby TL & Calkins EV. Self-evaluation in under-graduate medical education: a longitudinal perspective. *J Med Educ* 1985; 60: 21-8.

Overseas Trained Specialists Performance Assessment

The following candidates have completed the requirements of the Overseas Trained Specialists Assessment Process and been admitted to Fellowship:

Helen Lesley ASHWORTH	NSW
Helen Margaret JEFFREY	NSW

Deaths

The death of the following Fellow is noted with regret:

Dr John Hamilton Stace (SA) – FFARACS 1952, FANZCA 1992
Dr Trevor Talbot Currie (VIC) – FFARACS 1956, FANZCA 1992
Dr Kevin John Byers (NSW) – FFARACS 1956, FANZCA 1992

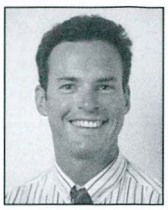
Primary Examination

March/April 2003

Front: Drs Neil Warwick, Renald Pirelli, Neville Gibbs (Chairman), Prof. Guy Ludbrook, Assoc. Prof. Geoff Gordon
Back: Drs Tony Plowman, Tim Short, Assoc. Prof. Paul Myles, Drs Robert Wong, Alan McKenzie, Terry Loughnan

Retiring Examiner Dr Robert Wong with Dr Neville Gibbs, Chairman Primary Examination Committee

Undergraduate Prizes in Anaesthesia



Dr Michael Lees

The recipients of the 2002 ANZCA Prize for the University of Tasmania were Dr Michael Lees (Year 6) and Mr Roger Flekser (Year 5), who were presented with their Prizes at the University's Awards Ceremony in December 2002.

Dr Robert Mohr and Professor Nick Saunders

Dr Robert Mohr, the recipient of the 2002 ANZCA Prize for Monash University was presented with his Prize at the Faculty of Medicine, Nursing and Health Sciences Prize Winners Ceremony held in March 2003. Dr Mohr is pictured with the Dean, Professor Nick Saunders.

Admission to Fellowship by Examination

The following were admitted to Fellowship:

Ching Ping CHAU	HONG KONG
Philip John CRAFT	QLD
Richard Stuart EMMETT	NSW
Jonathan Murray GRAHAM	VIC
David William MCLEOD	NSW
Michael Sean MCMANUS	QLD
Ian Dougal Craig MILLER	NSW
David Lloyd MORGAN	VIC
Sarah Amanda NICOLSON	VIC
Christopher Brian O'SULLIVAN	NSW
Nicholas John SCURRAH	VIC
Murray James STOKAN	NSW
Minh Duc TRAN	NSW
Andrew Michael TYMMS	VIC
Michael Gerard Francis VAN GULIK	NT
Angel On Kei WONG	HONG KONG
Karen WONG	WA (incorrectly indicated NZ in June 2003 Bulletin)

Regional Annual Reports

Australian Capital Territory

Office Bearers and Members

Chairman,
Dr Frank Lah

Secretary,
Dr Michelle Mulligan

Regional Education Officer,
Dr Prue Martin

Formal Projects Officer,
Dr Paul Burt

ASA Representative,
Dr Nicholas Gemmell-Smith

Committee Member and CME Officer,
Dr Vida Viliunas

Regional Administrative Officer,
Mrs Eve Edwards

After an inspirational visit to the Region in February 2002 by then President, Professor Teik Oh and the Chief Executive Officer, Mrs Joan Sheales, the Regional Committee began its formalised meetings in June 2002.

The Region had an AMC inspection in August 2002 prior to the issue of a formal report on the status of the College's education and training program. The inspectors indicated that they were more than satisfied with the quality and quantity of education and experience that registrars received in their Regional training program. This is particularly satisfying because the training program is in its earliest stages; 2003 will be the first year that registrars will complete their 4-year training program coordinated from the ACT. Particular thanks for this successful program should go to the Regional Education Officer, Dr Prue Martin and the Supervisors of Training at The Canberra Hospital, Dr Guy Buchanan and at Calvary Hospital, Dr Phil Morrissey.

In September 2002 a very successful Regional CME Meeting on Regional Anaesthesia was held. There were over 150 registrants for the meeting. The Regional Committee particularly wishes to thank Dr David Kinchington and Dr John Ellingham for this outstanding effort. The planning for the next Regional CME Meeting on 20-21 September 2003 is now complete. The theme of the meeting will be "Extreme Anaesthesia".

Issues that are currently being addressed by the Regional Committee are the introduction of the Revised FANZCA program and the development of a committee to investigate deaths associated with anaesthesia.

The Regional Committee particularly wishes to thank our Regional Administrative Officer, Mrs Eve Edwards, for the many roles and the behind the scene effort she undertakes with such cheerfulness.

Frank Lah
Chairman

New South Wales

Office Bearers and Members

Chair:
Dr Frank Moloney

Deputy Chair:
Dr Michael Jones

Hon Secretary:
Dr Jenny Beckett-Wood (to June 2002)
Dr Joanna Sutherland

Regional Education Officer:
Dr Ross Kerridge

Formal Project Officer:
Dr Richard Morris

Continuing Education Officer:
Dr Michael Jones

Ex-Officio Members:
Councillors:
Professor Michael Cousins
Assoc. Professor Greg Knoblanche

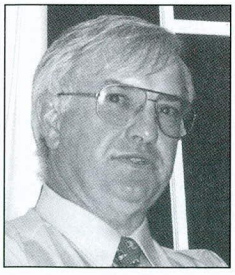
Faculty of Intensive Care Representative:
Dr Dorothy Breen

ASA Representative:
Dr Greg Purcell

New Fellows Representative:
Dr Anthony Padley

Course Organizer Primary:
Dr Peter Kam

Course Organizer Final Fellowship:
Dr Michael Bookallil
Dr Tim McCulloch



Dr Frank Moloney
Chairman

Dr Joanna Sutherland
Honorary Secretary

Total No. of Regional Committee Meetings for Year: 6

Committee Members:	Meeting Attendance
Dr Michael Amos	5 out of 5
Dr Margaret Bailey	5 out of 5
Dr Stephen Barratt	4 out of 5
Dr Jenny Beckett-Wood	1 out of 2
Dr Matthew Crawford	5 out of 6
Dr Richard Halliwell	6 out of 6
Dr Michael Jones	6 out of 6
Dr Michele Joseph	1 out of 2
Dr Ross Kerridge	6 out of 6
Assoc Prof Peter Klineberg	2 out of 2
Dr Frank Moloney	6 out of 6
Dr Richard Morris	3 out of 6
Dr Greg O'Sullivan	2 out of 5
Dr Tony Quail	6 out of 6
Dr Joanna Sutherland	4 out of 6

Education – Dr Ross Kerridge

The last 12 months have been eventful with regard to Anaesthetics training in NSW.

The limited scope for paediatric training has been a concern for a long time. Following a number of years of negotiations, a major change in paediatric training in NSW has taken place. This has involved a reduction in the duration of exposure to paediatric anaesthetics that most trainees receive during their time at the major paediatric anaesthetic training location (The Children's Hospital at Westmead). As a result of these changes, it has been possible to increase the number of training positions in NSW quite significantly.

I would like to reiterate my recognition of the support and co-operation of many people in the last 2 years during the difficult negotiations over paediatric anaesthetic training.

At the same time that these changes have occurred, there has been recognition of the need to increase the exposure of anaesthetic trainees to practice in rural and regional hospitals. In particular, the NSW Health Department was particularly keen to see an increase in accredited registrar training in rural and regional hospitals. By working constructively with NSW Health Department, we have been able to obtain funding for increased anaesthetic registrar positions at both the Sydney Children's Hospitals, at the same time as developing an increased number of accredited positions in rural hospitals.

The increased number of positions in rural hospitals is both recognition of community needs, and a recognition of the excellent training that can be obtained by registrars in these hospitals. The casemix that registrars are exposed to in major metropolitan hospitals is now quite significantly different from the casemix that anaesthetists will encounter in their long-term professional career. In some teaching hospitals, the number of patients suitable for junior trainees is becoming relatively small.

There has been recognition of a need to increase the number of trainees generally, particularly in view of the latest AMWAC report. A severe shortage of anaesthetists in any part of the state, but particularly in rural areas, could 'force' the government to take extraordinary steps to address a shortage of anaesthetic services. This may include initiatives that are to the long-term detriment of the speciality and to patient care. Ensuring an adequate supply of trained anaesthetists, and an appropriate distribution of specialist anaesthetists, is the best means to avoid government intervention using steps such as these.

Regional Administrative Officer:
Janice Taylor

Administrative Assistant/Course Secretary:
Annette Strauss

Representatives on External Committees:

Dr Frank Moloney

Committee of Chairmen of NSW State Committees of Medical Colleges

Standing Committee of College Chairmen

NSW State Committee, Royal Australian College of Surgeons

Joint Consultative Committee-Anaesthesia

Executive Committee, Rural Special Interest Group

Dr Michael Jones

Committee of Management, Australian Society of Anaesthetists

Assistant Editor, Australasian Anaesthesia

Dr Matthew Crawford

Peer Review Subcommittee, NSW Council on Quality in Health Care

Safe Work Hours Working Party, NSW Health

Dr Jo Sutherland

Scientific & Technical Advisory Committee, Australian Red Cross Blood Service

Blood Use Improvement Group, NSW Health Department

The focus of changes in educational activity in NSW is now on the introduction of the Revised FANZCA Program, and the concurrent changes to training arrangements. Implementation of this decision has the potential for disrupting the comprehensive training scheme structure that has been established in NSW in recent years. It will be necessary to be careful to about the implementation of the new training arrangements and revised FANZCA, to avoid losing the benefits of the current scheme structure. It will require considerable work in the next 12 months to ensure that this does not happen.

The next twelve months promises to be busy while these challenges are dealt with.

Continuing Education – Dr Michael Jones, Chairman NSWACE

NSWACE had another extremely successful year in 2002. In May we reviewed 'Issues in Perioperative Care'. This included revisiting traditional topics such as diabetes and fasting, and a look at some more unusual areas such as office based surgery, complementary medicines and pushing the limits of day only surgery.

In August we expanded our geographical horizons to visit the Hunter Valley. The new location proved a winner and attracted 150 registrants. The two day meeting focused on Paediatric Anaesthesia, but aimed more at the non sub-specialist level. Once again, the workshop format featured strongly, and a wide range of excellent topics were presented. Dr Don Maxwell, a noted vigneron, proved an entertaining dinner speaker, and the weekend was a great success all round. We will definitely be returning to the Hunter Valley in 2004 or 2005.

November saw a radical change in format from our traditional didactic presentations. Leonie Watterson and Michele Joseph organised a thoroughly entertaining, innovative and educational meeting involving video based interactive discussions, small group workshops, stage actors and panel discussions. The theme for the meeting was an examination of Decision-making and Risk Management in Clinical Anaesthetic Practice. The NSW Health Department launched its new Critical Incident Review Programme (root cause analysis) and the Australian Council for Safety and Quality in Health Care launched the National Standards for Open Disclosure.

Numbers were considerably restricted deliberately, to allow for intimate involvement of the audience. Feedback from participants revealed strong support and criticism (!) for different aspects of the day; overall no pattern emerged as different anaesthetists enjoyed different aspects of the day. However, over 95% of the audience strongly supported the innovative approach. We intend to repeat the meeting in May 2003, with some minor changes to allow a new cohort of anaesthetists to attend (and gain considerable QA points!).

In addition the meeting was professionally videotaped. It is intended to broadcast the edited meeting on the Health Communication Network Satellite to rural and remote hospitals across Australia in the near future. Discussions have also been undertaken to perhaps do this on a regular basis in collaboration with the Australian College of Rural and Remote Medicine. Videoconferencing of our meetings is planned for 2003, with the possibility of servicing all the capital cities and major centres in the near future. Please contact Jan Taylor (02 9966-9085) for further information on this exciting new possibility.

Towards the end of 2002 Mark Priestley joined the committee and we look forward to his involvement in 2003.

I would like to thank the NSWACE Committee of Matthew Crawford, Peter Isert, Michele Joseph, Ed Loughman, Mark Priestley and Leonie Watterson, together with Jan Taylor (Administrator) for the enormous effort involved in the organisation and committee work required to support CME in NSW.

Formal Projects – Dr Richard Morris

This year 44 formal projects were successfully completed. Only two required any revision. Thirty eight new proposals were submitted on a wide range of interesting topics.

The pool of reviewers has been further enlarged with several younger reviewers taking on the task with enthusiasm. In the coming year it is hoped to initiate contact with other formal project officers to further develop this element of the curriculum.

The 44 formal projects were:

Trainee	Project
Darren Wolfers	A critical review of the literature on Cardiac Arrest in Pregnancy
Murray Stokan	Laryngoscope Incisor Pressure Alarm
Robert Fabian	Measuring the effects of ANZCA examinations on candidates and their partners
Sally Browne	Neuropathic Pain in the Acute Pain Service: A Prospective Survey
Margaret Perry	Analgesia Post-Caesarean Section: An Evaluation of Current Practice at an Australian Teaching Hospital
Stuart Harrison	Anaesthesia for laser bronchoscopy. A five-year retrospective audit
Charlotte Johnstone	Anticoagulation and the Pain Management Physician
David Collins	Airway Management on Placental Support – The Anaesthetic Perspective
Adriana Davis	Oxytocic Agents: A Review of their Pharmacology and Clinical Applications for Postpartum Haemorrhage
Tri Bui	Can systolic contraction velocity from doppler tissue imaging accurately estimate LV ejection fraction intraoperatively
Toni Rentoul	The Effect of Aprotinin on Transfusion Requirements in Paediatric Orthotopic Liver Transplantation
Carlo Vernier	High trans-oxygenator pressures: the Australian experience
Joanne Walsh	An Assessment of the Quality of Cricoid Pressure in the Hunter Region
Jason Hollard	Simulated Epidural Test Doses using Adrenaline and Adrenaline/Clonidine in Sevoflurane-anaesthetized Children
Barbara Cuff	Sudden hearing loss in patients undergoing general anaesthesia for non-otologic, non-cardiopulmonary bypass surgery: a case report and review of the literature
Craig Hargreaves	Intrauterine Lignocaine Gel 2% versus placebo for analgesia during and after daystay Vesta Thermal Balloon Endometrial Ablation
John Hollott	Does the use of fenestrated adhesive plastic drapes reduce the insertion contamination of central lines?
Jason Chaffer	Evidence Based Taping: Adhesive Properties of Micropore®, Transpore®, Leucoplast® and Sleek®
May-Lin Liew	Formulation of a user-friendly guide to the management of pain and related issues in hospital patients for the use of Junior Medical Officers (JMOs) at St George Hospital, Kogarah
Neil Brown	Perioperative implications of varicella zoster infection in the pregnant patient: case report and literature review

John Poulos	Number Needed to Treat
Michel Poppinghaus	Did your reasons for specializing in Anaesthesia stand the test of Time?
Stefan Liew	Traditional Chinese herbal medicine: perioperative implications
Maria Hondronicola	Propofol anaphylaxis, how rare?
Gavin Pattullo	The influence of regular preoperative analgesia on patient-controlled analgesia in elective total hip replacement
Jonathan Rothwell	Brown Snake Bites in The Hunter Region
David R Sandford	Hip Surgery in Nonagenarians: in-hospital morbidity and mortality
Lisa Horrell	Introduction and audit of Post-Elective Caesarean Section Analgesic Regime: John Hunter Hospital, Newcastle
Patrick Liston	Emergency Awake Surgical Cricothyroidotomy for Severe Maxillofacial Gunshot Wounds: a Case Report and Literature Review
Simon Tame	Investigation of the radiological relationship between iliac crests, conus medullaris and vertebral level in children
Anthony Carrozzi	A Case of Spontaneous Intracranial Hypotension
Martin Shaw	Anaesthesia for pulmonary thromboendarterectomy
Paul Dunkin	Bispectral Index Monitoring – A review of the current place of BIS Monitoring in clinical anaesthesia
Helen Leggett	A clinical evaluation of the substernal epicardial echocardiography cannula (SEE IT™) device in post operative patients in cardiothoracic intensive care
Sue Ann Wan	The Initial Management of Airway Trauma
Nicholas A Barrett	Quinine ocular toxicity – Treatment of blindness using therapy for vasospasm
Janine Gregson	With independence for East Timor, the United Nations Mission in Support of East Timor (UNMISET) begins, and the United Nations Military Hospital in Dili closes. What has occurred in the last two years of Anaesthesia and Surgery?'
Ian Bridgland	An analysis of human-computer interaction aspects of anaesthesia monitors
Stephen Lightfoot	Nitrous Oxide, Anaesthesia and the Enhanced Greenhouse Effect
Euhan Chin	Comparison of the incidence and severity of postoperative throat symptoms between standard laryngoscopy and the intubating laryngeal mask
Kishore Jayanthi	The impact of an anaesthetic evidence based medicine journal club on knowledge and use of evidence based medicine
Adrian Walker	Clinical and epidemiological features of group A streptococcal bacteraemia in a region with hyperendemic superficial streptococcal infection
Cesar Fernandez-Cornejo	A comparison of the cardiovascular responses to intubation using conventional intubation and the intubating laryngeal mask airway in patients undergoing anaesthesia for elective cardiac surgery
Carmel McInerney	Handwashing and Implications for Anaesthetists

Professional Affairs – Dr Frank Moloney

A very busy committee year with significant changes in personnel, an agenda including the AMC inspection of ANZCA, the Revised FANZCA and its impact on hospitals and Supervisors of Training, increased training positions linked to rural and paediatric rotations, more Area of Need appointments, increased activity from NSW Health as the election approaches and the purchase and occupation of new premises at 117 Alexander Street, Crows Nest.

Leaving the committee were Assoc Professor Peter Klineberg and Dr Jenny Beckett-Wood who had completed their 12 years. Peter has chaired the NSWACE Committee for most of this time, his CME productions have been outstanding, popular and innovative. He contributed to all facets of committee work and we will miss his experience and expertise. Jenny has travelled from Newcastle and back to attend meetings for 12 years. She has professionally completed multiple hospital inspections but her major contribution has been her last four years as Committee Secretary.

Dr Michele Joseph has resigned after 8 years to pursue her interests in Medical Education. She has contributed to all committee activities including four years from 1994 as Committee Secretary. She continues to serve on the NSWACE Committee. Her understanding and involvement in trainee issues will be sorely missed.

Assoc Professor Greg Knoblanche resigned from Council in 2002, bringing to an end his formal association with ANZCA after 12 years on the Regional Committee and 6 years on Council. Greg's contribution to ANZCA has been tireless, and giving generously of his time in all areas of ANZCA activity. The committee has benefited greatly from his input and expertise.

Michelle Mulligan has left the committee after 2 years because she now lives in the ACT and is no longer eligible. This has been a great loss to the committee, I particularly appreciated having another rural colleague on hand.

Newly elected members are Dr Michael Amos (Concord), Dr Maggie Bailey (St George), Dr Stephen Barratt (Royal North Shore) and Dr Greg O'Sullivan (St Vincent's). We welcome them and look forward to their fresh ideas.

ANZCA traditionally has involved itself in all aspects of education, training and standards. Lately, however, we have become increasingly caught up with workforce issues. College Council has just released a document on Area of Need which clearly advises of the 7 steps of appointment. Unfortunately, in spite of all our educational initiatives, outlined by Ross Kerridge in the Regional Officer's Report, some rural Base hospitals and urban district hospitals continue to encounter problems with recruitment. It has been proposed at our February meeting that it may be helpful and preventative if a hospital about to embark on the Area of Need pathway, be entitled to request initial inspection by representatives of ANZCA, ASA and NSW Health. This would allow constructive advice on recruitment and retention criteria.

Hospital inspections have occurred at Campbelltown/Camden, Coffs Harbour, Concord, Dubbo, Nowra, Port Macquarie, Tweed Heads and Westmead Private. Additional inspections will occur at Maitland, Nepean and Newcastle Mater Hospitals. Again, from the AMC report, we have been advised to inspect and approve training programmes rather than training posts.

Citation

At the December meeting a Council Citation was presented to Dr Michael Bennett for his work in the Hyperbaric Unit at the Prince of Wales Hospital.

Committee of Chairmen of NSW State Committees of Medical Colleges

Once again this stimulating forum provided contact with other disciplines and government. Medical Indemnity issues dominated the early part of the year, but other matters on the agenda were credentialling, safe hours, CME's in Accident and Emergency, nurse practitioners and procedural training of rural GP's.

The new Director General of Health, Ms Robyn Kruk, attended the October meeting promising her support. This committee was ably chaired by Dr Paul Beaumont representing the Ophthalmologists.

New Premises

In the latter half of 2002 ANZCA acquired new facilities at 117 Alexander Street, Crows Nest (02 9966-9085). Since October we have held Regional Committee meetings, examinations and educational activities there.

Thank you to all members of the committee for your assistance through the year, particularly ANZCA Vice President Professor Michael Cousins for his regular attendance, keeping us informed on Council business.

A final thank you to Jan Taylor and Annette Strauss for all your help behind the scenes with meetings, examinations and CME.

Frank Moloney
Chairman

Queensland

Office Bearers and Members

Chair
Assoc. Professor Geoffrey Gordon

Vice Chair
Dr Patricia Goonetilleke

Honorary Secretary
Dr Mervyn Cobcroft

Honorary Treasurer
Dr Michael Beem

Regional Education Officer
Dr Julia Byatte

Formal Project Officer
Dr Michael Fanshawe

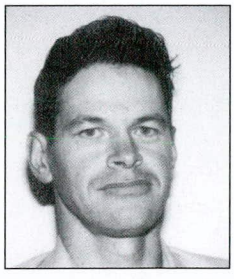
Continuing Education Officers
Dr Daryll Koch and Dr Anton Loewenthal

QRC IT Officer
Dr Ian Cameron

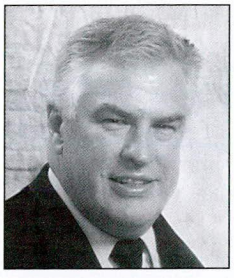
Committee Member
Dr Charmaine Barrett

Ex-officio Members
Dr Di Khursandi (Councillor)
Dr Kerry Brandis (Councillor)
Dr Tim Wong (ASA Representative)
Dr Ranald Pascoe (Joint Faculty of Intensive Care Representative)

Co-Opted New Fellows' Representative
Dr Ian Cooper



Assoc. Prof. Geoffrey Gordon
Chairman



Dr Mervyn Cobcroft
Honorary Secretary

Total No. of Regional Committee Meetings for Year: 8

Committee Members	Meeting Attendance
Dr Charmaine Barrett	7:8
Dr Michael Beem	6:8
Dr Kerry Brandis	7:8
Dr Julia Byatte	8:8
Dr Ian Cameron	2:8
Dr Mervyn Cobcroft	5:8
Dr Ian Cooper	6:7
Dr Michael Fanshawe	6:8
Dr Patricia Goonetilleke	8:8
A/Prof Geoffrey Gordon	7:8
Dr Daryll Koch	6:8
Dr Di Khursandi	6:8
Dr Anton Loewenthal	5:8

Financial Report

The accounts of the QRC continue to be managed in Melbourne. All of the educational activities of the QRC ran at a small surplus this year and the centralised accounts remain with sufficient funds for the anticipated operating activities of the committee.

The courses conducted by ANZCA, and the combined CME meetings have been very well attended.

Major purchases this financial year included a letter folder. This has greatly reduced the time it has taken to produce mailouts to Queensland Fellows and Trainees.

Education

Trainees

Queensland has 101 trainees in years 1 to 4. From January 2004 when we see the introduction of the Revised FANZCA, there is the potential for this to increase significantly as the College changes its focus and will accredit hospitals and not positions. With up to 50 non-accredited PHO's in Queensland which could all potentially become training positions, this would mean that not all trainees could be guaranteed sub-specialty rotations within the minimal training time as laid down by the College.

Again this year, demand for training positions was strong with trainees being selected on the basis of an interview, previous experience, referee reports and written application addressing the Key Selection Criteria. Existing trainees were re-appointed on the basis of satisfactory reports from their current Director and SOT. By March, all of the applicants who had been placed on the reserve list had either moved interstate or had been placed in training positions in Queensland.

Registrar Training Courses

Both the Primary and Final Long courses are again continuing successfully this year. 24 trainees are enrolled for the Primary Course, and 14 enrolled for the Final Course. These courses are being run by Dr David Liessman and Dr Ralph Whiteside.

Dr Chris Thomas conducted the Final Short Course in March which will be held again in July of this year, which leads up to both the exams.

There are now two Primary Short Courses. A new short course was introduced this year in February, convened by Dr Steve Clulow. The May Primary Course is being run by Dr Kerry Brandis, however this year the format will be slightly different, with registration being limited only to those sitting the upcoming exam.

Course Organisers

Primary Short Course:
Dr Steve Clulow/Dr Kerry Brandis

Primary Long Course:
Dr David Liessmann

Part I Practise Viva Sessions:
Dr Julie Byatte

Final Fellowship Short Course
[No appointment]

Final Fellowship Long Course
Dr Ralph Whiteside

Part II Practise Viva Sessions:
Dr Martin Wakefield

Advisor of Candidates for Anaesthesia Training:
Dr Gerard Handley

Regional Administrative Officer
Ms Joyce Holland

Administrative Assistant
Ms Anne Strasburg

Representatives on External Committees

Associate Professor Geoffrey Gordon:
Committee of Queensland Medical Colleges, Medical Workforce Specialist Working Party
Staff Panel of Peers, Senior Staff Specialist Status, Queensland Health
Visiting Panel of Peers, Senior Visiting Specialist status, Queensland Health

ANZCA/RACS Building Committee

Dr Bart McKenzie:
Medical Workforce Specialist Working Party
Queensland Ambulance Medical Advisory Committee

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

Dr Di Khursandi:
Medical Advisory Committee of Queensland
Post-graduate Medical Education Committee, University of Queensland
ANZCA/RACS Building Committee

Dr Ian Stephens:
Maternal Morbidity and Mortality Sub-committee of Queensland Council on Obstetric and Paediatric Morbidity and Mortality

Dr Paul Mead:
Australian Resuscitation Council

Dr Norris Green:
RACS Queensland Trauma Committee

Other Training Issues

Over the period covered in this report, 22 trainees have been successful in the Final Examination and 24 have been successful in the Primary examination. Notably, Dr N Fairweather was awarded a Merit Certificate in the Final Examination and Dr G Liu was awarded a Merit Certificate for her performance in the Primary Examination.

Dr R Gray was awarded the Cecil Gray prize for his performance in the Final Examination in September 2002.

Continuing Education

The 26th Annual Combined CME meeting was held on the 27 – 29th September 2002 at Hamilton Island. The major theme of the meeting was Paediatric Anaesthesia. 104 delegates attended the meeting with 50 attending from interstate and New Zealand. The successful meeting was concluded with an evening Dinner/Dance. The meeting was convened by Dr J Christie and Dr A Vartis.

The 6th Combined ANZCA-ASA Annual Registrars' Meeting was held at College House in Brisbane on the 9th November 2002. Seven registrars presented their projects with Dr Cameron McAndrew being awarded the Tess Cramond Prize for Best Formal Project presented on the day. This year a prize for excellence in technical presentation was also awarded. This prize was given the name of a Queensland Anaesthetist who has made a significant contribution to the speciality in Queensland. The prize donated by Axxon Health, was presented by Dr Mary Daly to Dr Sean McManus. The afternoon was given over to a well received session on "Introduction to Specialist Practice".

Other CME Matters

Following the QRC Annual General Meeting, held on the 23rd July 2002, Dr Leona Wilson presented a paper on the Revised FANZCA Program. This paper was greeted with some concern from the Fellows in attendance who generally felt that the current program has proven its robustness in the training of Anaesthetists.

Professional Affairs

A Vocational Training Expo for junior doctors was held in June 2002. Drs Di Khursandi, John Gibbs and Lyndall Patterson manned a booth and promoted our speciality at this very popular and well attended event.

A Health Expo organised by the Australian Medical Association (Queensland Branch) was run over the weekend of the 27-28 July 2002. Over 100 exhibitors attended this event and the ASA combined with ANZCA to man a large booth that presented an operating theatre setup. This received a lot of interest from the general public and the industry. More than 7,000 people attended the expo and this event certainly raised the profile of our profession.

Acknowledgements

The Queensland Regional Committee would once again like to acknowledge the extraordinary contribution made to the activities of the Committee, Fellows and Trainees in Queensland by Joyce Holland, the Regional Administrative Officer. Without her organisation, thoughtfulness, forbearance and management skills, we would not be able to engage ourselves in the range of activities that are currently available to the Fellows and Trainees in Queensland. We also wish to acknowledge the countless and undocumented hours spent on College affairs by Queensland Fellows over the past year.

Geoff Gordon
Chairman

South Australia and Northern Territory

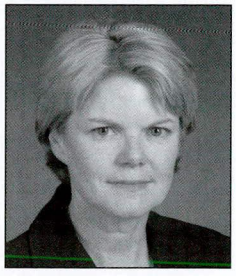
Office Bearers and Members

Chair
Dr Margaret Wiese (until May 2002)
Dr Margaret Cowling
(from May 2002)

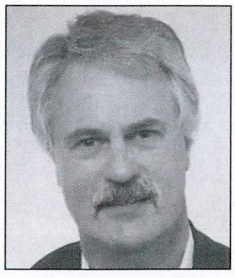
Vice Chair
Dr Margaret Cowling
(until May 2002)
Dr Lynne Rainey (from May 2002)

Hon. Secretary/Treasurer
Dr Margaret Cowling
(until May 2002)
Dr Daryl Catt (from May 2002)

Committee Members
Dr Christopher Higham
(until May 2002)
Dr Tony Laver
Dr Robin Limb
Dr Lisa McEwin (until May 2002)
Professor Don Moyes
Dr Alisteir Norton
Dr Jackson Harding (until May 2002)
Dr Peter Doran (from February 2003)
Professor Harry Owen
(May 2002 to Feb 2003)
Dr Kym Osborn (from May 2003)
Dr Glenys Miller (from May 2002)



Dr Margaret Cowling
Chairman



Dr Daryl Catt
Honorary Secretary

Total No. of Regional Committee Meetings for Year: 9

Attendances of Elected Members	Meeting Attendance
Dr Margaret Wiese	2 of 2
Dr Margaret Cowling	9 of 9
Dr Lynne Rainey	6 of 9
Dr Daryl Catt	6 of 8
Dr Chris Higham	0 of 2
Professor Don Moyes	5 of 9
Dr Tony Laver	6 of 9
Dr Robin Limb	5 of 9
Dr Lisa McEwin	0 of 2
Dr Alisteir Norton	2 of 9
Dr Jackson Harding	0 of 2
Dr Peter Doran	2 of 2
Professor Harry Owen	2 of 6
Dr Kym Osborn	6 of 8
Dr Glenys Miller	5 of 8

Incorporation of the Northern Territory with South Australia

At the June 2002 Council meeting the name of the South Australian Regional Committee was changed to the South Australian and Northern Territory Regional Committee.

This change formalizes the connection between South Australia and the Northern Territory that has existed for some years. The twelve Fellows in the Northern Territory are represented by a coopted Fellow to the Regional Committee and trainees from South Australia rotate to Royal Darwin Hospital.

A number of initiatives since this union have improved communication between the two regions. In particular video conferencing of CME meetings from Adelaide has been introduced and funding for Dr Brian Spain (coopted member of SA& NT Regional Committee) has allowed him to attend some meetings in Adelaide.

Funding has also been approved for Dr S Hams (Supervisor of Training at Royal Darwin Hospital) to attend a Regional Education Sub Committee meeting in 2003. This will also provide an opportunity for trainees to meet Dr Hams and discuss the Darwin rotation.

Education

Trainee Selection

The interview and selection process will now be held in January and July rather than once a year. This will enable all time expired trainees wishing to re-enter the program to be reviewed.

In 2003 53 of 54 training positions were filled. 17 trainees are in their first year.

Rotational Supervisor

Dr Tim Strong has moved to Tasmania and Dr Suzy Szekely has taken on this important position.

Courses

The Part I course has been completely restructured by Dr Lynne Rainey and Dr Peter Doran. It has changed to an interactive learning format rather than didactic lectures and is proving to be very successful.

I would like to thank Dr Grace Koo who previously ran the course and is still involved in organizing Viva practice.

The Part II course, organized by Dr David McLeod remains unchanged.

Formal Projects Officer
Professor Don Moyes

Northern Territory Representative
Dr Brian Spain

Faculty of Intensive Care Representative
Dr Sandra Peake

Faculty of Pain Medicine Representative
Dr Pam Macintyre

Younger Fellows Representative
Dr Peter Doran

ASA Representative
Dr Neil Maycock

Ex Officio
Member of Council : Dr Richard Willis

Directors Representative
Dr Peter Lillie

Regional Education Sub-Committee
Chairman, Regional Education Officer
Dr Glenys Miller

Organiser – CME
Dr Lynne Rainey

Course Organiser – Primary
Dr Grace Koo
Dr Lynne Rainey
Dr Peter Doran

Course Organiser – Final Fellowship
Dr David McLeod

Regional Administrative Officer
Ms Jane Hinchey

Revised FANZCA

Preparation for the introduction of the Revised FANZCA training program in 2004 is under way. The entire South Australian and Northern Territory rotation is currently being reviewed. All Supervisors of Training have been asked to consider which specific modules their own institution can offer. A meeting is planned in late May where this information will be discussed and collated so suitable rotations for trainees can be devised.

This is an enormous task and I thank all who are involved but in particular Dr Glenys Miller (Regional Education Officer) for her untiring effort in coordinating this process.

Meetings

Registrar Scientific Meeting

This was held in November 2002. The four excellent presentations were video conferenced to Darwin. The prize for best paper was a Simulator Session in Sydney donated by Abbott and was awarded to Dr Philip Lee.

Challenges of your anaesthetic training and beyond

An evening meeting was held in March 2003 for new trainees and their partners. Aspects of training were addressed and issues around personal health and professional conduct were discussed.

CME

Many thanks to Dr Lynne Rainey for her enthusiastic work as Chair of the CME. Apart from coordinating an interesting mix of evening meetings, Lynne has established the video conferencing link to the Northern Territory. Feedback from Darwin is only positive, with good attendances at the Royal Darwin Hospital.

Meetings held over the last 12 months are:

10 April 2002	Risk Management is here to stay Dr Scott Simmons
12 June 2002	Low Dose Spinals, the 20:20 mix Dr Graeme Newcombe and Dr David McLeod
7 August 2002	Acute Pain Management – is there any evidence for what we do? Dr Pam Macintyre
17 September 2002	MOP's Update, QA Points – are they achievable? Dr Leona Wilson
20 November 2002	Registrar's Scientific Meeting
17 December 2002	Christmas Quiz Dr Michael Chittleborough
5 March 2003	Cardiology Update Dr Cameron Singleton

As Adelaide was the host of the ASA NSC the annual weekend CME meeting was not held in 2002. However a meeting on Saturday 6th September 2003 is already planned and will be held at The Novotel Barossa Valley Resort. The meeting 'Advances in Regional Anaesthesia' has Professor Thomas Bruessel from ACT as guest speaker.

New Fellows for the Hobart ASM

Dr Peter Doran, South Australia
Dr Philip Blum, Northern Territory.

Hospital Accreditation

As many of you are aware there is a current problem with staffing levels in South Australian Teaching Hospitals. Over the last few years more than 50% of new Fellows have either moved interstate or ventured into private practice leaving several vacancies for staff specialists unfilled. There have been concerns that this may impact on supervision and training of registrars. Fortuitously the South Australian rotation was ready for the regular review undertaken by the Hospital Accreditation Committee. These inspections occurred in late March and the final report from the Hospital Accreditation Committee is awaited.

Bill Fuller Museum

A collection of historical Anaesthetic equipment is exhibited in the foyer of the South Australian headquarters. Dr Bill Fuller must be congratulated for compiling this display and the accompanying educational catalogue. The South Australian and Northern Territory Regional Committee unanimously voted that it be known as the Bill Fuller Museum.

Acknowledgements

I would like to thank Ms Jane Hinchey for her cheerful and reliable secretarial assistance over the last year. Jane is moving to a new position in April and I wish her every success.

Finally, thank you to all members of the South Australian and Northern Territory Regional Committee for their enthusiasm and support over the last year.

Margaret Cowling
Chair

Victorian Regional Committee

Office Bearers and Members

Chairman:
Dr Peter McCall

Deputy Chairman:
Dr Rowan Molnar

Honorary Secretary/Social:
Dr Elizabeth Ashwood

Honorary Treasurer:
Dr Mark Fajgman

Continuing Medical Education / IT:
Dr Rowan Thomas

Regional Education Officer:
Dr Mark Buckland

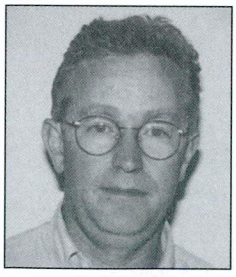
Assistant Education Officer:
Dr Winifred Burnett

Paramedical Personnel/Assistant CME Officer:
Dr Philip Ragg

Formal Project Officer:
Dr David Bain

Safety Officer:
Dr Rod Tayler

Rural:
Dr Mark Tuck



Dr Peter McCall
Chairman

Dr Elizabeth Ashwood
Honorary Secretary

Total number of Regional Committee Meetings for Year 2002/2003 14

Attendances of Elected Members:

Dr Ashwood	9/11	Dr Bain	9/10	Dr Buckland	6/11
Dr Burnett	8/11	Dr Fajgman	6/11	Dr Lilley	7/10
Dr McCall	8/11	Dr Molnar	9/11	Dr Ragg	8/11
Dr Tayler	7/10	Dr Thomas	9/10	Dr Tuck	4/11

2002 was an election year, which saw my election to the Chairmanship of the VRC. Four new Members were also elected: Alison Lilley, David Bain, Rod Tayler and Rowan Thomas. The co-opted New Fellow is Sesto Cairo and Julia Fleming the Faculty of Pain Medicine representative. Kate Leslie is now an ex-officio Member of the Committee along with Rod Westhorpe and Tony Weeks. Otherwise VRC Membership remains unchanged. Unable to continue his role as CME/Rural Officer because of numerous commitments Mark Tuck has regretfully resigned. Rowan Thomas has accepted the role of CME Officer and Philip Ragg in addition to his Paramedical Personnel portfolio, Assistant CME Officer. The Committee is actively canvassing for a replacement Rural Officer. At the 2002 Annual Combined ANZCA/ASA CME Meeting, ANZCA Citations were awarded to Ian Rechtman and Peter Roessler for their contribution to Anaesthesia over many years.

The VRC remains very much committed to and involved in health care committees and workshops as follows:

Committee	Fellow
Coroner's Health and Medical Advisory Committee	Dr Mark Langley
MPB Working Group on the problem of sexual misconduct	Dr Rowan Molnar
Committee of Chairmen of Victorian State Committees of Medical Colleges	Dr Peter McCall
RACS Victorian State Committee	Dr Peter McCall
ASA State Committee	Dr Peter McCall
Consultative Council on Anaesthetic Mortality and Morbidity	Dr Pat Mackay, Chair Dr Mark Langley Dr Philip Ragg Dr David Scott
NHMRC – Blood Group	Dr Peter McCall
NHMRC Blood and Blood Product Working Group	Dr Craig French (ANZCA) Dr Megan Robertson (IC)
DHS Planning for Intensive Care Service in Victoria – Issues Paper Workshop	Dr Craig French (ANZCA) Dr Megan Robertson (IC)
Trauma Foundation (Trauma Verification Project)	Dr Arthas Flabouras JFICMANZCA, ANZCA)
Victorian Quality Council (DHS)	Dr Tony Weaver Dr Brendan Flanagan
Victorian Doctors Health Program	Dr Stephen Chester
Anaesthesia Continuing Education Co-ordinating Committee	Dr Rod Westhorpe
Tort Law Reform Group (Comprises representatives from the AMA, RACGP, the OSA, the RACOG and Executive Members of the Committee of Chairmen (VIC)	Dr Mark Tuck
Chinese Medicine Regulation Working Party (MPB)	Dr Tony Chow

Ex-Officio Members:
Councillors - Assoc. Professor Kate Leslie
Dr Rod Westhorpe
Assoc. Professor Tony Weeks

Co-opted:
Royal Australasian College of Surgeons:
Professor Paddy Dewan

Consultative Council on Anaesthetic Mortality and Morbidity:
Dr Patricia Mackay

Australian Society of Anaesthetists Representative:
Dr Simon Reilly

Joint Faculty of Intensive Care Medicine Representative:
Dr Craig French

Faculty of Pain Medicine Representative:
Dr Julia Fleming

New Fellow Representative:
Dr Sesto Cairo

Administrative Officer:
Ms Corinne Millane

Victorian Consultative Committee on Road Traffic Fatalities	Dr Andrew Silvers
RACS Victorian Trauma Committee	Dr John Moloney
RACS Victorian Road Trauma Committee	Dr John Moloney

Consultative Council on Anaesthetic Mortality and Morbidity

The Victorian Consultative Council met monthly in 2002 and is working effectively. The expansion of the Council with additional anaesthetists has meant that there is always a quorum of anaesthetists in addition to the members representing other specialities. In 2002 forty-two deaths were analysed, the majority of which (35) were inevitable or related to the surgery. Seven were classified as being within the province of the anaesthetist in some way. This figure is similar to previous years but the Council has extended its scope of enquiry to include complications of pain management, non-invasive procedures and resuscitation.

The Council has accepted the national definition of anaesthesia-related mortality as "a death which occurs during an operation or procedure (or within 24 hours of its completion) performed with the assistance of sedative, analgesic, local or general anaesthetic drugs or any combination of these, or a death which may be the result (either partially or totally) of an incident during or after such operation or procedure even if more than 24 hours has elapsed since its completion." Every effort is being made to persuade the Victorian Coroner to accept this definition for reportable deaths associated with anaesthesia.

Victoria is currently the only state in which morbidity is also collected by the relevant Council. Ninety-six cases of morbidity were analysed in 2002, twenty-seven collected from direct reports and sixty-nine from hospital Q.A. programmes.

It is the belief of Council members that this is the more important activity in terms of teaching and anticipation of problems with new technology and drugs. For this to be effective there must be rapid feedback where problems are identified. Thus the development of the website in 2002 has been a major achievement in facilitating this and there is good evidence of an increasing usage of this site.

A small number of Sentinel events (22) were also referred to the Council and while they all outlined organisational errors and contained some risk reduction strategies the Council was of the opinion that valid conclusions could not be provided in the absence of medical input about the cases and there was concern that there could be loss of confidentiality if the case was also reported directly to the Council. Thus the Council has elected to have very limited input into this programme until it has been clarified and modified.

A major initiative of the Council in 2002 was to prepare a submission to the Quality Council outlining concerns about mortality and morbidity associated with pain management. Accordingly the Quality Council sponsored a one-day workshop with 78 representatives encompassing all disciplines involved in acute pain management and with Dr Norman Swan as facilitator. Agreement was reached that pain management should be a major governance issue for all Victorian Hospitals and a list of operational principles was established which will need further refinement. These have been taken to the Victorian Quality Council for consideration and for appropriate funding.

The Council is most appreciative of the assistance provided by the Victorian Regional Committee of ANZCA and the Victorian Section of the Australian Society of Anaesthetists in their support and assistance in promoting the work of the Council.

All anaesthetists can be confident that absolute confidentiality is maintained and that any information provided is protected by Section 24 of the Health Act.

Education

The past year has seen the finalisation of the Revised FANZCA Program, and with its planned introduction in time for the 2004 Registrar training year, is certain to keep departments busy. The College Education Unit plans to run a number of educational activities to assist Supervisors of Training and other staff in handling this change.

The 2002 Annual Anaesthetic Registrars' Scientific Meeting was held on 19th July at ANZCA House, the Friday before the annual Combined ANZCA/ASA CME Meeting, and was another success. Again, the standard of registrar presentations was commendable and was very well attended. The Anaequip (Vic) Pty Ltd Prize for the best paper was awarded to Dr David Canty for his paper "Superior Laryngeal Nerve Block in Human Cadavers – an anatomical study comparing two techniques".

The Orientation to Anaesthesia Course was again held on 28th February 2003. The afternoon was very well attended and feedback good. Presentations outlined the College training program, the role of the College, the Formal Project and research, techniques and styles of adult learning, exam preparation and professionalism. EMAC Course guidelines were added to this year's program. Dr Leona Wilson, Chair, Education & Training Committee gave an informative and detailed presentation on the implementation of the Revised FANZCA and its effect on Trainees. Dr Wilson responded to numerous questions from the audience.

The success of these events was assured with the valuable assistance and expertise of the Assistant Education Officer, Dr Winifred Burnett and the Administrative Officer, Ms Corinne Millane.

The VRC and the Education SIG convened another joint meeting with the theme "Teaching Anaesthesia – theory and practice" in October. Although a smaller number of Fellows were in attendance, it was well received, and the VRC has determined that it will hold a workshop at least once a year following College guidelines for the support and education of Supervisors of Training.

3rd Year Training

The VRC formed a Sub-committee to review and resolve the problem of 3rd year Anaesthesia training in the sub-specialities of paediatrics and obstetrics. With the co-operation of the Directors of Departments and additional funding obtained from the DHS a solution was achieved that has enabled all 39 applicants to be placed in 2003. An overall strategy for the number of Trainees in each department has been agreed to. This should ensure an ongoing resolution to this problem.

Finance

The Committee in 2002 continued its involvement with and support of Supervisors of Training workshops, the Orientation to Anaesthesia Course, Part 1 and Part 2 Courses and CME events.

Continuing Education

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

13th April 2002	Victorian Regional Committee Workshop, ANZCA House "Teaching in the Operating Theatre – practical approaches"
19th July 2002	Annual Registrars' Scientific Meeting, ANZCA House
20th July 2002	23rd Annual Combined ANZCA/ASA CME Meeting, Hotel Sofitel, Melbourne. "Welfare of the Anaesthetist"
27th August 2002	Victorian Regional Committee CME Evening Meeting: "Anaesthetists At Risk", ANZCA House Dr Terence Little, Member of the Board, MDAV; Mr Russell Ball, Solicitor, John W Ball & Sons, Solicitors for MDAV; Dr Mark Tuck Convenor and CME Officer
18th-20th October 2002	Victorian Regional Committee Supervisors of Training Workshop, Cumberland Lorne Conference and Leisure Resort, Lorne, "Teaching Anaesthesia – theory and practice" (not videotaped)
19th November 2002	Victorian Regional Committee CME Evening Meeting "Teaching in the OR", ANZCA House Dr Bernie Creati, Staff Anaesthetist, Department of Anaesthesia, the Geelong Hospital.

All of these Meetings were videotaped and may be borrowed from the ANZCA Library.

The 23rd Annual Combined Continuing Medical Education Meeting. The Meeting theme, "Welfare of the Anaesthetist" addressed psychological, social, financial and insurance issues, as well as drug addiction, exercise and safe hours for anaesthetists. Contributors included prominent local and interstate anaesthetists, psychologists, business managers, and drug addiction specialists.

The 24th Annual Combined ANZCA/ASA CME Meeting will be held on 19th July 2003 at the Sheraton Towers Southgate. The theme of this meeting will be "Current concepts in Perioperative Care" and will update risk assessment, perioperative disease management and medical defence in 2003 for anaesthetists. Local and interstate anaesthetists, physicians, cardiologists and risk managers will contribute to the meeting.

It is appropriate to acknowledge and thank the Anaesthetic Departments who organise additional CME activities for Victorian Fellows. The high standard of these meetings combined with College and ASA activities provide ample CME activities in Victoria. A local Register of Meetings is maintained. Anyone with details of planned meetings wishing inclusion on this list should contact the VRC Administrative Officer via e-mail vic@anzca.edu.com, phone (03) 9510 6299 or fax (03) 9510 6786.

Rural Activities

The continuing rural issue is the recruitment and maintenance of an adequate anaesthetic workforce in non-metropolitan hospitals.

Two events, relating to this ongoing problem, occurred during the last 12 months. The Commonwealth has engaged consultants to address this issue at a Federal level and the rural representative met with one of the consultants to discuss primarily the disincentives to rural practice in anaesthesia, although the study's brief is rural medical practice in general.

The disincentives are significant and range from concerns relating to adequate community resources such as schools and other social infrastructure, to local health resources, and eventually to issues such as workforce numbers, training, CME and maintenance of standards and other issues, which are the direct province of the College.

Unfortunately, as one might expect from an examination of the long-term pattern of socio-economic drift that has occurred from rural to city for many years, the issues over which the College might exert direct influence are minor.

One positive contribution to this area was achieved during the year when the State Health Department agreed to fund an extra registrar position at third year level in Bendigo. This means that three anaesthetic registrars will be able to experience anaesthesia in a major regional centre in addition to achieving increased through-put for obstetric and paediatric training during the third year rotation.

Safety

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

Victorian Doctors Health Program (VDHP)

The annual meeting of the Consultative Council of VDHP was held on Wednesday 12th March 2003 where it was reported that the VDHP has received 225 contacts since 19th April 2001 when the program began.

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

All consultations are confidential. Of those seen 25% have been self-referrals and 75% referred by concerned colleagues and spouses or the Medical Practitioners Board. The latter is not notified of doctors presenting to the VDHP. There were 187 presentations until the 31/12/2002, including 14 anaesthetists. Over half the total presentations were related to alcohol and drug abuse and psychiatric illness and 25% of the substance abuse disorder cases had psychiatric disorders. Of the 187 cases 91 have been treated and the cases closed, 63 are on follow-up and 33 are being monitored. Currently 4-5 new contacts are being seen each week.

Victorian Medical Postgraduate Foundation Inc.

The VRC once again represented the College at the VMPF – Careers Advice and Training Expo for Medical Students and Recent Graduates, Saturday 3rd August 2002. In coordination with Rod Tayler, Sesto Cairo with the assistance of six volunteers manned the College booth, which generated a lot of interest.

Formal Projects

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

Many were presented at the Annual Anaesthetic Registrars' Scientific Meeting (ARSM) organised by the Regional Education Officer, Dr Mark Buckland and the Assistant Education Officer, Dr Winifred Burnett. For this reason, to aid prize session judging and Formal Project assessment, presenters at the ARSM will now be required to submit a declaration of contribution with their abstract.

Dr Jean Wellington	Elective Infrarenal Abdominal Aortic Aneurysm Patients: Determining where these Patients are Best Managed
Dr Nicholas Scurrach	Peripartum management of a patient with dopamine beta hydroxylase deficiency, a rare congenital cause of dysautonomia
Dr Attila Nagy	Development and Psychometric Testing of a Quality of Recovery Score after General Anaesthesia and Surgery in Adults
Dr Richard A Jones	Anaesthesia for Caesarean Section in a Parturient with a Fontan Circulation, Assisted by Trans Oesophageal Echocardiograph
Dr Brian Cowie	A Prospective Study of Recovery Following Laparoscopic Cholecystectomy
Dr Mathew Piercy	Antimicrobial guidelines and febrile neutropenia – balancing risk and resistance
Dr Paul M Mezzavia	A randomised trial of the effectiveness of bupropion as an aid to smoking cessation in patients awaiting elective surgery
Dr David Linscott	Paediatric Epidural Catheter Associated Epidural Abscess: Case Report and Literature Review
Dr Peter Squire	Theories of Consciousness
Dr Christopher Hoy	Awake Craniotomy – Ropivacaine Assay Study
Dr Christopher W Scarff	The Effect of Posture on Post-operative Nausea and Vomiting
Dr Joel A Symons	Anaesthetists' attitudes towards awareness and depth- of-anaesthesia monitoring
Dr Deral Tanil	Development and Psychometric Testing of a Quality of Recovery Score After General Anaesthesia and Surgery in Adults
Dr David J C Ware	The Pharmacokinetics and Safety of Lignocaine Infusions Used in the Treatment of Complex Regional Pain Syndromes
Dr Andrew Tymms	An Unusual Presentation of an Orbital Haemangioma during Spinal Surgery
Dr Wei-Ping Chan	Induction of Anaesthesia in the Home

Finally, the Victorian Regional Committee would like to thank all the staff at College Headquarters for their valuable assistance during the year. We extend our particular thanks to our Administrative Officer, Ms Corinne Millane for her excellent support.

Peter McCall
Chairman

Western Australia

Office Bearers and Members

Chairmen:
Dr Grant Turner
Dr Simon Maclaurin (from 18.02.03)

Honorary Secretary:
Dr Simon Maclaurin (to 18.02.03)

Continuing Education Officer:
Assoc Professor Michael Paech

Education Officer:
Dr Nedra van den Driesen

Regional Education Officer:
Dr Lindy Roberts

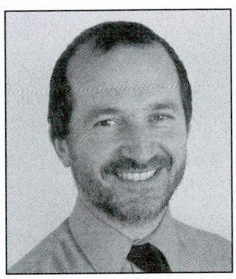
Webmaster / Simulation:
Associate Professor Richard Riley

Convenor of ASM 2004:
Dr Mark Josephson

Committee:
Dr Andrew Imison
Dr T Mark Allen
Dr Chris Cokis

Councillors:
Professor Teik Oh
Dr Wally Thompson

Co-opted:
New Fellows Representative:
Dr Andrew Gardner



Dr. Grant Turner
Chairman

Dr. Simon Maclaurin
Honorary Secretary

Total No. of Regional Committee Meetings for Year: 6

Committee Members	Meeting Attendance
Dr Grant Turner	4/6
Dr Simon Maclaurin	6/6
Dr Michael Paech	4/6
Dr Nedra van den Driesen	1/6
Dr Lindy Roberts	5/6
Dr Richard Riley	4/6
Dr Mark Josephson	5/6
Dr Andrew Imison	2/6
Dr T Mark Allen	2/6
Dr Chris Cokis	3/6
Prof Teik Oh	2/6
Dr Wally Thompson	2/6

Chairman's Report – Dr Grant Turner

Committee Composition and Office Bearers

Dr Stuart Inglis did not seek re-election as Secretary in June 2002 and Dr Simon Maclaurin was elected to that position. Dr Grant Turner handed over the role of Chairman to Dr Simon Maclaurin in February 2003 but remains on the Committee as Immediate Past Chairman. The position of Secretary is currently vacant.

Dr Mark Allen and Dr Chris Cokis were welcomed as newly-elected members of the Committee in June 2002.

Continuing Education for Rural GP Anaesthetists

The College and Society in collaboration with CTEC continues its innovative three-day combined classroom and simulation program over the past year specifically for rural GP Anaesthetists. This continues to be a high value educational activity.

New Fellows Conference

Dr Michael Veltman and Dr Steve Myles will be the WA representatives to the New Fellows Conference in Hobart in May 2003

Nerida Dilworth Prize

The Nerida Dilworth Prize for the best Registrar presentation at a Western Australian Meeting was jointly awarded to Dr Jason Wells and Dr Jodi Graham.

ANZCA and ASA in Western Australia

The past 12 months has seen a continuation of the close working relationship between the ASA and ANZCA. The two committees have held their respective bi-monthly meetings after a joint combined meeting. In doing so we have been able to avoid duplication of effort while constantly providing a unified voice on issues affecting all anaesthetists in Western Australia.

WA Regional Education Officer Report – Dr Lindy Roberts

Trainee Numbers

The WA Programme currently has 45 Trainees in Years 1 to 4, an increase of 7 funded training positions since last year (2 at Royal Perth Hospital, 2 at Princess Margaret Hospital, 1 at King Edward Hospital, 1 at Fremantle Hospital, 1 at Sir Charles Gairdner Hospital).

Trainee Rotations and Subspecialty Experience

Hospital rotations continue to be organised with reference to trainee preferences which are sought by me in September each year. There are rotations to all major metropolitan hospitals (including 6 months each in obstetric and paediatric anaesthesia), and one non-metropolitan position in Bunbury.

Mortality Committee:
Dr Neville Gibbs

Australian Resuscitation Council:
Dr Aileen Donaghy

Country Representative:
Dr Wilson Lim

Day Care Anaesthesia:
Dr Stephen Watts

SARG/ Rural Education:
Dr Leigh Coombs

ASA Representative:
Dr Ken Williams

Faculty of Pain Medicine:
Dr Roger Goucke

Joint Faculty of Intensive Care Medicine:
Dr Bernice Ng

Administrative Officer:
Mrs Patricia Luxford

The compulsory 3 month ICU rotation has become a bottleneck in WA. Simon Maclaurin and I have written to the Health Minister requesting additional funding for ICU positions. (This follows our successful approach last year regarding funding of additional positions in Paediatric Anaesthesia.)

Selection of Trainees

In WA, a standardised selection process based on ANZCA guidelines is organised by the REO with applications handled through the administration at Sir Charles Gairdner Hospital. Applicants are required to address selection criteria and obtain standard format confidential referee reports. A committee of 3 or 4 shortlists applicants who are then interviewed by a panel of three. Appointments are finalised by a joint committee of Heads of Department and ANZCA representatives (Chair of Regional Committee, SOTs and REO).

Trainee Orientation

Since 2000, this meeting has been held in the first or second week of the new training year. Most recently it has been convened by Simon Maclaurin. Topics covered include the role and structure of the College, training requirements and role of the REO and SOTs, the ASA, and the Part I exam. Martin Chapman, a local psychiatrist with an interest in doctors' health, runs a very successful session on 'Looking after yourself during training'.

Trainee Newsletter

This continues to be a regular communication between the REO and trainees.

The following trainees joined the WA Training Program in 2003:

Tai Ma, Serge Kaplanian, Alistair Davies, Lloyd Green, Jamie Stevens, Chris Duffy, Ed O'Loughlin, Rowan Drayton, Jenny Phillip, Shanon Jarvis, Markus Schmidt, Rebecca Martin, Stephen Lamb, Szu-Lynn Chan, Claire McTernan, Andrew Miller

Meeting for Supervisors of Training

A meeting for SOTs from Anaesthesia, Pain Medicine and ICU entitled 'Giving feedback to trainees' was held on 16th November 2002, convened by Russell Jones. The meeting was well received. In view of the size of the region, there was support for holding future meetings every two years.

Formal Projects

The standard of formal projects and quality of supervision in WA has remained high. Trainees are encouraged to present their work at the Autumn or Winter Scientific meetings in Perth.

Formal projects approved during the past year are as follows:

Dr M.Lennon, P Seigne, AJ Cunningham	Pituitary apoplexy after spinal Anaesthesia. Br J Anaes 1998;81:616-618
Dr C Smit	Effect of systemic hypothermia on brain temperature during craniotomy. Supervised by Dr J Fabling at SCGH. Presented at Brisbane ANZCA ASM, May2002.
Dr A Millard	Double respiratory sequelae following head injury: a case report of subglottic stenosis and bilateral pneumothoraces. British Journal of Anaesthesia 2003;90:94-6
Dr J Lain	A randomised evaluation of a disposable and a reusable laryngeal mask airway. Presented at the WA ANZCA ASA Winter Scientific meeting in June 2002.

Dr P Coleman, JM Goddard	Harlequin Syndrome following internal jugular vein catheterisation in an adult under general anaesthetic. Anesthesiology 2002;97(4):1041.
Dr J Wells, M Paech	Intrathecal fentanyl-induced pruritis. The effect of prophylactic ondansetron in labour. Presented at the Winter Scientific Meeting. Drafted for submission.
Dr R Pang	The principles of night shift rostering. A review. Drafted for submission.
Max Majedi	Bacterial contamination of epidural needles after multiple skin passes. Supervised by Chris Orlikowski (KEMH). BJA 2002;89:922-4. Presented Winter Scientific Meeting, 2001.
Karen Wong	Analgesic effect of continuous subacromial bupivacaine infusion after shoulder surgery (RCT). Supervisor Steve Watts (SCGH). Drafted for submission for publication.

Part-Time Trainees

There are currently three registrars training part-time. In 2004, this will increase to six. This has workload implications for Departments (particularly when an uneven number precludes job-sharing), and their continuing support in this area is acknowledged.

Trainee Courses and CME

Part 1 Course: Held on a Friday afternoon at Sir Charles Gairdner Hospital. An integrated programme with Physiology coordinated by Jay Bruce (Fremantle Hospital) and Pharmacology by Brien Hennessy (Sir Charles Gairdner Hospital). Trainees attend in-hours with the support of local Departments.

Part 2 Course: Coordinated by Bill Weightman (Sir Charles Gairdner Hospital). An evening tutorial programme is held throughout the year, and viva-oriented sessions are run in-hours by Simon Maclaurin and Chris Cokis (Royal Perth Hospital) in the two months prior to each exam. Many local anaesthetists contribute to the tutorial programme.

EMAC Course: The local simulation centre (CTEC) has recently started offering EMAC and three courses are planned for 2003. Trainees have been made aware of this.

Winter Scientific Meeting: At the request of trainees, it is planned to hold a session regarding "stress and anaesthesia" at this meeting on 14th June 2003.

Careers Expo

Once again, ANZCA had a booth at this annual event held for medical students and junior doctors. The Anaesthesia stand was staffed by trainee volunteers. Michael Paech gave a formal presentation about Anaesthesia as a career choice.

Many thanks to the following whose contribution to the WA Training Program is greatly valued:

Supervisors of Training

Mark Somerville (Joondalup Health Campus)
Jay Bruce (Fremantle Hospital)
Ramin Gharbi (Royal Perth Hospital)
Polly Harmon (King Edward Memorial Hospital)
Soo Im Lim (Princess Margaret Hospital)
John Male (Bunbury Regional Hospital)
Steve Myles (Sir Charles Gairdner Hospital)

Those involved in Trainee Selection: Simon Maclaurin, Michael Paech, Andrew Gardner and Nedra vanden Driesen.

Clinical teachers, lecturers, trial examiners, mentors, and project supervisors: Too many to mention by name, thanks for your input.

Continuing Education Report – Associate Professor Michael Paech

Regional Scientific Meetings

The 2002 Winter Scientific Meeting (WSM): The WSM was held on 29th June 2002 at the St John of God Conference Centre, Subiaco. This was the second of three such meetings honouring Dr John Hankey. Professor Guy Ludbrook of Royal Adelaide Hospital was the Visiting Lecturer. Prof Ludbrook undertook a busy program in the week preceding the WSM, including visits to Bunbury and several metropolitan teaching hospitals.

The WSM proved an ideal forum for presentations by local anaesthetists and the standard of free papers, principally by trainees, was excellent. WA Anaesthesia thanks Boots Healthcare for their generous sponsorship and their commitment to sponsorship again this year.

The 2003 WSM will be held on 14th June 2003 at the St John of God Conference Centre, Subiaco. The Visiting Lecturer will be Dr. Alison Lilley, Head, Department of Anaesthesia, The Royal Women's Hospital, Melbourne.

The 2003 Autumn Scientific Meeting was held on March 29-30 at the Hyatt Regency, Perth. This was a highly successful multidisciplinary meeting organised by WA Anaesthesia, largely by members of the ASA Committee.

The theme of "Complication and Complaints" allowed contributions by outstanding local speakers including a haematologist and microbiologist, and by visitor Dr Mark O'Brien of the Cognitive Institute in Queensland, an expert on medical litigation and risk management. It was pleasing to see a strong attendance by anaesthetic technicians and nursing staff. Thanks go to the major sponsors, Anaesthetic Supplies and AstraZeneca, plus all the trade exhibitors.

Other Activities

In October 2002 we welcomed Professor Michael Harmer of Cardiff, Wales on his return trip from the ASA Scientific Congress in Adelaide. Professor Harmer's evening presentation "There's no such thing as a difficult airway – do you really think so?" was kindly supported by Abbott Australasia.

Anaesthesia WA continues to support rural General Practitioners with continuing education sessions and hospital visits, now held on a regular basis in Perth at the Centre for Anaesthetic Simulation and Medical Collaborative and Royal Perth Hospital. Thanks to Leigh Coombs for his organisation of these courses.

Future Continuing Education

Perth is to host the 2004 Annual Scientific Meeting of the College and organisation is well underway, with appointment of Conference Organisers, speakers selected and a venue booked. The Convenor is Dr Mark Josephson, the Scientific Program Convenor Dr Lindy Roberts and the Social Convenor Dr Andrew Gardner.

Anaesthesia WA Website – Clinical Associate Prof Richard Riley, Webmaster

The Anaesthesia WA website (maintained by the Anaesthesia WA Continuing Education Committee) remains online at the following Internet address: http://www.anaesthesia-wa.iinet.net.au. The website may also be found by using the simpler domain name: www.anaesthesiawa.org. Our site continues to be sponsored through the generosity of AstraZeneca Pty Ltd.

The main page features a news column and links to ANZCA and the ASA. It also directs the user to pages detailing various committees, educational material and other resources, such as malignant hyperthermia and anaesthetic allergy testing facilities in Western Australia. ANZCA Part 1 references and tutorial timetables for trainees are also available from this site.

Many of the information pages are being converted into the Adobe PDF format. PDF files preserve formatting and help protect the intellectual property of authors. The home page is also a portal to Departments of Anaesthesia located in Western Australia. A link to our Emergencies and Guidelines page has been placed on the Australian Anaesthesia website.

Changes and modifications to the website are made following ANZCA and ASA Committee approval.

Representation on Committees

Australian Resuscitation Council – WA Branch
Dr Aileen Donaghy represents WA Anaesthetists in this regional committee.

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

Joint Faculty of Intensive Care Medicine
Dr Bernice Ng has represented the Faculty on the Regional Committee

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

Health Department of Western Australia Committees
ANZCA WA contributes to the state committee on Rural General Practice Anaesthesia.

Chair of Anaesthesia in WA
Dr Michael Paech has been appointed Clinical Associate Professor of Obstetric Anaesthesia and Dr Richard Riley has been appointed Clinical Associate Professor of Anaesthesia.

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

On behalf of the College I thank all the WA Committee members and Councillors who give so much of their time and talents to the ANZCA WA Committee and the specialty in Western Australia.

Grant Turner
Chairman

Tasmania

Office Bearers and Committee Members

Chair:
Dr Margaret Walker

Deputy Chair:
Dr Phil Browne

Honorary Secretary:
Dr Daniela Eugster

Treasurer:
Dr Richard Waldron

Regional Education Officer:
New Fellows Representative:
Dr Mike Grubb

Co-opted Councillor:
Dr Mike Martyn

Co-opted Committee Member:
Dr Mark Reeves

Dr. Margaret Walker
Chair

Training Issues

Training for Supervisor of Training and tutors is now being provided via an information pack available from the College website. The College has asked that there be a 'buddy' for each Supervisor of Training, for support and advice. The Regional Committee thought that given the small departments at Launceston General Hospital and North West Regional Hospital this was probably not necessary, and Dr Margaret Walker was nominated to fulfil this role at the Royal Hobart Hospital. Dr Peter Lane has agreed to be the Rotational Supervisor of Training, which means he will keep track of all trainees experience and allocate subspecialty experience where required.

'Revised FANZCA' to be introduced from January 2004 for all trainees. Trainees currently in the scheme will be integrated into the Revised FANZCA with a package to be developed by the College over the next few months. Information is available on the ANZCA website, and information packs will be provided to all teaching hospitals. A significant change will be the change in accreditation process, in that Departments will now be accredited for training, not posts. Trainees will have a training portfolio in which they will document their training exposure and how valuable they found it.

North West Regional Hospital Burnie was inspected by ANZCA and accredited for an additional trainee for 2003. This position is not currently occupied.

Trainee supervision at Royal Hobart Hospital was investigated after some complaints of inadequate supervision levels were received. Trainees were found to be working too much of the time out of hours, and with supervision which did not meet College guidelines. The rostering practices have now been changed, and the Regional Committee continues to monitor the situation closely.

2003 ASM

The 2003 ANZCA ASM was held in Hobart from 3-6 May 2003 at the Hotel Grand Chancellor Convention Centre. The ASM progressed successfully under the guidance of Convenor, Richard Waldron. Further reports will be presented to ANZCA from the Convenor and Scientific Convenor.

The Organising Committees comprised:

Convenor	Dr Richard Waldron
Deputy Convenor	Dr Margaret Walker
Scientific Convenor	Dr Phil Browne
Social Programme	Dr Peter Sayers
Workshops and Problem Based Learning	Dr Malcolm Anderson
Trade Liaison	Dr Colin Chilvers
Audio-visual	Dr Jeremy Wallace
Joint Faculty of Intensive Care Medicine	Dr Stuart Miller
Faculty of Pain Medicine	Dr Hilton Francis

Professional Documents

As usual, the Regional Committee has reviewed at least 20 Professional Documents during the year, which is part of the ongoing process of maintaining ANZCA policy at an up to date level.

Statewide Surgical Services Committee

This committee held a review of Anaesthetic services during the year. It was found that all the major teaching hospitals had significant specialist anaesthetist staff shortages, with the North West Regional Hospital, Burnie in the worst situation. The Committee resolved to present their findings to the Department of Health with some recommendations for funding of extra staffing.

Tasmanian School of Medicine

The College was represented on the Committee involved in re-accreditation of the TSOM. Malcolm Anderson continues to represent us. The TSOM has received reaccreditation for a further 3 years, with subsequent accreditation dependent on the satisfactory development of a five year medicine course.

Representation on Other Committees

Ambulance Council:	Dr Marcus Skinner
Post-Graduate Medical Committee:	Dr Michael Hodgson
Australian Resuscitation Council:	Dr Malcolm Anderson
School of Medicine Advisory Committee:	Dr Malcolm Anderson
Australasian Anaesthesia Sub-Editor	Dr Malcolm Anderson
Younger Fellows Conference:	Dr Mike Grubb

Tasmanian Anaesthesia Education Committee

Chair:	Dr Mike Grubb
Committee members:	Dr Margaret Walker
	Dr Richard Waldron
	Dr Colin Chilvers
	Dr Marcus Skinner

Supervisors of Training

Royal Hobart Hospital	Dr Peter Lane
Launceston General Hospital	Dr Rob Eadie
North West Regional Hospital:	Dr Mark Reeves

Margaret Walker
Chair

New Zealand National Committee

Office Bearers and Members

Chairman
Dr Sharon King

Deputy Chairman
Dr Peter Cooke

Honorary Secretary
Dr Vaughan Laurenson

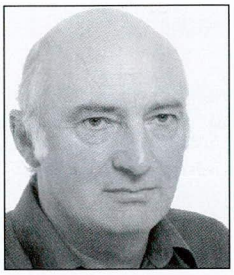
Honorary Treasurer
Dr Brent Boon

Education Officer
A/Prof. Michael Harrison

Formal Projects Officer
Dr Hugh Spencer

Committee Members
Dr David Jones
Dr Don Mackie
Dr Malcolm Stuart
Dr Tom Watson
Dr Jennifer Weller

Dr Sharon King
Chairman



Dr Vaughan Laurenson
Honorary Secretary

Total number of National Committee Meetings for year: 4

Attendance of Elected Members:

June 2002 (2000-2002 Committee):
Apologies from Professor A Merry, Dr M Futter, Dr V Laurenson,

August 2002 (Outgoing/Incoming Committee):
Apologies from Professor A Merry, Dr M Futter, Dr T Watson

November 2002: Full attendance
March 2003: Full attendance

Chairman's Report – Dr Sharon King

New Zealand continues as a test tube for "innovations" in health care. The Nurse Practitioner role is developing in New Zealand as an independent autonomous model. An example of such a practitioner that has been raised, is the nurse anaesthetist with the USA CRNA quoted as an example of a possible direction for nursing. It challenges our thinking about whose domain the giving of anaesthesia should lie in. Does it require a medical base? What factors determine who needs supervision or who can work independently? Are overseas trends or models of anaesthesia delivery relevant to New Zealand/Australia?

It is becoming increasingly apparent that in many countries (not the least in the UK and the US) the demand for medical anaesthetists is outstripping the numbers that are being trained. There are a multitude of reasons why production is not meeting demands but the main question we need to ask ourselves is, if doctors cannot meet the demands then how can the needs of the community be met?

In New Zealand, it is a situation of distribution. Like many other professional groups, anaesthetists prefer to stay in the larger cities. How do we get anaesthetists in to the smaller centres, areas that New Zealanders call the provincial areas and Australians call rural and remote? With the recent adverts arriving in our mail, one almost wonders whether this is changing when there are positions vacant in cities like Canberra, Geelong and Palmerston North, whereas a few years ago it was adverts for outlying areas.

Perceived anaesthetic shortages, a desire of health professional groups to no longer be confined to traditional roles and economists' view of the world that doctors are controlling the cost of health, thereby making it expensive, brings interesting challenges to New Zealand anaesthetists.

The tension between the containment of health costs versus public safety is demonstrated through a recently introduced government controlled purchasing of hospital drugs (PHARMAC). The inability to avoid having suxamethonium and metoclopramide in virtually identical ampoules, including the colour of printing on the ampoule, as a result of an imposed contract with one sole company raised enormous concerns of medication error. It is with great relief that good sense has prevailed, but only through lobbying, and that money did not outvote patient safety.

Providing a continuing education programme for anaesthetists in New Zealand has been under the successful auspices of CECANZ, a joint venture of the New Zealand National Committee and the New Zealand Society of Anaesthetists. HELP modules have been a core activity of CECANZ for many years and it is with great reluctance that the production of this booklet has ceased this year. Production costs, technology and changing lifestyles of doctors has required CECANZ to look again at ways of delivering adult education. Dr Jenny Weller is leading this change as the CECANZ Chair.

Trainees, the core of the existence of our College, have been actively supported by superbly run exam preparation courses in Auckland, Hamilton, Wellington and Christchurch. Credit has to go to the enthusiasm and commitment of the local anaesthetists to these activities.

New Fellows' representative
Dr Alastair McGeorge

Councillors
Dr Steuart Henderson
Dr Leona Wilson

Joint Faculty of Intensive Care Medicine
Dr Ross Freebairn
Chair, JFICM

NZSA Representative
Dr Annette Turley
President, NZSA

Executive Officer
Heather Ann Moodie

Administrative Officer
Lorna Berwick

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

The CECANZ conferences have been of high quality and well attended, even by Australians! The courage of the smaller departments to take on the task alongside the larger ones is amazing. Our thanks to Whangarei and Christchurch for holding excellent meetings over the past 12 months.

There are many more activities that have been undertaken by all members of the New Zealand National Committee that have not been mentioned in my report but I would like to record my thanks for their dedication and hard work.

In August, Heather Ann Moodie was appointed as Executive Officer at the New Zealand National Office. Things cannot happen, ideas cannot advance unless there is an office ready and willing – thank you to Lorna Berwick, Jan Brown and Heather Ann Moodie for anchoring the committee.

Lastly I would like to acknowledge my gratitude to all New Zealand anaesthetists in their efforts to do something that we are not accustomed to – promoting our specialty! After all, it is the doctors administering anaesthesia who have the conviction, the passion and the knowledge of anaesthesia to tell people who we are and what we do.

Treasurer's Report – Dr Brent Boon
(Year ending 31 December 2002)

In the second half of the year, Dr Brent Boon was nominated as Honorary Treasurer, a position previously held by Dr Peter Cooke.

The New Zealand Committee Expenditure increased significantly during the year ending 31 December 2002 compared with the previous year. By far the major component of the increase is attributable to the costs incurred as a result of the Nurse Anaesthetist initiative. The cost of this to 31 December 2002 is $78,637. The other area where there was a three-fold increase in expenditure was collectively called the Melbourne expenses. These were expenses carried by the NZNC accounts. Extra expenditure was incurred with the ANZCA Executive meeting held in Wellington in August, and with monies contributed on Melbourne's behalf to the planned ASM in Auckland (2005).

In most other areas expenses have remained approximately the same.

Total expenditure was $328,853. The CME account is stable and expenses were of a similar size to the previous year. Seed monies did not draw much from the account and conference profits are expected from early conferences in the 2003 year. CECANZ expenses were one third of the previous year. CECANZ is reviewing its operations and future directions at the moment.

The fixed assets of the committee amount to $71,968 plus the Elliott House value.

National Education Officer's Report – Michael Harrison

The Revised FANZCA

An SOT meeting was held on April 3rd in Auckland. There were 25 registrants, including 17 SOTs, several HODs and some module coordinators, the NEO and the EO. At this meeting the implementation of the Revised FANZCA was addressed and the nature of the transition period for those already in the training scheme. A teleconference was held in February where all REOs were able to discuss the new system with the EO and College President.

Trainee Placements

A spreadsheet containing the names of all NZ trainees (ANZCA and non-ANZCA) has been created which, if updated six-monthly, should help the NEO keep a track of trainee placements. I have been informed that it is not perfect but time should sort out the inaccuracies.

SOT Teleconference

A teleconference to enable discussion between the NZEO and the SOTs took place on 13th March.

2003 ANZCA ASM Hobart

Unfortunately arrangements for a deputy to attend the REO meeting at the Hobart conference failed.

New Zealand Courses:

Part I FANZCA Course – Hamilton
Course dates for 2003: Monday 9 – 20 June
Course Convenor: Dr John Barnard, Department of Anaesthetics, Waikato Hospital, Hamilton.

Part I FANZCA Course – Christchurch
February 2003 (ten day duration)
Course Convenor: Dr Wayne Morris, Department of Anaesthesia, Christchurch Hospital

Part II Revision Course – Wellington
Course in Clinical Assessment for the Final FANZCA Examination
Course dates for 2003: Thursday 10 April – Saturday 12 April;
Thursday 14 August- Saturday 16 August
Course Convenor: Dr Frank Thomas, Department of Anaesthesia and Pain Management, Wellington Hospital

Part II Revision Course – Auckland
Course dates for 2003: 23 June – 4 July
Registration was restricted to NZ trainees until the end of January.
Course Convenor: Dr Jane Torrie, Department of Anaesthesia, Auckland Hospital.

NZNC Formal Projects Report – Hugh Spencer

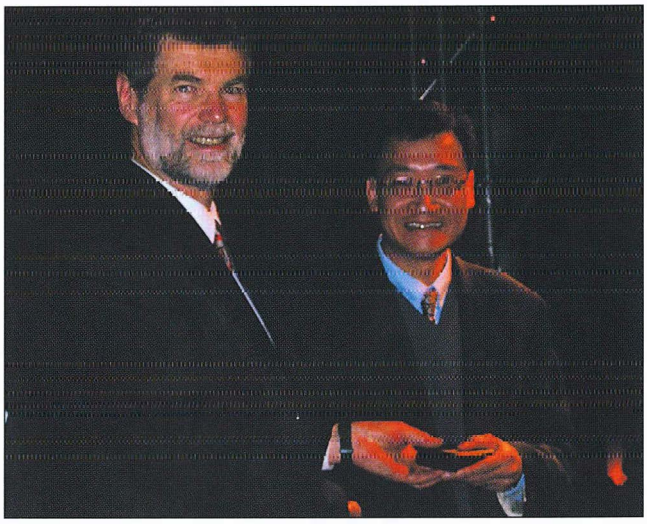
The undernoted Formal Projects were approved by the Assessor:

Bishay Maged	Low dose naloxone and morphine in PCA reduces pruritus but is not opioid sparing
Christian Brett	EF-2 kinase and S6 kinase as modulators of long-term potentiation
Simon Burrows	Redefining environmental gas exposure: end-tidal sampling of anaesthetists' breath.
Lisa Chapman	Postoperative Hypotension in Hip Joint Replacement Surgery
Bryce Curran	Hepatic and renal failure associated with amiodarone infusion in a patient with hereditary fructose intolerance.
John Faris	Practical Perioperative Transoesophageal Echocardiography
Hamish Gray	Ludwig's angina
Justin Imrie	Anaphylaxis to chlorhexidine in urethral catheter lubricant
James Lai	Substernal epicardial echocardiography: clinical evaluation of a new imaging technique in the postoperative cardiac patient
Alison Kirkman	The Paxpress Pharyngeal Airway – a new device: a report on the incidence of minor side effects
Paul Murphy	Bispectral index monitoring during electroconvulsive therapy under propofol anaesthesia
Lance Nicholson	Chapter in *Myler's Side Effects of Drugs*
Frank Thomas	Development of a Course in Clinical Assessment for the Final FANZCA Examination
Bevan Yee	Hypertrophic Cardiomyopathy: Recent Advances and Perioperative Management

Foundation Visitor, Prof. James B Eisenkraft with College President, Dr Richard Willis

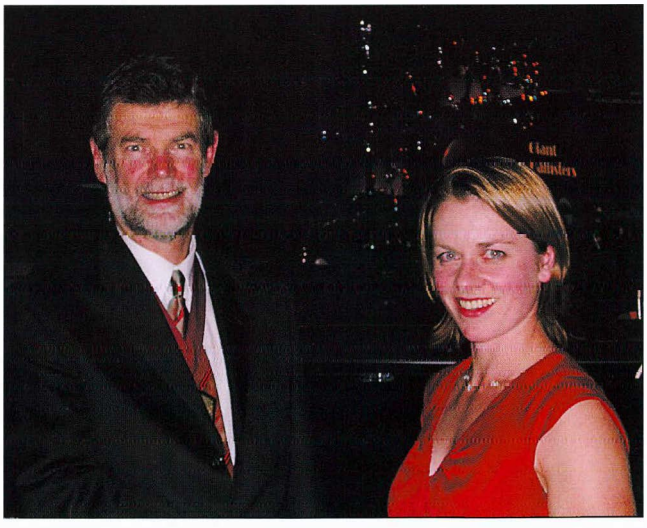
Dr K. Inbasegaran, on behalf of the College of Anaesthesiologists, Academy of Medicine, Malaysia, presented a pewter bowl to the College during the ASM.

International Speaker and presenter of the Gwen Wilson Historical Lecture, Prof. Edmond Eger with Dr Michael Hodgson and Dr Richard Willis.

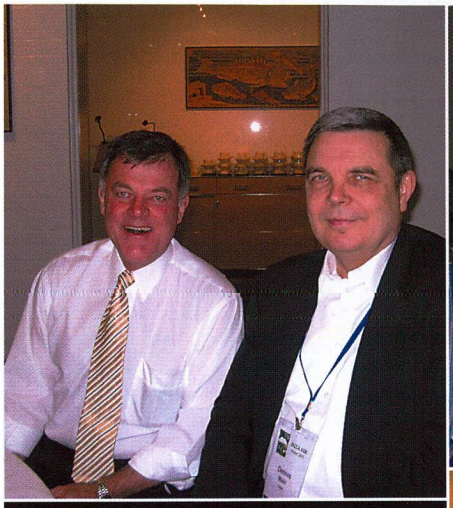


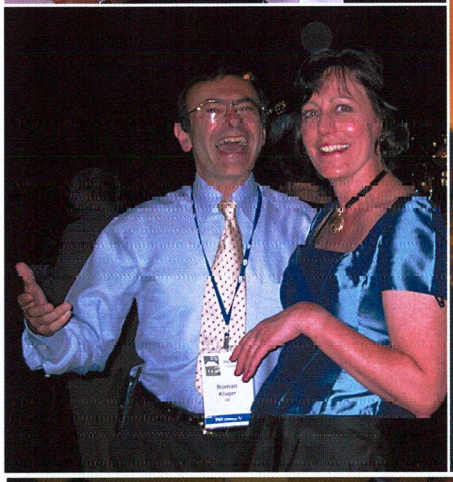
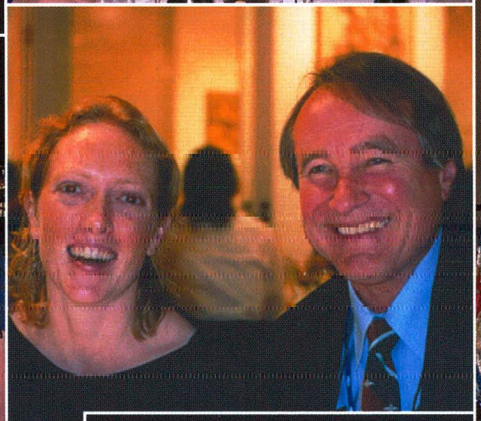
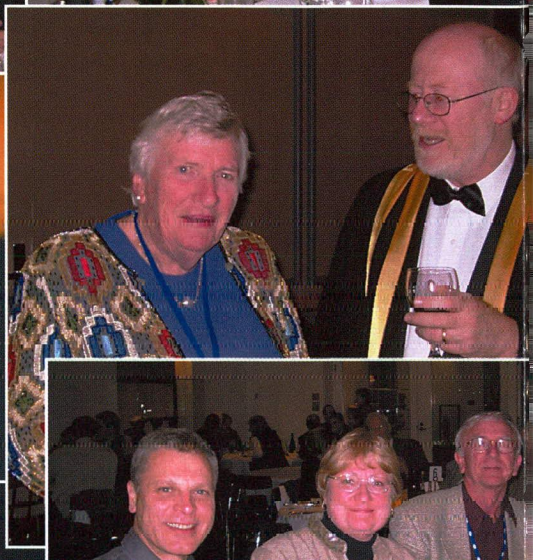
Dr Richard Willis presents Dr Ho Kwok Ming with the Gilbert Brown Prize medal.

Australasian Visitor, Assoc. Prof. Kate Leslie with Dr Richard Willis.

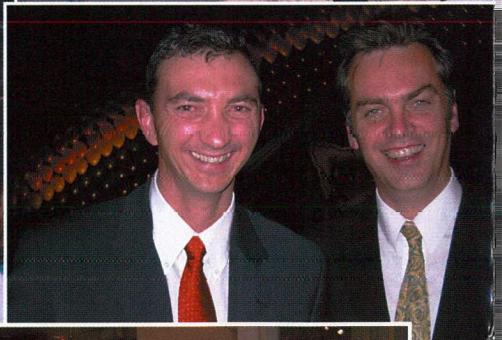


Dr Kerryn Martin, winner of the Formal Project Prize, with Dr Richard Willis.








Report from the President to Fellows of The Australian and New Zealand College of Anaesthetists as at the 5th May 2003

It is my pleasure to report on behalf of Council on matters pertaining to the College since the last Annual General Meeting. I report a small number of activities of the College, its Council and the myriad of other College Committees, but emphasise some major developments.

GENERAL

AMC Accreditation Process

The Australian Medical Council has established a process for accreditation of the 'Specialist Medical Education and Training Programs' which are the core business of the specialist Medical Colleges.

ANZCA has been the first College to undergo the definitive process. This entailed review of all matters related to education, training, management of trainees, assessment and examinations, Maintenance of Professional Standards, Overseas Trained Specialists, and Continuing Medical Education. The report included several recommendations that the College is addressing, but overall was considered to be excellent, with accreditation granted for six years, with a possible extension to 10 years, subject to satisfactory annual reports.

This exhaustive independent review and report has great significance for ANZCA. The College is most appreciative of the efforts of the many Fellows around Australia and New Zealand who contributed.

Finance

The complex process of separately accounting for the finances of the Joint Faculty of Intensive Care Medicine has been essentially completed.

Communication with Regional/NZ Committees

In an effort to improve communication between Council and the Regional/NZ Committees, regular teleconferences have been convened by me with the Chairmen, and interstate Executive Meetings have been organised in conjunction with Regional/NZ Committee Meetings, providing the opportunity for information exchange, and this process will continue during 2004. Chairmen have also been invited to attend Council Meetings on a rotational basis, and during the past year Drs Sharon King (NZ), Margaret Cowling (SA&NT) and Frank Lah (ACT) have participated. In addition, I have attended as many CME and Regional/NZ Committee Meetings as time has allowed.

Presentations to the College

To mark the opening of ANZCA House, the College was presented with gifts from the Australian Society of Anaesthetists and Royal Australasian College of Surgeons. ASA President, Dr Michael Hodgson presented a German Kieninger wall clock, and RACS President, Professor Kinglsey Faulkner presented a painting entitled *Return to Forever* by Trevor McNamara.

EDUCATION AND TRAINING

Revised FANZCA Program

Planning for the implementation of the Revised FANZCA Program is well underway and a number of workshops have been organised both interstate and in New Zealand to provide information and obtain feedback prior to its implementation from the 2004 Hospital Year.

Trainees

The College has considered the issue of Trainees on College Committees, and it has been agreed that a trainee representative will be included in the membership of the Education and Training Committee.

Council is considering the establishment of a Trainee Committee to consider issues relating to education and training, and other matters affecting training, examination and standards. Terms of Reference have been drafted by the Executive and it is proposed that the trainees in each Australian region, and in New Zealand will be requested to nominate a representative annually. These nominees will form the Committee and elect the Chairman. It is anticipated that the Trainee Committee will meet annually at the time of the ASM, and by teleconference prior to meetings of the Education and Training Committee.

Hospital Accreditation Committee

Ongoing accreditation visits to training hospitals have continued during the past 12 months. This process ensures that appropriate standards of training are maintained.

CONTINUING PROFESSIONAL DEVELOPMENT

The utilisation of videoconferencing, particularly for Continuing Medical Education has advanced with the availability of Commonwealth funding for health initiatives and the professional input of the company Global Telehealth.

Maintenance of Professional Standards

During the past year, minor revisions have been made to the MOPS Eligibility Statement and the Annual Return Declaration.

Certificate in Diving and Hyperbaric Medicine

Council approved a Certificate Program in Diving and Hyperbaric Medicine which commenced in January 2003. We look forward to the first candidates presenting for examination either later this year or early 2004.

Annual Scientific Meetings

This 2003 ASM is proving to be a very successful, educational and friendly Meeting. It has been maintaining the high standards of previous Meetings and has been exceptionally well supported by the Fellows, trainees and the Health Care Industry. The Foundation Visitor to this Meeting is Professor James Eisenkraft from the USA who delivered the Ellis Gillespie Lecture titled *Hazards of Anaesthesia Gas Delivery Systems*. Dr Kate Leslie (Vic) delivered the Australasian Visitor's Lecture, titled *Awareness Under Anaesthesia*.

The award of the Gilbert Brown Prize and Formal Project Prize, will be announced tonight during the Dinner and will be noted in future editions of the ANZCA Bulletin. I thank the Organising Committee for this immensely successful Meeting.

The 2004 ASM will be held in Perth from 1st to 5th May and Professor Mike James from South Africa has accepted the invitation to attend as Foundation Visitor.

Following the success of the Combined Scientific Meeting in Hong Kong, it was planned to hold the 2005 ASM in Kuala Lumpur in association with our Malaysian and Singaporean colleagues. However, as a result of the Bali bombing and the publicised targeting of Western events for further incidents, warnings were issued by the Australian Department of Foreign Affairs and Trade regarding travel and attendance at large gatherings in several neighbouring countries. With great regret Council decided to defer these plans. The 2005 ASM will now be held in Auckland, New Zealand from 7th to 11th May.

It is worthy of note that the 2002 ASM was named Queensland's Meeting of the Year (over 500 delegates) at the 2002 Queensland Meetings and Events Industry Awards for Excellence.

PROFESSIONAL AFFAIRS

Asia-Pacific

Professor Phillips continues to coordinate training for the Master of Medicine in Anaesthesia in Papua New Guinea, assisted by anaesthetists visiting PNG as part of the AusAID sponsored RACS Tertiary Health Services program.

Rural Health

ANZCA has been awarded a Commonwealth grant of $300,000 to pilot a scheme to use mobile simulation facilities for resuscitation training in Queensland and New South Wales.

ANZCA International Scholarship

Council established the ANZCA International Scholarship to assist an anaesthetist who has completed training in his/her own country's anaesthesia training program and who would benefit from additional training in Australia or New Zealand. It is expected that he/she would provide leadership to the specialty of anaesthesia on returning home. Applications have been sought from anaesthetists from developing countries in the South-East Asia/South Pacific region, excluding those countries in which the College examines.

ANZCA Mortality Committee

Towards the end of 2003, the College published the third triennial report entitled *Safety of Anaesthesia in Australia – A review of anaesthesia related mortality 1997 – 1999*. I congratulate Dr Patricia Mackay who undertook the role of Editor. It was pleasing that there were several positive press reports and feedback following release of the report.

Multi-Centre Trial Secretariat

The College has agreed to co-ordinate a Multi-Centre Trial Secretariat, with the provision of priming funds of $100,000.

WORKFORCE MATTERS

A further survey of Fellows in late 2002 regarding work patterns has been completed and is currently being analysed.

Shortage of Anaesthetists

The College has more than fulfilled the recommendations which arose from the second report on the anaesthesia workforce from the Australian Medical Workforce Advisory Committee. Nevertheless, there are perceptions of anaesthesia workforce shortages in several regions of Australia and New Zealand.

Area of Need Positions

The College is assisting this process by assessing the credentials of Overseas Trained Specialists (OTS) appointed to such positions, ascertaining their suitability for their participation, appointing supervisors, and then ensuring that they undertake the College's formal OTS Assessment Process. This includes a written and oral examination.

Obstetric Anaesthesia

Availability of anaesthesia services for emergency obstetrics in private hospitals has become a problem in some regions. ANZCA and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists have formed a joint working party to examine this problem and provide recommendations.

AWARDS, HONOURS AND APPOINTMENTS

During the past year many of our Fellows have been the recipients of Awards, Honours, and Appointments.

- Dr Bruce Rounsefell (SA) was created a Member in the Order of Australia (AM) in the Australia Day Honours list.
- Dr Edmund Loong (NSW) was awarded a Medal of the Order of Australia (OAM) in the Queen's Birthday Honours list.

- The following Fellows were recipients of the Centenary Medal – Professor Tess Cramond (Qld), Dr Patricia Mackay (Vic), Dr Brian Pollard (NSW) and A/Professor Richard Walsh (NSW).
- Professor Michael Cousins (NSW) was presented with the Carl Koller Gold Medal of the European Society of Regional Anaesthesia.
- Dr Richard Willis (SA) was elected to Fellowship of the Academy of Medicine of Singapore.
- Professor Teik Oh (WA) was granted Fellowship of the College of Anaesthetists, Colleges of Medicine of South Africa.
- A/Professor José Carvalho (Canada) was appointed Associate Professor of Anaesthesia, University of Toronto, and Director of Obstetric Anesthesia, Mount Sinai Hospital.
- Professor Stephen (Butch) Thomas (USA) was appointed the Marjorie Topkins – Alan Van Poznak Professor of Anesthesiology at Cornell University.
- Dr Kate Leslie (VIC) was appointed Honorary Associate Professor, Department of Pharmacology, University of Melbourne.
- Dr Michael Paech (WA) – was appointed Associate Professor of Obstetric Anaesthesia, School of Medicine and Pharmacology, Faculty of Pain Medicine and Dentistry, University of Western Australia
- Professor Harry Owen (SA) was appointed Professor of Anaesthesia, School of Medicine, Flinders University.
- Dr Simon Towler (WA) was admitted to AMA Roll of Fellows.
- Dr James Wilkinson (NSW) completed a Master of Health Law, University of Sydney.

Although not a Fellow, Council noted the award of the American Society of Anesthesiologists 2002 Excellence in Research Award to Professor Daniel Sessler MD, a Foundation Visitor at the 2000 ASM in Melbourne.

ANZCA MEDAL

It gave me great pleasure to award the ANZCA Medal to two highly deserving Fellows during the College Ceremony.

Dr Ian Rechtman (VIC) who has contributed immensely to the Faculty, College and Victorian Regional Committee in many roles over the years from 1975 to 2002. In 1991 he identified and encouraged the purchase of 'Ulimaroa' on St Kilda Road, Melbourne as the independent home of our College, and was instrumental in the planning of the new building, ANZCA House.

Dr Margaret Smith, OBE QJM (NZ), a Foundation Fellow who was recognised with this Award for her pioneering work in anaesthesia, particularly paediatric anaesthesia in New Zealand, and is a community and medical leader and role model for New Zealand medical women.

ANZCA COUNCIL CITATIONS

The College established the ANZCA Council Citation in December 2000 to recognise significant contributions to activities of the College, particularly in education.

Citations were awarded to the following ANZCA Fellows:

- Dr Michael Bennett (NSW)
- Dr John Board (QLD)
- Dr Malcolm Futter (NZ)
- Dr Alison Holloway (QLD)
- Dr Ian Rechtman (VIC)
- Dr Peter Roessler (VIC)
- Dr Kandasamy Vijayakumar (NT)

Presentation of these Citations takes place at appropriate Regional meetings.

DEATH OF FELLOWS

It is with regret that I report the death of the following Fellows:

Dr John Winter Ashton (VIC) – FFARACS 1969, FANZCA 1992

Dr Michael John Bookallil (NSW) – FFARACS 1961, FANZCA 1992

Dr Henry Michael Bray (VIC) – FFARACS 1957, FANZCA 1992

Dr Choy Tak-Chiu David (HK) – FFARACS 1968, FANZCA 1992

Dr Robert Love Coulter (NZ) – FFARACS 1960

Dr Graeme Alexander Donaldson (Qld) – FFARACS 1977, FANZCA 1992

Dr Edwin Robert Fawcett (NZ) – FFARACS 1961, FANZCA 1992

Dr Peter John Forgan (SA) – FFARACS 1967, FANZCA 1992

Dr Loraine Clare Hibbard (NSW) – FFARACS 1961, FANZCA 1992

Prof Emanuel M Papper (USA) – Honorary FANZCA 1996

Dr Ronald Justin Henry Tapson (Tas) – FFARACS 1966, FANZCA 1992

Dr John Spencer Windeyer (NSW) – MFARACS 1952, FFARACS 1956, FANZCA 1992

RESEARCH

Research Grants for 2003

25 applications were received, with one withdrawn following the review process. $353,945 funding was available, with an additional $10,000 for the inaugural award of the Organon Research Award. After payment of the four three-year Research Fellowships awarded in 2002 ($93,812), $270,133 was available to fund Research Project Grants for 2003. No Research Fellowship applications were received for 2003. A total of $363,932 was allocated.

Each application was reviewed by three independent assessors. The Reviewers' comments were fed back to the applicants and then all applications, assessments and comments were considered by the Research Committee.

Grants were awarded to:

1. Dr David Andrews VIC $30,000

Blood cardioplegia enhancement with L-arginine and its effects on the ischaemic myocardium

2. Prof Laurence Mather NSW $46,000

New analgetic and anti-inflammatory treatment strategies related to NMDA receptor antagonism

3. Dr Peter McNicol VIC $25,000

Effectiveness of a combined post-operative pain and clinical intervention program

4. Dr John Morgan QLD $28,000

Optimal crystalloid strong ion difference for acute haemodilution to prevent dysoxia

5. A/Prof Paul Myles VIC $36,000

A pilot study for the evaluation of nitrous oxide in the gas mixture for anaesthesia: a randomised controlled trial (the ENIGMA Trial)

6. Dr Philip Siddall NSW $30,000

Magnetic resonance imaging of the brain in patients with diabetic neuropathy and neuropathic pain

7. A/Prof Bala Venkatesh QLD $25,000

Critical tissue oxygenation and acidosis: Implications for dysoxia, and apoptosis in the critically ill

8. Dr Russell Vickers NSW $12,000

Development and validation of an analytical method for endomorphin-1, -2 using liquid chromatography – mass spectrometry

9. Dr Rob Watson VIC $10,000

Milrinone for the prevention of vasospasm during free flap surgery

2002 Research Fellowships (4) $28,120
Funding for ongoing project maintenance costs in 2003 ($7030 per project)

Harry Daly Research Fellowship

On the recommendation of the Research Committee, the Harry Daly Research Fellowship for 2003 was awarded to Professor Laurence Mather (NSW) for his project *New analgetic and anti-inflammatory treatment strategies related to NMDA receptor antagonism.*

Inaugural Organon Research Award

On the recommendation of the Research Committee, the Organon Research Award was awarded to A/Professor Paul Myles (Vic) for his project: *A pilot study for the evaluation of nitrous oxide in the gas mixture for anaesthesia: a randomised controlled trial (the ENIGMA Trial).*

Academic Anaesthesia Enhancement Grant 2002

The 2002 Academic Anaesthesia Enhancement Grant of NZ$75,000 was awarded to the Academic Department of Anaesthesia and Intensive Care, Waikato Clinical School, University of Auckland.

Simulation/Education Grant 2003

The following projects were supported for the award of the 2003 Simulation/Education Grant:

Prof Alan Merry NZ $18,825

A simulator model to evaluate safety interventions to reduce error in anaesthesia

A/Prof Harry Owen SA $16,175

Developing valid and reliable assessment of airway management for caesarean section under general anaesthesia

Lennard Travers Professorship 2003

The 2003 Lennard Travers Professorship of $30,000 was awarded to A/Professor Paul Myles (Vic) *to encourage and develop the conduct of large, multi-centre clinical trials in anaesthesia to enhance collaborative projects in our region and improve evidence-based medicine.*

ADMISSION TO FELLOWSHIP BY ELECTION

The following were elected to Fellowship of the College:

Under Regulation 6.3.1(b)
Dr Antony Mark Alford (NZ)
Dr Alison Margaret Berry (QLD)
Dr Pieter Wilhelm Hattingh (QLD)
Dr Marian Michelle Hussey (NZ)
Dr Mark Alan Kaplan (NSW)
Dr Andrew William Winter (QLD)

Under Regulation 6.3.1(c)
Dr Alexander Laird Gillies (VIC)
Dr Stephanie Phillips (NSW)

PRIMARY EXAMINATION

July/September 2002

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

A total of one hundred and ninety five (195) candidates presented for the Pharmacology and Physiology Modules and ninety seven (97) candidates successfully completed the Primary Examination.

One hundred and forty four (144) candidates presented for the Pharmacology Module and one hundred and fifty three (153) candidates presented for the Physiology Module.

	TOTAL No CANDIDATES		INVITED TO ORAL		APPROVED	
	Pharmacology	Physiology	Pharmacology	Physiology	Pharmacology	Physiology
MELBOURNE	144	153	128	140	103	107

	TOTAL No CANDIDATES SITTING BOTH SUBJECTS	CANDIDATES PASSED BOTH SUBJECTS AT THIS SITTING	PRIMARY EXAMINATION APPROVED
MELBOURNE	102	59	97

MERIT LIST

In line with Council's decision to recognise candidates who have achieved excellence in their examination results, the following candidates were awarded the inaugural Merit Certificate for their performance at the July/September 2002 Primary Examination.

Keith Davenport	NZ
Grant Lindsay Hounsell	NZ
Gloria Sui-Yeng Liu	QLD
Julie Elizabeth McArthur	WA
Suzanne Marie McKenzie	WA
Ng Yuen Chong	HKG

PRIMARY EXAMINATION

July/September 2002

Names of successful candidates:

M W K Acheson	VIC	E J Freihaut	NSW	M A Minehan	NZ
S J Allen	NZ	K M Fry	SA	T S Morgan	NSW
M L Andrews	NSW	D S Gradstein	VIC	A E Murdoch	QLD
D Arumugam	MAL	J D Griffiths	VIC	M Narayanaswamy	NSW
L J Bannon	QLD	N Gupta	NSW	J M P Nayagam	NZ
K Barker	SA	I D Ha	QLD	Ng Yuen Chong	HK
L A Beckmann	QLD	G L Hounsell	NZ	E D O'Connor	QLD
D N Bell	WA	R Hui	VIC	L S Partridge	SA
S M Berrill	NZ	N A Jansen	VIC	A R O Phillips	NSW
D M Bertholini	QLD	S Kabir	NSW	F D Phillips	QLD
D F Brown	NSW	M J Keane	SA	A Ratnavadivel	NZ
D M Brown	QLD	L P Y Khoo	WA	T J Rawdanowicz	VIC
F F Buchanan	VIC	J N King	NZ	A H Rehak	VIC
M L Buenaventura	NSW	R Kishen	MAL	J Rotherham	NZ
J T Butler	WA	J F Knuckey	WA	M L-C Soh	VIC
Louisa Yuk Li Chan	MAL	M O Krumrey	NZ	J M M Tan	NSW
W Y C Cheng	SA	Lam Kar Yee Katherine	HK	Wen Tien James Tan	SIN
Cheung Suk Yan Olivia	HK	P Z Laverty	VIC	Tang Kong Choong	SIN
A B Chisholm	NZ	A I Leavy	NSW	Alvin Teo Yeng Hok	SIN
A H H Chuan	NSW	A N H Lee	WA	M P Thompson	QLD
M M Conroy	VIC	T C Lee	VIC	D L Trappett	QLD
N M Courtney	QLD	Lee Yuk Ming Sunny	HK	A E Tse	NZ
D J Cox	NSW	S X Li	NSW	D R Tsui	QLD
A L Craig	NZ	K S Lim	NSW	P Vats	VIC
A G Crowther	NZ	G S-Y Liu	QLD	J R Vieusseux	NSW
R Dabars	VIC	P F Lockington	NZ	Wai Chor Keung	HK
E L Darbar	NSW	B Manasiev	NSW	E M Weeks	QLD
K Davenport	NZ	J E McArthur	WA	I Y Y Wong	HK
A E Donaldson	QLD	C McGrath	VIC	Wong Chak Man	HK
S M Doneley	QLD	S M McKenzie	WA	P W Wright	NZ
M L Dreux	NSW	J E McLennan	QLD	Wu Wai San Janet	HK
W J Egerton	ACT	C M McNally	VIC		
B A Fraser	VIC	A G Millard	WA		

The **Renton Prize** for the period ending 31st December 2002 was awarded to **Dr James Nicholas King** of Auckland, New Zealand

March/April 2003

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

A total of one hundred and seventy four (174) candidates presented for the Primary Examination and ninety six (96) candidates were approved.

One hundred and thirty two (132) candidates presented for the Pharmacology Module and one hundred and forty one (141) candidates presented for the Physiology Module.

	TOTAL No CANDIDATES		INVITED TO ORAL		APPROVED	
	Pharmacology	Physiology	Pharmacology	Physiology	Pharmacology	Physiology
MELBOURNE	122	130	112	114	92	92
HONG KONG	10	11	6	9	5	3
TOTAL	132	141	118	123	97	95

TOTAL No CANDIDATES SITTING BOTH SUBJECTS	CANDIDATES PASSED BOTH SUBJECTS AT THIS SITTING	PRIMARY EXAMINATION APPROVED
100	60	96

MERIT LIST

In line with Council's decision to recognise candidates who have achieved excellence in their examination results, the following candidates were awarded a Merit Certificate for their performance at the April 2002 Primary Examination.

Luke David Barnett	NSW
Alistair Brendan Bishop	VIC
Peter Kwok-Chen Chong	QLD
Paul Lung Sun Kwei	QLD
Volker Mitteregger	VIC
Michelle Ann Natividad	VIC
Phillip Adam Russell	WA
Peter David Waterhouse	UK

SUCCESSFUL CANDIDATES

March/April 2003

Names of successful candidates:

Norman Borge Barlev	NZ	Pavel Gajdusek	NZ	Andrea Maree Noar	QLD
Luke David Barnett	NSW	Kalpesh Ratanchand Gandhi	NSW	Jennifer Alison Nosworthy	NSW
Kirsty Bennett	QLD	Craig Bennett Garfinkel	NSW	Usha Padmanabhan	VIC
Alistair Brendan Bishop	VIC	Susan George	NSW	Simon James Pattullo	NSW
Robert John Bolger	NSW	Trevor Ghidella	QLD	Ronald Joseph Pereira	NZ
Thomas Patrick Bookallil	NSW	Iain Charles Stuart Gilmore	NZ	Tania Chee Rogerson	WA
David Edmund Piers Bramley	VIC	Wendy Goh	NSW	Kellie Ann Rudd	QLD
Liam Joel Broad	VIC	Dale Patrick Greer	NSW	Philip Adam Russell	WA
Campbell Kenneth Brodie Brown	NSW	Matthew John Griffiths	NSW	Sanjay Satchithanantham	NSW
Alison Louise Burke	NSW	Joshua Jonathan Hargrove	VIC	Markus Helmut Schmidt	WA
Andrew Jeremy Donald Cameron	NZ	Sean Stephen Hearn	VIC	Mark Udo Schutze	WA
Janet Sue-An Chan	NSW	Brad Michael Hockey	NZ	Katherine Jillian Shelley	WA
Choi Hung Chan	HK	Lynn Pei Er Hong	VIC	Jim Greg Shim	NSW
Kwok Bun Chan	HK	Georgina Lisbeth Loane Imberger	VIC	Sharon Smedley	WA
Sok Ping Cheong	SA	Manoja Prashanthi Kalupahana	NZ	Julian Gary Smith	VIC
Wui Kin Chin	SIN	Alexandra Maree Kent	VIC	Jeffrey Bruce Smith	NZ
Peter Kwok-Chen Chong	QLD	Madhari Kishore	SA	Matthew Hayden Gray Taylor	NZ
Marcus Chuen Kae Choy	VIC	Irina Heidi Silva Kurowski	WA	Teoh Chuan Yeong	MAL
Nicholas Charles Chrimes	VIC	Paul Lung Sun Kwei	WA	Meredith Christine Tey	NSW
David Nicolas Closey	NZ	Keat Leong Lee	SA	Thanh Truc Tran	ACT
Joanne Lisa Cowan	NSW	Robert Andrew Lewin	NSW	Narko Anthony Tutuo	NZ
Carmen Bao Gia Dang	VIC	Kian Lee Clarence Lim	NSW	Benjamin F H Van Der Griend	QLD
Vincent Johann DaSilva	NSW	Enjarn Lin	VIC	Rod Matthew Van Twest	QLD
Alistair Huw Davies	WA	Benjamin Simon Lloyd	QLD	Rasa Maria Venclovas	NSW
Robert Nasir Dean	NSW	Tai Que Ma	WA	Thomas Bruce Walker	NSW
Peter James Devonish	SA	Joanne Elizabeth McNaught	QLD	Eldon William Ward	NZ
Leigh Kevin Dotchin	NZ	Simon Andrew McPherson	VIC	Peter David Waterhouse	UK
Tania Mary Dutton	QLD	Gavin John Millar	NSW	David Matthew Woods	NSW
Pamela Alice Eccles	NZ	Volker Mitteregger	VIC	Caroline Yeoh	NSW
Victoria Anna Eley	QLD	Jillian Elissa Morgan	VIC	Denise Li-Furn Yim	WA
Adrian Lachlan Feint	ACT	Taryn Ann Naggs	QLD		
Micah Richard Friend	NSW	Michelle Ann Natividad	VIC		
Nga Yin Fung	HK	Lucia Georgeta Nicolae	QLD		

The **Renton Prize** for the half year ended 30th June, 2003 was awarded to **Markus Helmut Schmidt** of WA.

FINAL EXAMINATION (ANAESTHESIA)

August/September 2002

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

The viva examination was held at The Prince of Wales and Sydney Children's Hospitals, Sydney.

One Hundred and seven candidates presented in Sydney and 88 were approved.

SUCCESSFUL CANDIDATES

Names of successful candidates:

Stephanie Clare Aplin	NSW	Christine Louise Lee	SA
Amira Bishai	NSW	Elaine Mooi Lian Lee	NSW
Tillman Wolf Boesel	NSW	John Jeonghoon Lee	NSW
Alexandru Borsaru	VIC	Kevin Andrew Lee	NSW
Miles Patrick Brodie	QLD	Sumin Lee	HKG
David Llewellyn Brown	TAS	Stefan Andre Lombaard	NZ
Christopher John Bryant	QLD	Hugh Roland Albert Longworth	NSW
Jonathan Leslie Byrne	NSW	Susan Martha Lord	NSW
Miriam Canham	NZ	Jeremy MacFarlane	WA
Sam Cavallaro	NSW	Payam (Max) Majedi	WA
Melissa Ann Cebula	NSW	Sheila Elizabeth Malcolmson	NZ
Mark Edward Chaddock	NZ	Kwan Yin Man	HKG
Cheah May Hong	MAL	Cameron Richard McAndrew	QLD
Mae Fong Chen	VIC	Jamie Desmond McCarney	NSW
Cheng Pui Gee, Bonnie	HKG	Catherine Ann McIntosh	NSW
Richard Wee Chee Chin	NSW	Lisa Mohanlal	QLD
Desmond Chu	NSW	Jane Louise Morris	QLD
Steven Alexander Clulow	QLD	Stephen Daniel O'Donoghue	NZ
Patrick Joseph Coleman	WA	Adam Alexander Osomanski	NSW
Julie Ann (Janne) Marie Coman	QLD	Helen O'Toole	QLD
David Andrew Costi	SA	Ranjan Chaminda Perera	NSW
Gretel Leigh Davidson	NSW	Claus Michele Poppinghaus	NSW
Peter McLaren Davidson	NSW	Felicity Maria Re	NSW
Melinda Jane Davis	NSW	Alan Bruce Rouse	TAS
Jonah Crispin William Desforges	NZ	Kirsten Seipolt	NSW
Gregory Scott Euston	QLD	Leon Serfontein	NZ
Paul John Gardiner	NZ	Jeremy Alistair Sheard	NSW
Goy Wee Lip, Raymond	S'pore	Prani Prakash Shrivastava	WA
Jodi Maree Graham	WA	Jocelyne Slimani	SA
Christopher Graves	QLD	Tan Chee Keat	S'pore
Robert Andrew Gordon Gray	QLD	Deral Tanil	VIC
Liam Macdonald Grundy	SA	Dan Connie Tao	NSW
Victoria Wing Shuen Ha	HKG	Tay Teik Guan	HKG
Ian James Harrison	NZ	Gary Kok-Meng Tham	SA
Amanda Jane Harvey	QLD	Gianpiero Traini	NSW
Irvin Chai Min Heng	VIC	Rachel Mary Vassiliadis	NSW
Holger Joerg Holldack	QLD	Aruntha Vinayagamoorthy	NZ
Bruce John Hullett	WA	Mark Stuart Waddington	NZ
Eng-Leng Edwin Khoo	NSW	Adrian Michael Walker	NSW
Quentin Gilbert Alan King	NSW	Rajeewa Lakmal Sirisena Walpitagama	NSW
Shu Wing Ku	HKG	Paul Nikolaus Wieland	NZ
Priya Kumaradeva	NSW	Leigh Karen Winston	QLD
Sarah Shirley Kurian	QLD	Jennifer Barbara Woods	VIC
Law Cheuk San	HKG	Craig Matthew Young	TAS

The Cecil Gray Prize for the period ending 31st December 2002 was awarded to Dr Robert Andrew Gordon Gray of Queensland

MERIT LIST

In line with Council's decision to recognise candidates who have achieved excellence in their examination results, the following candidates were awarded the inaugural Merit Certificate for their performance at the May 2003 Final Fellowship Examination.

David Andrew Costi	SA	Amanda Jane Harvey	QLD
Paul John Gardiner	NZ	Jeremy MacFarlane	WA

PROFESSIONAL DOCUMENTS

The following Professional Documents were reviewed and promulgated during the past twelve months:

- PS39 – *Minimum Standards for Intrahospital Transport of Critically Ill Patients*
- TE4 – *Policy on Duties of Regional Education Officers in Anaesthesia*
- TE5 – *Policy for Supervisors of Training in Anaesthesia*
- PS1 – *Recommendations on Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia*
- PS21 – *Guidelines on Conscious Sedation for Dental Procedures*
- PS29 – *Statement on Anaesthesia Care of Children in Healthcare Facilities without Dedicated Paediatric Facilities*
- PS46 – *Recommendations for Training and Practice of Diagnostic Perioperative Transoesophageal Echocardiography in Adults*
- PS47 – *Guidelines for Hospitals Seeking College Approval of Posts for Vocational Training in Diving and Hyperbaric Medicine*
- PS48 – *Statement on Clinical Principles for Procedural Sedation*

Withdrawal of Professional Document

College Professional Document PS17 – *Guidelines on Endoscopy of the Airways* was withdrawn at the October Council Meeting.

Addition to Disclaimer

Council approved the addition of the following statement to the disclaimer contained in all Professional Documents – *This document is intended to apply wherever anaesthesia is administered.* This statement indicates that Professional Documents that are unrelated to training issues are applicable to **all** hospitals, not just training hospitals.

COLLEGE AFFAIRS

Finance

The College remains in a good financial position. A full Financial Report of the College will be presented by the Honorary Treasurer, Dr Mike Martyn. It is noteworthy that Annual Subscriptions and Training/Registration Fees have remained static for the past five years.

COLLEGE COUNCIL MEMBERSHIP

In accordance with the provisions of the Articles of Association, nominations were called for one vacancy on Council. One nomination was received from standing Councillor, Dr Leona Wilson so no election was necessary, and I congratulate Dr Wilson on her re-appointment to Council.

COLLEGE ADMINISTRATION

A number of changes have occurred in the Examination and Training Department in the past year. Miss Kate Silverback was appointed to the position of Administrative Assistant (Final Examination) in May 2002. Kate resigned from the College in December and a replacement appointment is still being considered.

Following the resignation of Miss Angela Sparano as Administrative Assistant (Trainees), Miss Kelly Phillips was appointed in June 2002. After the resignation of Miss Brigette McDonald as Administrative Assistant (Primary Examination), Kelly was appointed to this position in April. Interviews are underway for the position of Administrative Assistant (Trainees).

Miss Megan Freeth was appointed Administrative Assistant to the Joint Faculty of Intensive Care Medicine in May 2002.

In November a new position of Executive Officer (Professional Areas) was created, and Mrs Jill Horton was appointed

Following the resignation of Ms Nelly Katsnelson as Administrative Officer (RARS and OTS), Ms Ann Bailey was appointed in June 2002. Ann tendered her resignation in March, and the position was revised.

Miss Juliette Mullumby was appointed Administrative Officer (RARS) in addition to her involvement with the Continuing Education and Quality Assurance Department, and in particular the MOPS Program.

Miss Bridget Ure was appointed Administrative Assistant/Relief Receptionist in November. Following Ms Bailey's resignation, the position of Administrative Assistant (OTS) was advertised, and Bridget's application was successful.

Ms Carolyn Lee resigned as Administrative Officer (Executive Services) in August.

Following the retirement of Mrs Jane Merrillees from the position of Administrative Assistant (Courses) with the New South Wales Regional Committee, a full-time position was created, and Ms Annette Strauss was appointed in January.

Mrs Jane Hinchey tendered her resignation from the South Australian and Northern Territory Regional Committee in April, and Ms Christie Richards was appointed Administrative Officer in her place.

Due to an increase in the workload relating to the Queensland Regional Committee, the part-time Administrative Assistant's position was made full-time. Ms Deidre Beach did not wish to accept a full-time position, and in April, Ms Annette Strasburg was appointed to the position.

In April, Miss Nicole Barns was appointed Clerical Assistant.

IN CONCLUSION

To conclude this report, I wish to record my grateful thanks to Councillors, members of Boards of Faculties, Chairs and members of Regional Committees and the New Zealand National Committee, members of College Committees, Fellows who contributed time pro bono to the College, and the CEO Mrs Joan Sheales and all the College administrative staff. Our combined efforts will provide the basis for the development and promotion of our College and specialties.

Richard J Willis
PRESIDENT

Dean's Message

Neil Matthews

Following a review by the Australian Medical Council, ANZCA, the Faculty of Pain Medicine, and the Joint Faculty of Intensive Care Medicine received six years accreditation of their training programs. For the Joint Faculty, the Council made several recommendations including establishment of an Education Committee, development of rural training programs, increased flexibility for assessment of overseas trained specialists and improved recruitment to intensive care as a specialty. All recommendations have been instituted or are being developed.

The previous Faculty had direct involvement in the Committee of Presidents of Medical Colleges (CPMC). Following a recent workshop, I am pleased that the Joint Faculty's involvement in that body will continue. The CPMC is the link between specialties and Government, and it is important that the specialty of intensive care have direct input into debate and decision-making, especially on common issues related to maintenance of standards and training.

The last 12 months has seen the development of several new training initiatives. As outlined in the previous Bulletin, a new training program will commence from the start of the 2004 hospital year, and will allow more flexibility and interaction with other programs while still maintaining the core components of the present program. The new program will apply to those trainees registering for the first time at the start of the 2004 hospital year. It will be important to promulgate the new program in as many forums as possible over the next six months. Other developments in training include the formalisation of an Education Committee, and discussions on the feasibility of establishing an intensive care primary examination for those Trainees wishing to commence specialist training solely in intensive care.

The recent ANZCA ASM in Hobart was hugely successful from scientific and social perspectives. Our Foundation Visitor, Professor Dennis Maki spoke on SARS, Bioterrorism, cross infection in ICU and sepsis beyond antibiotics with authority and common sense, and was well received. Our Fellows and other visitors contributed to a well constructed program, thanks to Stuart Miller, John Myburgh and Carol Cunningham Browne.

Many important challenges remain for the Joint Faculty. As previously mentioned, manpower issues are critical with many specialist positions being unfilled and training positions relying on overseas trained graduates. Inadequate numbers of medical graduates, the AMA safe working hours document, shorter hours mandated in awards and appropriate lifestyle decisions of a younger generation mean an acute shortage of both specialists and trainees. We need to identify the reasons for the problem, and develop strategies to address the issues. Finally and most importantly, as a specialty the Fellowship of the Joint Faculty needs to decide where it is heading and in what timeframe, ensuring it safeguards its achievements and acknowledges its heritage.

N T Matthews
Dean

Joint Faculty of Intensive Care Medicine

Honorary Fellowship – Citation

Gracie Siok Yang Ong

"The Board may confer Honorary Fellowship of the Faculty on distinguished persons who have made a notable contribution to the advancement of the science and practice of intensive care who are not practising intensive care in Australia or New Zealand"

Mr Dean, I have the honour of presenting to you Gracie Siok Yan Ong.

Gracie commenced specialist training in Anaesthesia and Intensive Care with the Faculty of Anaesthetists, RACS in 1972. Her training was undertaken at the University Hospital, University of Malaya, Kuala Lumpur and she sat the Fellowship Examination in Singapore. To gain extra experience she worked at Prince of Wales Hospital, Sydney from 1975 to 1978 under the guidance of Drs Graham Fisk and George Davidson, where she gained an insight into the intricacies of paediatric and adult intensive care, working first as a resident medical officer, then anaesthetic registrar and then temporary staff specialist. George Davidson described her contributions to the Paediatric Intensive Care Unit as 'most outstanding'.

Gracie returned home to Kuala Lumpur in 1979 and commenced work as a Lecturer in the Department of Anaesthesiology, University of Malaya, helping to run the busy ICU at the University of Malaya Medical Centre (UMMC). She was appointed Associate Professor in 1981 and Professor and Senior Consultant in 1992. In 1999 she was appointed Head of the Department of Anaesthesia and Intensive Care.

During the 23 years Gracie has been at the University of Malaya she has been deeply involved in patient care, teaching, training and research. Her efforts have been integral to the development of intensive care services and specialist anaesthetic services (especially open and closed heart surgery) for the University of Malaya Medical Centre. She has put into action a philosophy of life long learning and teaching having spent attachments as clinical assistant in the Liver Unit of King's College Hospital, London, Visiting Fellow to the Cardiothoracic Unit of St Vincent's Hospital, Sydney and spending time at Great Ormond Street, Hammersmith, University of Liverpool and Memorial Hospital North Carolina.

She has over 40 peer reviewed publications, eight book chapters and more than 50 major presentations mostly on Intensive Care Medicine related topics. At the same time, she has found time to raise three children, be an internal and external examiner for the Master of Anaesthesiology courses in Malaysia, Supervisor of Training for specialist trainees, lecturer and tutor for undergraduates and author and coordinator of the Critical Care Nursing Course.

Gracie seems to have been a member of every relevant medical committee in Malaysia (from Critical Care to Pain to Anaesthesia) and on the University of Malaya Senate. As a member of the National Resuscitation Committee she has helped to spread the word on CPR. Through her work in helping to set up the clinical skills laboratory and the simulation centre at the UMMC she has improved the critical skills training of doctors, nurses and paramedics.

Her research projects have encompassed spinal immobilisation and its effect on neurologic injury, severity of illness scoring, endotoxin assay, immunodiagnosis of candidiasis, assessment of nutrition, catheter related sepsis, endothelial dysfunction and antimicrobial resistance in ICU.

In short, Professor Gracie Ong has made a notable contribution to the advancement of the science, teaching, training and practice of Intensive Care Medicine. Her contributions to Intensive Care Medicine particularly in Malaysia have been invaluable.

Mr Dean, I have the honour to present to you Gracie Siok Yan Ong for conferment of Honorary Fellowship of the Joint Faculty of Intensive Care Medicine.

Richard Lee

Joint Faculty of Intensive Care Medicine

Honorary Fellowship – Citation Bernard George Clarke, PSM

Mr Dean, I have the honour of presenting to you Bernard George Clarke.

Bernard Clarke graduated from the University of Melbourne in 1958. He spent the next five years training as a resident and registrar in respiratory medicine at St Vincent's Hospital in Melbourne. At this time the specialty of intensive care medicine was very much in its infancy and Bernard travelled overseas to train – firstly for two years at the Hammersmith Hospital in London and subsequently as an Associate Professor of Medicine at the University of Iowa.

He returned to St Vincent's Hospital, Melbourne in 1968 and practised as a Respiratory Physician. There was still no formal Department of Intensive Care and at that time Bryan Galbally was seen as the Resuscitation Officer of the hospital. In 1975 Dr Clarke was appointed as the first 'Director of Intensive Care' at St Vincent's Hospital, Melbourne and brought a physician approach to the management of critically ill patients and to the teaching of residents and registrars working in the ICU. Bernard remained the Director of Intensive Care at St Vincent's Hospital until 1985.

Bernard Clarke was also deeply involved in the early attempts to establish a joint training program in intensive care medicine involving the Royal Australasian College of Physicians and the Faculty of Anaesthetists, Royal Australasian College of Surgeons. Meetings to discuss a joint diploma were held in 1974 and 1975, but unfortunately, although it was unanimously agreed that the most desirable outcome was a joint training program, agreement could not be reached on some key elements. These meetings were chaired by Bob Wright and involved in addition to Bernard, John Sands, Neil Gallagher, Jim Lawrence and Graeme McLeod from the RACP and Don Harrison, Douglas Joseph, Brian Dwyer, Graeme Fisk and Maurice Sando from the Faculty of Anaesthetists, Royal Australasian College of Surgeons. Bernard also chaired the Australian Society of Critical Care Medicine (ASCCM), a medical/nursing society which was the forerunner of both the Victorian Branch of the Australian and New Zealand Intensive Care Society and the Victorian Branch of Australian College of Critical Care Nurses.

Critical Care Services was set up by the Victorian State government in November 1984 following the 'Azzopardi' case when a patient died travelling in an ambulance from Dandenong to Geelong. Bernard Clarke was appointed the first Critical Care Coordinator of the service and was crucial to its early development. The Office of the Coordinator of Critical Care Services was set up the following year and under Bernard's guidance its role developed from facilitating interhospital transfers of critically ill patients to a broader one that includes monitoring the number and availability of intensive care beds in Victoria, providing a medical emergency adult retrieval service and assisting the public-private interface. He also worked in an advisory capacity for the Victorian State Health Department in the 1980s.

Bernard has a strong interest in bioethics and took over the St Vincent's Bioethics Centre when Nick Tonti Filippini retired. He is an exceptional teacher and inspired several of Australia's best known intensive care specialists to follow in his footsteps when he taught them as students – John Santamaria, the current Director of Intensive Care at St Vincent's Hospital and the President of ANZICS being a prime example. He remains a very 'people' person. He is always ready to talk, ready to advise and always helpful. Not surprisingly, he has always been extremely popular and respected by his patients and their families. These characteristics have also been reflected in his involvement in the Medical Practitioners Board of Victoria, where he served for six years.

Although no longer practising intensive care medicine it is clear that Dr Bernard Clarke has made a major contribution to the specialty.

Mr Dean, I have the honour to present to you Bernard George Clarke, PSM for conferment of Honorary Fellowship of the Joint Faculty of Intensive Care Medicine.

Felicity Hawker

Severe Acute Respiratory Syndrome (SARS)

Severe Acute Respiratory Syndrome (SARS), was first observed in Guangdong, a southern province of China in November 2002[1]. The first doctor to alert the Western medical community to this new microbiological threat was Dr Carlo Urbani, who himself succumbed to the disease. In February 2003 a doctor who had been treating patients with SARS in Guangdong became ill in a hotel in Hong Kong and infected a number of travellers and a local man[2]. These cases spread SARS to Vietnam, Canada, Singapore, USA, Ireland and triggered a major outbreak in Hong Kong[3]. There has now been rapid spread of SARS with over 20 countries reporting suspected or probable cases. The medical profession and public health officials worldwide need to prepare a response to this new global threat.

Diagnosis and Cinical Features

Severe acute respiratory syndrome is probably caused by a new coronavirus[4,5]. The CDC diagnostic criteria for SARS are evolving and clinical, epidemiological and laboratory criteria have been proposed[6]. Suspected cases should demonstrate the clinical features of a temperature of $>38°C$, and one or more clinical findings of respiratory illness (e.g., cough, shortness of breath, difficulty breathing, or hypoxia), as well as the epidemiological features of travel (including transit in an airport) within 10 days of onset of symptoms to an area with current or recently documented or suspected community transmission of SARS, or close contact within 10 days of onset of symptoms with a person known or suspected to have SARS. Probable cases are defined as those having the same features as suspect cases, as well as demonstrating radiographic evidence (chest radiograph or computerized tomography (CT) scan) of pneumonia, or acute respiratory distress syndrome, or autopsy findings consistent with pneumonia or respiratory distress syndrome without an identifiable cause.

Laboratory tests that may assist in identifying the presence of SARS coronavirus include the isolation of SARS coronavirus, detection of RNA by repeated RT-PCR or detection of antibody in specimens obtained either during acute illness or during convalescence – more than 21 days after the onset of illness[6]. Note that as all diagnostic assays for SARS coronavirus are still under investigation, laboratory diagnostic criteria currently play no part in defining suspect or probable cases, but accurate laboratory diagnosis will eventually be essential to support future advances public health understanding and management. Exclusion of previously known causes of atypical pneumonia by performing sputum and blood culture, serological tests for atypical pneumonia agents and urine for Legionella antigen should be routine.

The median incubation period is about 6 days, ranging from 2 – 16 days[3]. The clinical course of SARS is prolonged and seems to occur in identifiable phases. In the first week most patients present with symptoms of fever, chills and rigors, myalgia, headache and cough. Diarrhoea is present in a moderate number of patients. In contrast to other common respiratory conditions, only a minority may complain of sore throat, rhinorrhoea or arthralgia[3,7]. Laboratory features are also unusual and include a raised LDH, raised creatinine kinase, moderately elevated liver enzymes, lymphopaenia, and thrombocytopaenia[3,4,7]. This early phase appears associated with viral replication[8]. In the second week respiratory symptoms predominate and radiographic deterioration is common. Examples of radiological features can be obtained online[9]. Dyspnoea and hypoxia become prominent. This phase is possibly the consequence of a vigorous immunological response[3,8]. From the middle to end of the second week the more severe cases develop severe respiratory failure resembling acute respiratory distress syndrome (ARDS). About 20% of patients eventually require intensive care monitoring and of these about 60% require mechanical ventilation[3].

Treatment

The treatment of SARS is controversial. Based on a rudimentary understanding of the disease and clinical observation, a regime of steroid and ribavirin therapy has been developed. Ribavirin inhibits DNA and RNA polymerase activity, initiation and elongation of RNA fragments, resulting in inhibition of viral protein synthesis and viral replication. Steroid therapy may be potentially useful later in the disease as the relatively late onset of the respiratory complications, coupled with features suggestive of broncheolitis obliterans organizing pneumonia (BOOP) on CT scan images, suggests an immunological mechanism might be implicated[3,8]. Currently patients are treated with ribavirin in the initial phase, methylprednisone 1mg/kg or equivalent is added once radiological features and dyspnoea develop, and pulse methylprednisolone 0.5 to 1 G on two to three consecutive days is added if radiological progression and severe hypoxia occur.

Salvage therapy with convalescent plasma, IgM enriched immunoglobulin or cyclophosphamide has been used in an attempt to provide further viral suppression or immunomodulation in selected cases in our institution. Responses have been variable, with apparently few side effects. There has been no shortage of suggestions for the therapy of SARS and these include the use of Cysteine protease inhibitors (lopinavir/ritonavir), thalidomide, pentoxyphiline, monoclonal antibodies to

TNF alpha, traditional Chinese medicine and high doses of vitamins C and E.

The supportive management of SARS is directed primarily at the respiratory system. Initial management consists of supplemental oxygenation. Criteria for intensive care admission include an inability of the patient to maintain an arterial oxygen saturation of more than 90% while breathing an oxygen concentration of at least 50%, or a respiratory rate that exceeds 35 breaths per minute, or both. Management in ICU is supportive and standard organ support protocols are followed. As most of these patients only develop single organ failure (respiratory failure), we have focused on avoiding fluid overload, which we believe may further compromise gaseous exchange.

Criteria for intubation are a persistent failure to achieve arterial oxygen saturation of 90% while receiving 100% oxygen via a non-rebreathing mask and/or onset of respiratory muscle fatigue as evidenced by an increase in $PaCO_2$, sweating, tachycardia or a subjective feeling of exhaustion. Once mechanical ventilation is needed, every attempt is made to minimize ventilator induced lung injury and barotrauma. Utilization of small tidal volume (6ml/kg estimated lean body mass) and low pressure ventilation (plateau pressure ($\leq 30cmH_2O$) and careful use of positive end-expiratory pressure is routine[10]. Permissive hypercapnia is allowed provided that arterial pH is kept above 7.15. Despite this lung protective strategy, the incidence of barotrauma appears unusually high. There appears to be a poor response to PEEP and recruitment maneuvers, particularly in patients with advanced disease. Prone ventilation may be attempted, but in our experience the response is variable.

Disease induced immunosuppression as well as the use of high dose pulse methylprednisolone is likely to predispose to nosocomial infection. The incidence of nosocomial sepsis does appear to be unusually high and prophylactic anti-bacterial antibiotics are now administered at the time of institution of high dose pulse methylprednisolone therapy. In the absence of clinical sepsis in the first 3 to 5 days following high dose steroid therapy, anti-bacterial antibiotics are withdrawn. Suspected infection is treated early with empirical board spectrum antibiotics and if necessary, anti-fungal agents. The main side effect of ribavirin is haemolytic anemia and daily monitoring of hemoglobin and the reticulocyte count is routine.

Infection Control

SARS is highly transmissible and high viral RNA concentrations have been detected in respiratory secretions and faeces[5]. Spread probably occurs via droplets and aerosols, which may be enhanced by the use of nebulizers or similar devices[11]. Spread has also been linked to contaminated sewerage systems[12]. The virus may be stable on surfaces for days after shedding and so contact with infected surfaces could also be a possible source of contamination.

Strict adherence to infection control procedures is important. Details of infection control procedures used in the ICU of the Prince of Wales Hospital can be obtained online[13]. A high index of suspicion must be maintained. In Hong Kong all hospital in-patients are currently considered potentially infectious. This is particularly important in operating theatres, where high risk and potentially aerosol generating procedures are common. Intubation alone is likely to be a high-risk procedure. Operating theatre staff are therefore fully protected at all times. Patients with suspect or probable SARS should be isolated or if isolation is not possible, cohorted. High-risk areas dedicated to the treatment of SARS should only be accessible to staff directly involved in patient care. Personal protective equipment such as N95 masks, caps, goggles, disposable gowns and gloves should be readily available and all staff should undergo proper training and close supervision during preparation in a designated "gown-up" area. Initial, formal "fit-testing" should be performed to ensure adequate mask size and fit for each individual on the staff. Inanimate objects must either be placed in a protective covering or are not allowed to leave the high-risk area. Regular hand cleansing is essential. All clinical areas should be disinfected regularly and thoroughly with chlorine or hypochlorite solutions[14]. Visitors should only be allowed under exceptional circumstances. Bronchoscopy, nebulization, oxygen delivery by Venturi masks and non-invasive positive pressure ventilation are avoided, if possible, to minimize dissemination of contaminated aerosols by these high flow and pressure-generating devices. Oxygen is be delivered by nasal catheters, Hudson mask or non-rebreathing mask. For patients requiring tracheal intubation, manual assist ventilation should be avoided if possible, but if necessary a bag-valve resuscitator with a high efficiency viral filter should be used for preoxygenation. For intubated patients, a high efficiency heat and moisture exchanger filter and viral filter should be incorporated in the breathing circuit. Scavenging of expired gases and closed suction systems minimize the generation of aerosols[15]. To avoid cross infection among staff, sharing of food or utensils is not recommended. Dining rooms should be spacious and distant from the high-risk areas. Staff should be encouraged to wear masks in communal areas when they are not eating to avoid possible social cross infection[15].

Conclusion

SARS is a severe disease that causes critical illness in approximately 20% of the patients.[3] The crude mortality rate is evolving but appears likely to be in the region of 10%-20%, with patients over 60 years old possibly suffering a mortality rate of 50% or greater. Until a successful vaccine is capable of preventing transmission, or improved therapy is developed, the highly contagious nature of the disease and high rate of critical illness among infected cases means that SARS has the potential to impose a heavy burden on the population and health care services in any country that fails to contain the disease.

This article is dedicated to all the health care workers who continue to perform their duty so courageously under difficult circumstances.

Gavin M Joynt MBBCh, FJFICM
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Hong Kong.
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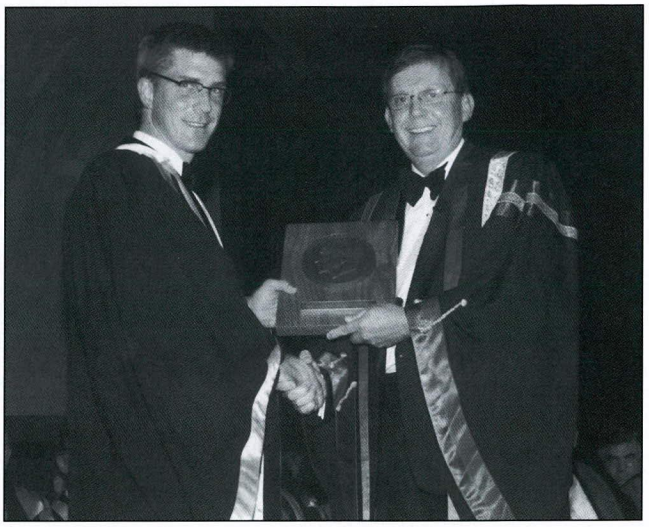
Admission to Fellowship of the Joint Faculty of Intensive Care Medicine

The following have completed all requirements for admission to Fellowship by examination as at May 2003:

Francis Charles Michael (Carl) Fagan	Ireland
Pauline Whyte	SA
Andrew Kent Hilton	Vic
Laven Padayachee	Vic
Niall Peter Kavanagh	Ireland
Katrina Louise Ellem	NSW
B.A. Rodd Brockett	Qld

Dr Neil Matthews presented Professor Dennis Maki with the Foundation Visitors Medal for his plenary on Advances in the Management of Septic Shock Beyond Antimicrobial Therapy.



Dr Neil Orford of Geelong Hospital (Vic) was presented with the G A (Don) Harrison Medal for 2002

Drs Michael Parr and Gill Bishop

John and Jeanette Santamaria with new Fellow, Julian Hunt-Smith and partner

John Myburgh, John Lambert and Ranald Pascoe

Dean, Professor Dennis Maki and Stuart Miller

Annual Scientific Meeting

HOBART, MAY 2003

The Annual Scientific Meeting of the Joint Faculty of Intensive Care Medicine was held at the Hotel Grand Chancellor in Hobart from 3rd to 5th May. This was preceded by the New Fellows Conference at Port Arthur and was attended by 16 representatives, including 5 Joint Faculty Fellows. This meeting was very stimulating and characterised by excellent presentations by all delegates that resulted in vigorous and dynamic discussions. Dr Julian Hunt-Smith will be providing a report to the Board at its next meeting. New Fellows (< 8 years post fellowship) are encouraged to attend this unique and rewarding meeting.

The Joint Faculty's Scientific Program Convenor, Dr Stuart Miller, and the organising committee are to be congratulated on the interesting and stimulating JFICM program. All sessions were very well attended, although, as in previous years, the numbers of JFICM Fellows attending the ASM continues to be low. The Foundation Visitor, Professor Dennis Maki delivered a plenary entitled '*Advances in the Management of Septic Shock Beyond Antimicrobial Therapy*', plus a number of other presentations that were highly topical – addressing issues of bioterrorism and SARS. These sessions were complemented by presentations from Professor Richard Smallwood and Dr John Iredell. An excellent session on early interventions in trauma heard presentations by Associate Professor Jamie Cooper, Dr Barbara Shields (on the Irradiation Casualty) and Dr George Merridew, who spoke on the Bali evacuations. Sessions on the activities of the ANZICS Clinical Trials Group and advances in renal medicine attracted a large audience and resulted in interesting discussions.

At the College Ceremony, Honorary Fellowships were conferred upon Professor Gracie Ong from Malaysia, and Dr Bernard Clarke (Victoria) and their citations are reprinted elsewhere in this section of the Bulletin. The G.A. (Don) Harrison Prize for the best performance in the Fellowship Examination in 2002 was awarded to Dr Neil Orford. Eight new Fellows presented for formal admission by the Dean. Prof Richard Smallwood delivered a thought provoking address about the future of health care in Australia.

The Intensive Care Dinner was held at the Moorilla Estate Winery, situated in a museum of antiquities, set amongst artefacts from Ancient Egypt, Roman, Greek and pre-Columbian cultures. This provided an interesting exhibition prior to fine dining and sampling of the wines at dinner.

A workshop was also held on the New Training Program and this provided a good opportunity to outline the program and receive feedback from Supervisors.

At the Faculty's Business Meeting, the Dean, Censor, Treasurer and ASM Officer delivered reports from the Board. The 2004 ASM will be held in Perth as part of the ANZCA ASM. The format of the 2005 ASM is being finalised and an independent meeting, possibly in collaboration with ANZICS, is being planned. Details about the 2005 ASM will be issued as soon as possible and it hoped that this meeting will be attended by the majority of Fellows of the Joint Faculty.

Congratulations to Richard Waldron, ANZCA Convenor, Stuart Miller, Phil Brown and the Organising Committee as well as the excellent speakers for a great meeting.

John Myburgh
ASM Officer

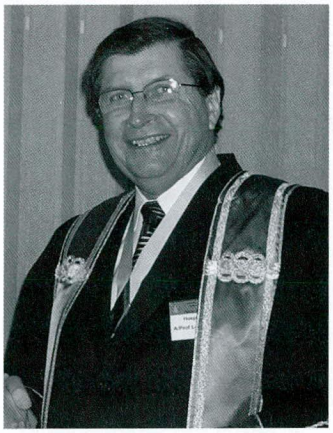
Joint Faculty of Intensive Care Medicine

ABN 82 055 042 852

POLICY DOCUMENTS

IC-1	(1997)	Minimum Standards for Intensive Care Units *Bulletin August 1994, pg 44*
IC-2	(2000)	The Duties of an Intensive Care Specialist in Hospitals with Approved Training Posts *Bulletin November 2000, pg 53*
IC-3	(2002)	Guidelines for Intensive Care Units seeking Accreditation for Training in Intensive Care Medicine *Bulletin June 2002, pg 63*
IC-4	(2000)	The Supervision of Vocational Trainees in Intensive Care *Bulletin March 2000, pg 57*
IC-5	(1995)	Duties of Regional Education Officers in Intensive Care *Bulletin November 1995, pg 50*
IC-6	(2002)	The Role of Supervisors of Training in Intensive Care Medicine *Bulletin September 2002, pg 36*
IC-7	(2000)	Secretarial Services to Intensive Care Units *Bulletin March 2000, pg 58*
IC-8	(2000)	Quality Assurance *Bulletin November 2000, pg 55*
IC-9	(1997)	Statement on Ethics and Patients' Rights and Responsibilities *Bulletin November 1997, pg 68*
IC-10	(2003)	Minimum Standards for Transport of Critically Ill Patients *Bulletin March 2003, pg 29*
IC-11	(2002)	Guidelines for the In-Training Assessment of Trainees in Intensive Care Medicine *Bulletin June 2002, pg 66*
IC-12	(2001)	Examination Candidates Suffering from Illness, Accident or Disability *Bulletin November 2001, pg 63*
IC-13	(2002)	Recommendation on Standards for High Dependency Units Seeking Accreditation for Training in Intensive Care Medicine *Bulletin June 2002, pg 68*
PS38	(1999)	Statement Relating to the Relief of Pain and Suffering and End of Life Decisions *Bulletin June 1999, pg 93*
PS39	(2003)	Minimum Standards for Intrahospital Transport of Critically Ill Patients *Bulletin June 2003, pg 90*
PS40	(2000)	Guidelines for the Relationship Between Fellows and the Healthcare Industry *Bulletin March 2000, pg 55*
PS45	(2001)	Statement of Patient's Rights to Pain Management *Bulletin March 2002, pg 72*
PS48	(2003)	Statement on Clinical Principles for Procedural Sedation *Bulletin March 2003, pg 73*

13 May 2003



Dean's Message

Leigh Atkinson

Professional Development

Scientific advances, new technology, professional isolation, internet-wise patients and litigation are but some of the challenges to today's busy clinician.

While we are a small Faculty of 170 Fellows, your Board is conscious of the need to provide increasing support to each Fellow. Now, as we seek specialty recognition with the Australian Medical Council (AMC), we have the opportunity to develop this vision.

On May 2nd we held our first Continuing Medical Education Day in Hobart. Seventy-six registrants attended. Michael Cousins started with an overview of the scientific basis of persistent pain. Felix Bochner examined the thorny issue of "detoxification from polypharmacy". Stephan Schug presented some unsettling material on drug interactions. Our Foundation Visitor, Henrik Kehlet, reviewed the value of the pre-emptive management of acute pain. Geoff Booth and Dianne Pacey presented three case studies of patients and gave us a generous perspective of the role of rehabilitation medicine. Faiz Noore and Milton Cohen interviewed a difficult patient and challenged our interviewing techniques. The six presentations allowed for a probing discussion and some debate. The inter-dependence on the skills of our different disciplines was teased out during the day. Our first Continuing Medical Education Program has laid down a valuable template for future meetings. This is a beginning.

Your new Board has welcomed the presence of Rob Helme, a senior neurophysician from Melbourne. The Board has elected Rob as our MOPS Officer which will encompass the role of the Professional Development Program. In future the CME day will precede our Annual Scientific Meeting which, in turn, will be linked to the ANZCA meeting. We also appreciate the need to develop smaller regional meetings during the coming year. We hope to work on a timetable for this in the near future.

The Annual Scientific Meeting of the Royal Australasian College of Surgeons in Brisbane gave us the opportunity to present a conjoint session with the neurosurgeons. This worked well. Henrik Kehlet joined the program with a presentation on persistent pain associated with surgery for hernia, thoracotomy and cholecystectomy. It is possible that in 2004 a more expanded pain medicine program might be run in association with the surgeons and we hope to develop similar conjoint sessions with our sister colleges.

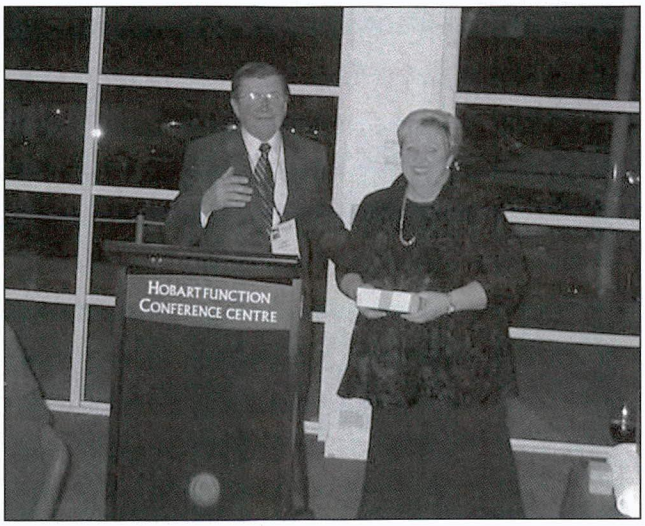
Your Board plans to build the website and provide more professional documents and more educational material. We have arranged for the American Academy of Pain Medicine Journal to be on-line for a six month trial. Your feedback on the articles will be most important.

Your Board has noted that some Australian states and New Zealand, the Australian Council on Health Care Standards and many hospital accreditation committees require annual evidence of a MOPS program from all clinicians. Our Faculty has accepted the ANZCA MOPS record as being suitable for all our Fellows. In addition, your Board believes that the MOPS program should be mandatory for all Fellows as from 2004.

I am of the view that many colleges have emphasised trainee education and research activities at the expense of the Fellows who pay the subscriptions. Your Board will commit itself to providing more educational support to our Fellows. Your individual feedback on what you would like from the Faculty as well as your commitment to assist would be appreciated.

Leigh Atkinson

Leigh Atkinson
Dean



Leigh Atkinson and Pam Macintyre at the Faculty Dinner

David Hansen (Guest Speaker from the Tasmanian Art Gallery), Edward and Pam Cohen and Leigh Atkinson at the Faculty Dinner

Humphry and Tess Cramond with Terry Little at the Faculty Dinner

Michael Cousins, Henrik Kehlet and Leigh Atkinson following the Michael Cousins Foundation Lecture

Lorna Fox, Greta Palmer and Anne Jaumees with Leigh Atkinson at the College Ceremony Reception

Leigh Atkinson, Margaret Benjamin, Michele Cousins, Henrik Kehlet and David Jones at the College Ceremony Reception

Highlights from the Board Meeting

HELD ON FEBRUARY 13, 2003

Election of Dean-Elect

Leigh Atkinson was re-elected as Dean.

Education

Psychosocial Assessment of Patients with Chronic Pain document. A few minor amendments are now only required. Frank New and Faiz Noore are to be congratulated on the preparation of this document.

Pain Orientated Physical Examination. Progress is being made on this cd. A trial video has been produced.

Module 10 will be amended for inclusion in the Revised FANZCA Training Manual.

The *Objectives of Training and Reading List* will be readdressed by the Education Committee in due course. Assistance from Fellows with regard to updated references will be requested.

Questionnaire to New Fellows. The Board agreed that this document be circulated to Fellows admitted by training and examination between 1999-2001 to assess where they are currently practising and what they see as future challenges in the field of Pain Medicine.

Acute Pain Management: Scientific Evidence Guidelines Revision. It was noted that the first meeting of the working party will be held on February 14 to discuss the work plan and contents.

MOPS. The Board noted the number of Fellows now using the MOPS Program and agreed this is encouraging.

Examination

It was agreed that the 2003 examination be held on October 30 and 31 at Royal Brisbane Hospital.

Pre-Examination Short Course. P Briscoe commented that it is anticipated to again hold this course for trainees at Royal Adelaide Hospital.

Hospital Accreditation

Royal Brisbane Hospital. This Board noted this review will be undertaken on February 21.

Professional Documents

PM2 *Requirements for Multidisciplinary Pain Centres Offering Training in Pain Medicine.* A revised document was discussed. It was agreed that this document remain under revision and that a further document be circulated to the Board prior to the next meeting.

Intercollegiate Forum

The Board noted that Council has agreed that the College and Faculty host an intercollegiate forum on Pain Medicine at the College. It was agreed to arrange a date for this possibly in August.

Recognition of Pain Medicine as a Specialty

A draft of the Preliminary Application was tabled. It was agreed that further fine tuning is required before its submission on the closing date of February 19. The Board are grateful for the enormous contribution of Garry Phillips.

Administrative Instructions

The Board agreed that a clause should be inserted into the AIs defining the length of time a trainee can remain in the training program. It was agreed that the College Regulation be followed of ten years. A Notice of Motion is to be prepared for the next meeting of the Board.

Multicentre Trials

M Cousins commented that a working party has been appointed by ANZCA Research Committee to consider when an ANZCA Multicentre Clinical Trial Secretariat would benefit research by ANZCA Fellows. Council has supported this development in principle.

Research Committee

Following discussion it was agreed that the Faculty would benefit from a Research Committee, particularly due to the multicentre trials possibly being developed. Julia Fleming agreed to Chair this Committee and will develop the Committee's responsibilities as well as to nominate members to the next Board Meeting.

National Institute of Clinical Studies

The Dean commented he recently met with Dr Heather Buchan, CEO and Dr Ruth Cornish, Project Manager regarding NICS and the Pain Management Project. The Dean also thanked Julia Fleming for attending NICS Meetings. NICS will be forming a multidisciplinary advisory group to guide the detailed planning and implementation of the project.

Refresher Course Day, May 2, 2003 – Hobart

The Board noted that the brochure will be mailed to all Fellows within the next two weeks. A flyer will also be placed in the March 2003 Bulletin to all Fellows. All speakers are now confirmed.

Annual Scientific Meetings

Hobart 2003

The Dean commented he is encouraged that there are approximately seven free papers. The program and all speakers are confirmed.

Annual Dinner

The invitation to the dinner will be included on the Refresher Course Day brochure.

New Fellows Conference 2003

Dr Jennifer Morgan will attend as the Faculty's representative.

Perth 2004

The Board noted that Professor Ralf Baron from the Department of Neurology, Kiel has accepted the invitation as the Faculty's Foundation Visitor.

Auckland 2005

It was agreed that Professor Mark Sullivan, USA be invited to attend this meeting as the Foundation Visitor.

It was agreed to invite Bob Large and Mike Butler to be the co-convenors for the Faculty's scientific program.

Combined FPM/Acute Pain SIG Meeting

This meeting is to be held on September 30 and October 1 at the Grand Hyatt Hotel in Melbourne. J Fleming commented that the Faculty's working party met with Colin Goodchild to develop the program. A teleconference will soon be held to discuss this meeting further.

Web Page

It was noted that there had not been any responses to the Faculty's offer to advertise vacancies in Pain Management Centres on the Faculty web page.

Admission to Fellowship

The following have been admitted to Fellowship by training and examination for admission to Fellowship of the Faculty of Pain Medicine

CHU, Ming Chi	SA
Anne Veronica Jaumees	NSW
Stephanie Louise Keel	WA
Martin John McNamara	QLD
Jennifer Mary Morgan	WA
Frederick Marc Walden	QLD
Charlotte Mary Wilsey	NSW
Alex YEO Sow Nam	SING

The following has been admitted to Fellowship by election

Roman Boris Jaworski	NSW

Highlights from the Board Meeting

HELD ON MAY 1, 2003

Education

A meeting of the Education Committee was held on April 11. The main outcomes from this meeting were:

Case Scenarios for PBL Sessions

A framework for evaluating and developing a case scenario was developed. This is based on a revised format for the SoT Quarterly In-Training Assessment Reports. Committee members will use this new framework as a template for the case scenarios being developed by members of the Committee.

Supervisor of Training Quarterly Reports

The Board approved modifications to the SoT Quarterly In-Training Assessment Reports on a recommendation from the Education Committee. The modifications will include the following areas under Roles and Competencies: Knowledge, History Taking, Physical Examination, Patient/Staff Interactions, Communication with Patient, Therapeutic Skills and Formulation. These changes will commence from the 2004 training year.

Psychosocial Assessment of Chronic Pain Patients. It is anticipated this document will be completed within the next two months. This document will then be available for downloading from the web.

Pain Orientated Physical Examination. A meeting will be held in Hobart to view and further develop this cd.

Refresher Course Days

The Committee suggested the Board perhaps run half day sessions as part of the scientific meetings of the participating Colleges as a service to non-FANZCA Fellows. The Board agreed to approach the participating Colleges.

Attracting Trainees

The Committee requested the Board view the issue of how to attract new trainees. The Board agreed this is an on-going issue and that a strategy needs to be developed. This was further discussed under the Intercollegiate Forum.

Examination

P Briscoe commented she has commenced plans for the 2003 examination.

Pre-Examination Short Course

It is proposed to hold this course at Royal Adelaide Hospital on 18th and 19th September.

Hospital Accreditation

The Royal Brisbane Hospital was approved for training.

The Board approved that effective from the 2004 training year, the Faculty move from accrediting training positions to accrediting training programs.

The American Academy of Pain Medicine Journal

The first on-line *Pain* Journal has now been circulated to Fellows. Assessment by Fellows will be requested following further editions being received.

Fellows are encouraged to also make contributions to this Journal.

NHMRC Acute Pain Management: Scientific Evidence

The Board noted that two meetings of the working party have been held with a further meeting arranged in Hobart at the ASM.

Regional Education Meetings

The Board agreed that it is important to run Regional Education Meetings and these could be held on specific topics to cover the broad subject of Pain Medicine. It was agreed that input from Faculty Fellows to assist with running these meetings will be required.

MOPS

The Board agreed that the ANZCA Pain Medicine MOPS Program become mandatory for all Faculty Fellows. This will take effect from 2004.

Intercollegiate Forum

It was noted that this meeting will be held at the College on August 1. A list of participants has been drawn up and invitations will be forwarded.

Recognition of Pain Medicine as a Specialty

The AMC has accepted the Faculty's Preliminary Application and has now been invited to submit a Full Application by June. The Board agreed to accept this invitation. A meeting of the working group is to be held as soon as possible.

Administrative Instructions

Administrative Instruction 13.2 has been amended to replace the word "mandatory" with "structured" training program.

Administrative Instruction 13.5 has been amended to include the period of time a trainee can remain in the Faculty's Training Program. AI 13.5.2 states:

"Training must be completed within ten years from the date of commencement of training in accordance with AIs 13.2.2 and 13.2.3. This ten year period includes delays caused by examination failures, interrupted and part-time

training. Where this AI is associated with on-going problems, the Board (on the advice of the Censor) may approve an amended training program having regard to all relevant factors."

Multicentre Trials

M Cousins suggested this is an ideal opportunity for Pain Medicine to be involved. The Dean agreed to ask Fellows to make suggestions for suitable Pain Medicine multicentre trials.

Research Committee

J Fleming commented she is still working on the possible membership of this Committee.

Professional Documents

PM2 *Requirements for Multidisciplinary Pain Centres Offering Training in Pain Medicine* remains under revision.

PS48 (2003) *Statement on Clinical Principles for Procedural Sedation* was adopted as a joint College, FPM, JFICM and ACEM document.

PS49 (2003) *Guidelines on the Health of Specialists and Trainees* was adopted as a joint College, FPM and JFICM document.

Refresher Course Days

Hobart 2003

It was noted there are 76 registered to attend this meeting.

Future Refresher Course Days

It was agreed to hold these meetings the day prior to the College ASM. It was also agreed to approach the participating Colleges with a view to holding conjoint sessions at their scientific meetings.

Refresher Course Day 2004

It was agreed that this meeting be held on April 30 in Perth. A venue will be arranged.

Annual Dinner 2004

It was agreed to hold this dinner on Friday, April 30 in Perth.

Refresher Course Day 2005

This meeting will be held on May 6, 2005 in Auckland.

Annual Scientific Meetings

Hobart 2003

It was noted there are 8 Free Papers which is encouraging. In order for these papers to all be held within the FPM program, this session time has been extended.

Perth 2004

R Goucke commented that planning is now underway.

Auckland 2005

Bob Large and Mike Butler have agreed to be the scientific program co-convenors for the Faculty for this meeting.

Foundation Visitor

Professor Mark Sullivan from the Department of Psychiatry and Behavioral Sciences, University of Washington Medical Center has accepted the invitation to be the Faculty's 2005 Foundation Visitor.

Combined FPM/Acute Pain SIG Meeting, Septemeber 30 and October 1, 2003, Melbourne

J Fleming and J Trinca are continuing to work with Colin Goodchild on the program for this meeting.

Dean's Report

Annual General Meeting – 4th May, 2003

Welcome to the 5th Annual General Meeting of the Faculty of Pain Medicine. It gives me great pleasure to outline the Board's progress over the past twelve months. There have been successes and frustrations but at all times there has been an harmonious Board committed to growing this important initiative. Again, we would not be here without the support of the Australian and New Zealand College of Anaesthetists, its President Richard Willis and its CEO Joan Sheales. We owe them our thanks.

CENSOR

Our primary objective is education. The Censor, David Jones, has a heavy responsibility of reviewing all aspects of the programme for our trainees. He has the added support of his deputy, Graham Rice, who must review overseas occupational training visas and applications for elections as Fellows. Thank you.

EDUCATION

Our Education Committee has had a demanding year under the leadership of Milton Cohen. The training programme needs regular moulding and upgrading. The new FANZCA course based on modules meant that the pain module required attention. The Committee also moved to develop a pain module that might be accepted into the training programmes of our sister colleges and ones including the neurosurgeons and neurologists. One of the outstanding outcomes was the development of a document on the psychological assessment of patients with chronic pain and I know Milton Cohen would like me to thank Faiz Noore and Frank New for their enormous amount of work carried out in preparing this document.

MAINTENANCE OF PROFESSIONAL STANDARDS

Your Board appreciates that in the current challenging times of professional practice each Fellow must be supported with adequate continuing education and more resources. In many colleges this has been underplayed in the past. Our MOPS programme is based on the ANZCA one. This should meet the requirements of all our Fellows. I would like to thank Roger Goucke for steering this through.

This year we have introduced the first continuing education day for our Fellows. We will value your criticisms and your suggestions. We will continue to link this with ANZCA meetings and offer to have sessions at other scientific meetings. As a further educational support service, it is planned that the Faculty website will be expanded to provide increased educational resources.

In addition, Fellows will receive the American Academy of Pain Medicine Journal on-line for a six-month trial. It is hoped that Fellows will extend their international activities and contribute to this journal. Please understand that any suggestions you might have regarding further support for our Fellows would be examined carefully by your Board.

EXAMINATION

The 4th Annual Exit Examination was held at the Sir Charles Gairdner Hospital in Perth in November, 2002. The Chairman of the Committee, Penny Briscoe, was supported by Lindy Roberts. Penny Briscoe produced a faultless background for the examination and this was appreciated by the examiners and the trainees. Eleven of the thirteen candidates passed. Our thanks go to Penny Briscoe, Lindy Roberts and all those involved.

Following these examinations the Barbara Walker Prize for Excellence in Pain Management was awarded to Jennifer Mary Morgan FANZCA, Western Australia. In acknowledgement of the high standards in the examination there was a merit list including Stephanie Keel FANZCA, Western Australia, and David Holthouse our first neurosurgical trainee to complete the examination.

HOSPITAL ACCREDITATION

Hospital accreditation can be a ticklish exercise. Friendships can be tested. Roger Goucke again managed to steer a sensitive course. We need more accredited training centres. We need to respond to the Australian Medical Council observation that the programmes need to be more flexible and possibly include private clinics.

AWARDS, HONOURS & APPOINTMENTS

It is not surprising that the extra hours of commitment by our Fellows might be acknowledged from time to time. Bruce Rounsefell was awarded a Member of the Order of Australia (AM); Professor Michael Cousins received the Carl Koller Gold Medal from the European Society of Regional Anaesthesia; Professor Michael Cousins was also elected Vice-President of ANZCA. Dr. Michael Paech became the Associate Professor of Obstetric Anaesthesia at the School of Medicine Pharmacology, Faculty of Pain Medicine and Dentistry of the University of Western Australia. Prof. Tess Cramond was awarded the Australian Centenary Medal.

ADMISSION TO FELLOWSHIP BY TRAINING & EXAMINATION

In the past twelve months the following were admitted to the Fellowship by examination:

Stephen Bruce Gibson, FANZCA	NSW
Henry Wai-Fund Lam, FANZCA	NSW
Sarah Margaret Lindsay, FANZCA	Qld
Ivan Llewellyn Marples, FRCA	SA
Nicholas Patrick Plunkett, FRCA	NZ
Ming Chi Chu, FANZCA	SA
Anne Veronica Jaumees, FANZCA	NSW
Frederick Marc Walden, FANZCA	Qld
Charlotte Mary Wilsey, FRCA	NSW
Alex Yeo Sow Nam, FANZCA	NSW

In addition, Roman Jaworski FRACP, NSW was admitted to Fellowship by election.

THIRD PATHWAY FOR ADMISSION TO FELLOWSHIP

It is to be noted that the November, 2000 meeting the Board ratified a third pathway for admission to Fellowship. This is to enable individuals who had not had formal training in pain medicine during their primary specialty training and are not in a position to enrol prospectively in the Faculty training programme but who have been actively engaged in pain medicine since obtaining their primary specialty Fellowship.

This third pathway will cease following the 2005 examinations.

TOTAL FELLOWSHIP

I am happy to report that we have now a total Fellowship as at 30th April, 2003 of 164 Fellows, six of whom are Honorary Fellows.

RECOGNITION OF PAIN MEDICINE AS A SPECIALTY

In late 2002 your Board agreed to apply to the Australian Medical Council for speciality recognition. With the generous assistance and guidance of Professor Garry Phillips the documentation was completed and submitted to the Australian Medical Council for specialty recognition.

PROFESSIONAL DOCUMENTS

Further documents were developed and reviewed.

PM3 Lumbar Epidural Administration of Corticosteroids was promulgated in August, 2002.

The following documents were endorsed as joint statements with the College:

PS3 Guidelines for the Management of Major Regional Analgesia

PS48 Statement on Clinical Principles for Procedural Sedation

PS49 Guidelines on the Health of Specialists and Trainees.

WHITE PAPERS

Additional White Papers remain in the planning stage and more work has to be done in the coming months.

BOARD ELECTION

The Board election was conducted on the 31st March, 2003. There were 109 envelopes returned, 2 invalid and 107 votes counted. Elections are an opportunity to bring new energy and vision to your Board. I wish to sincerely thank all those who nominated this year.

The results of Board Election counted on Monday, 31st March, 2003

*ATKINSON	Rupert Leigh	Re-elected unopposed
*BRISCOE	Penelope Anne	99
*COHEN	Milton Laurence	94
*COUSINS	Michael John	92
*FLEMING	Julia Ann	Not due for re-election
*GOUCKE	Charles Roger	100
*HELME	Robert Darrel	65
*JONES	David	76
*KINLOCH	Bruce McNeill	Re-elected unopposed
*NOORE	Faizur Rahman	49
*RICE	Graham Inglis	57
*SCHUG	Stephan Alexander	53
*SHIPTON	Edward Archibald	54

*Successful

Membership of the Board will take office after the Annual General Meeting. The appointment of Office Bearers and Committees will occur at the new Board meeting.

Amendments to the Administrative Instructions were ratified by the Board in August, 2002 with respect to the composition of the Board. This amendment specifies that there will be ten Fellows of the Board, four of whom shall be FANZCA, at least one shall be from each of the participating Colleges and the Faculty and that the two remaining Fellows can be from any of the five participating specialties. At least one member of the Board will be resident in New Zealand.

In 2003, Pam Macintyre retired from the Board. I would like to thank her for her contributions, not only to the Board, but also as the ASM Officer and for her work on the committees. She will continue her role as Chair of the Division of the NHMRC Acute Pain Management Guidelines.

We welcome Robert Helme as the new Board Member from Victoria. We look forward to building important bridges with the neurologists in Australia and New Zealand.

I would like to also thank Steuart Henderson who has been the Co-opted member representing the ANZCA Council over the past twelve months.

MICHAEL COUSINS FOUNDATION LECTURE

You will note that the Board has re-named the major presentation at the Plenary Session the "Michael Cousins Foundation Lecture". This is in recognition of the thirty years of advocacy carried out by Michael Cousins for pain medicine in our countries.

EXECUTIVE OFFICER

The work of the Board and its numerous committees required constant guidance and attention to many small details. The efficient management of our Faculty could not be carried out without the generous commitment of Ms. Margaret Benjamin. I deeply appreciate her support.

CONCLUSION

The members of our Faculty face an epidemic of pain and disability in our two populations – an epidemic which seems to remain unseen by our politicians and hospital administrators. Needy patients are offered very patchy access to multi-disciplinary pain services. While legislators have offered generous and ready access to pensions they have provided little in the way of budget support for timely multi-disciplinary pain services aimed at rehabilitation, re-direction and re-employment. We appreciate that we need to be stronger advocates for pain management services that are neglected by our health administrators in many cases and dismissed by many other specialties in the competition for these budgets. We have much to do and I would like to thank the new members of the Board and our Committees for their commitment to this challenge.

Leigh Atkinson
Dean

Faculty of Pain Medicine

ABN 82 055 042 852

PROFESSIONAL DOCUMENTS

P = Professional PS = Professional standards

PM1	(2002)	Guidelines for Trainees and Departments Seeking Faculty Approval of Posts for Training in Pain Medicine *Bulletin September 2002, pg 62*
PM2	(2001)	Requirements for Multidisciplinary Pain Centres Offering Training in Pain Medicine (under revision) *Bulletin March 2002, pg 52*
PM3	(2002)	Lumbar Epidural Administration of Corticosteroids *Bulletin November 2002, pg 63*

COLLEGE PROFESSIONAL DOCUMENTS ADOPTED BY THE FACULTY:

PS3	(2003)	Guidelines for the Management of Major Regional Analgesia *Bulletin March 2003, pg 70*
PS4	(2000)	Recommendations for the Post-Anaesthesia Recovery Room *(Adopted February 2001)*
PS7	(1998)	The Pre-Anaesthesia Consultation *(Adopted February 2001)*
PS8	(1998)	The Assistant for the Anaesthetist *(Adopted February 2001)*
PS9	(2001)	Guidelines on Conscious Sedation for Diagnostic, Interventional Medical and Surgical Procedures *(May 2002)*
PS10	(1999)	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	(1997)	Protocol for Checking the Anaesthetic Machine *(Adopted February 2001)*
PS40	(2000)	Guidelines for the Relationship Between Fellows and the Healthcare Industry *Bulletin March 2000, pg 55*
PS41	(2000)	Guidelines on Acute Pain Management *Bulletin November 2000, pg 80*
PS45	(2001)	Statement on Patients' Rights to Pain Management *Bulletin March 2002, pg 72*
PS48	(2003)	Statement on Clinical Principles for Procedural Sedation
PS49	(2003)	Statement on the Health of Specialists and Trainees in Anaesthesia, Intensive Care and Pain Medicine

PROFESSIONAL DOCUMENTS

Australian and New Zealand College of Anaesthetists

ABN 82 055 042 852

and

Joint Faculty of Intensive Care Medicine

Australian and New Zealand College of Anaesthetists and Royal Australasian College of Physicans

ABN 82 055 042 852

and

Australasian College for Emergency Medicine

ABN 76 009 090 715

Review PS39 (2003)

MINIMUM STANDARDS FOR INTRAHOSPITAL TRANSPORT OF CRITICALLY ILL PATIENTS

Critically ill patients may have absent or small physiological reserves. Adverse physiological changes in these patients during intrahospital transport are common and can be life-threatening. Ventilator-dependent and haemodynamically unstable patients are at particular risk. Careful planning is required to move these patients between hospital facilities such as operating theatres, ICU, Emergency Department, imaging rooms, and wards. Such intrahospital transport is usually elective, but a need for urgency must also be anticipated (such as moving the patient to the operating theatres after a diagnostic procedure).

1. Protocol

1.1 Relevant staff should formulate their hospital's protocol of intrahospital transport of critically ill patients. The protocol should be made widely known and available.

1.2 The transport itself must be justified. Whatever benefits of proposed interventions must outweigh the risks of moving the critically ill patient and those posed by the interventions themselves.

2. Equipment

2.1 Equipment must be dedicated to intrahospital transport.

2.2 The equipment should be durable, and trolley linked devices must be able to enter lifts and pass through all doorways en route.

2.3 All equipment must be able to function in the specific intervention area (e.g. a magnetic resonance imaging room) and facilities for remote patient monitoring should be available where required. Gas, suction, and electrical supplies at the destination must be present and compatible.

2.4 No equipment should be placed on the patient; specially designed receptacles or transport trolleys are useful.

2.5 Basic monitoring of ECG, heart rate, blood pressure (by invasive or an automated non- invasive monitor), and oxygen saturation by pulse oximetry must be used for all patients. A capnometer must be used to monitor all patients receiving mechanical ventilation.

2.6 A defibrillator and a suctioning device must be available.

2.7 A portable ventilator with a disconnect alarm is required for ventilator-dependent patients. Nonetheless, a manual resuscitator bag must always be available. Facilities to deliver PEEP and different modes of ventilation are necessary for some patients.

2.8 Infusion pumps are highly recommended for accurate administration of drug infusions. They should have alarms set appropriately.

2.9 Appropriate fully charged, spare battery packs for electrically driven devices must be available.

2.10 Equipment to secure the airway, and emergency drugs, analgesics, sedatives, and muscle relaxants must be available.

2.11 A procedure must be implemented to ensure that all intrahospital transport equipment is readily accessible and regularly checked.

3. Staffing

3.1 Key personnel for each transport event should be identified. The transport team should consist at least of an appropriately qualified nurse, an orderly, and an appropriately trained doctor.

3.2 Each team must be familiar with the equipment and be sufficiently experienced with securing airways, ventilation of the lungs, resuscitation, and other anticipated emergency procedures.

4. Pre-Departure Procedures

4.1 The transport team must be freed from other duties.

4.2 The receiving person or staff at the destination must be notified, and the arrival time must be clearly understood.

4.3 All pieces of equipment must be checked, and notes and imaging films gathered. An example of a checklist is listed below. Individual responsibilities for checking equipment must be defined.

4.3.1 The monitors function properly and the alarm limits are set appropriately.

4.3.2 The manual resuscitator bag functions properly.

4.3.3 The ventilator (if used) functions properly; respiratory variables and alarms are set appropriately.

4.3.4 The suction device functions properly.

4.3.5 Oxygen ($\pm$ air) cylinders are full.

4.3.6 A spare oxygen cylinder is available.

4.3.7 Airway and intubation equipment are all available and working.

4.3.8 Emergency drugs, analgesics, sedatives, and muscle relaxants are all available.

4.3.9 Additional drugs are made available if indicated.

4.3.10 Spare IV fluids, inotropic solutions, or blood are available if needed.

4.3.11 Spare batteries are available for all battery-powered equipment.

4.3.12 Chest tube clamps (if an underwater chest drain is present) are available.

4.3.13 Patient notes, imaging films, and necessary forms (especially the informed consent form) are available.

5. Patient Status

5.1 Final preparation of the patient should be made before the actual move, with conscious anticipation of clinical needs. Examples include giving appropriate doses of muscle relaxants or sedatives, replacing near empty inotropic and other IV solutions with fresh bags, and emptying drainage bags.

5.2 The patient must be reassessed before transport begins, especially after being placed on monitoring equipment and the transport ventilator (if used). Transport preparations must not overshadow or neglect the patient's fundamental care. An example of a brief check on the patient is listed below.

5.2.1 Airway is secured and patent.

5.2.2 Ventilation is adequate; respiratory variables are appropriate.

5.2.3 All equipment alarms are switched on.

5.2.4 Patient is haemodynamically stable

5.2.5 Vital signs are displayed on transport monitors and are clearly visible to transport staff.

5.2.6 PEEP/CPAP (if set) and F_IO_2 levels are correct.

5.2.7 All drains (urinary, wound, or underwater seal) are functioning and secured.

5.2.8 Underwater seal drain is not clamped.

5.2.9 Venous access is adequate and patent.

5.2.10 IV drips and infusion pumps are functioning properly.

5.2.11 Patient is safely secured on trolley.

6. In-Transit Procedures

6.1 A best route should be planned. Lifts should be secured or reserved beforehand.

6.2 Adequate communication facilities during transit and at the destination must be available.

6.3 The status of the patient must be checked at intervals, especially if the journey takes considerable time. Any change in the patient's condition, unexpected event, or critical incident, must be acted upon immediately.

7. Arrival Procedures

7.1 On arrival at the destination, the receiving monitoring, ventilation, gas, suction, and power facilities are checked if the patient is to be transferred from the transport facilities.

7.2 The patient must be assessed when the new monitors, ventilators (if used), gas and power supplies are established.

7.3 If another team assumes responsibility of care, a complete hand over is given to the team leader. The transport staff must remain with the patient until the receiving team is fully ready to take over care.

8. Documentation

The clinical record should document the patient's clinical status during transport until handover occurs at the destination.

9. Quality Assurance

The process of intrahospital transport of patients should be continually evaluated to identify system problems and recommend improvements.

These guidelines should be interpreted in conjunction with the following document: IC-10 Minimum Standards for Transport of Critically Ill Patients.

Promulgated: 1982
Reviewed: 1987, 1993, 1998, 2001
Date of current document: Feb 2003

ANZCA Website: http://www.anzca.edu.au
JFICM Website: http://www.jficm.anzca.edu.au
ACEM Website: http://www.acem.org.au

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Review PS21 (2003)

GUIDELINES ON CONSCIOUS SEDATION FOR DENTAL PROCEDURES

1. Introduction

Sedation for dental procedures (with or without local anaesthesia) includes the administration by any route or technique of all drugs which result in depression of the central nervous system. The objective of these techniques is to produce a degree of sedation of the patient, without loss of consciousness, so that uncomfortable procedures may be facilitated. The drugs and techniques used should provide a margin of safety which is wide enough to render loss of consciousness unlikely. Loss of consciousness constitutes general anaesthesia and carries specific risks. These guidelines are not intended for very light techniques such as nitrous oxide/oxygen mediated sedation (see para 9).

These techniques are not without risk because of the:

1.1 Potential for unintentional loss of consciousness.

1.2 Depression of protective reflexes.

1.3 Depression of respiration.

1.4 Depression of the cardiovascular system.

1.5 Wide variety and combinations of drugs which may be used, with the potential for drug interactions.

1.6 Possibility of excessive amounts of these drugs being used to compensate for inadequate analgesia.

1.7 Individual variations in response to the drugs used, particularly in children, the elderly and those with pre-existing medical disease.

1.8 Wide variety of procedures performed.

1.9 Differing standards of equipment and staffing at the locations where these procedures may be performed.

It is important to recognise the variability of effects which may occur with sedative drugs, however administered, and that over-sedation, airway obstruction or cardiovascular complications may occur at any time. To ensure that standards of patient care are satisfactory, equipment and staffing of the area in which the patient is being managed should satisfy the requirements in the appropriate ANZCA Professional Documents.

2. General Principles

2.1 The patient should be assessed before the procedure and this assessment should include:

2.1.1 A concise medical history, examination (including blood pressure measurement), performance of appropriate investigations and identification of risk factors. The American Society of Anesthesiologists classification system is convenient for this purpose. (See Appendix 1)

2.1.2 Informed consent for sedation as well as the planned procedure.

2.1.3 Instructions for preparation for the procedure (including the importance of fasting), the recovery period, and discharge of the patient (including avoidance of driving, other dangerous activities, undertaking responsible business).

2.2 If the patient has any serious medical condition then the appropriate treating general medical practitioner and/or their specialist should be consulted prior to any planned treatment under sedation. If the patient is deemed to be seriously medically compromised then an anaesthetist should be present to administer sedation and to monitor the patient during the procedure.

2.3 The practitioner administering sedation requires sufficient knowledge to be able to:

2.3.1 Understand the actions of the drug or drugs being administered.

2.3.2 Detect and manage appropriately any complications arising from these actions. In particular medical and dental practitioners administering sedation must be skilled in airway management and cardiovascular resuscitation.

2.3.3 Anticipate and manage appropriately the modification of sedative drug actions by any concurrent therapeutic regimen or disease process which may be present.

2.4 Techniques intended to produce loss of consciousness must not be used unless an anaesthetist is present.

2.5 A written record of the dosages of drugs and the timing of their administration must be kept as a part of the patient's records. Such entries should be made as near the time of administration of the drugs as possible. This record should also note the regular readings from the monitored variables.

2.6 Techniques which compensate for inadequate local analgesia by means of heavy sedation must not be used unless an anaesthetist is present.

3. Staffing

3.1 If an appropriately trained medical or dental practitioner is not present to administer sedation and monitor the patient, there must be an assistant present during the procedure, appropriately trained in observation and monitoring of sedated patients, and in resuscitation whose sole duty shall be to monitor the level of consciousness and cardio-respiratory function of the patient.

3.2 If at any time spontaneous respiration and/or protective reflexes are lost, or the patient does not respond to verbal commands or stimulation, both the proceduralist and assistant must devote their entire attention to monitoring and treating the patient until recovery, or until such time as another medical or dental practitioner becomes available to take responsibility for the patient's care.

3.3 If general anaesthesia or loss of consciousness is sought for the procedure, then an anaesthetist must be present to care exclusively for the patient.

4. Facilities

The procedure must be performed in a location which is adequate in size and staffed and equipped to deal with a cardiopulmonary emergency. This must include:

4.1 An operating table, trolley or chair which can be readily tilted.

4.2 Adequate uncluttered floor space to perform resuscitation.

4.3 Adequate suction and room lighting.

4.4 A supply of oxygen and suitable devices for the administration of oxygen to a spontaneously breathing patient.

4.5 A self inflating bag suitable for artificial ventilation together with a range of equipment for advanced airway management.

4.6 Appropriate drugs for cardiopulmonary resuscitation and a range of intravenous equipment. (See Appendix II)

4.7 A pulse oximeter.

4.8 Ready access to a defibrillator.

5. Monitoring

All patients undergoing intravenous sedation must be monitored continuously with pulse oximetry and this equipment must alarm when certain set limits are exceeded. There must be regular recording of pulse rate, oxygen saturation and blood pressure. According to the clinical status of the patient, other monitors such as ECG or capnometry may be required.

6. Oxygenation

Degrees of hypoxaemia occur frequently during intravenous sedation without oxygen supplementation. Oxygen administration diminishes hypoxaemia during procedures carried out under sedation and should be routinely available.

Pulse oximetry enables the degree of tissue oxygenation to be monitored and must be used on all patients during sedation.

7. Drugs Used For Sedation

A variety of drugs and techniques are available for sedation. The most common intravenous agents used are small doses of a benzodiazepine (such as midazolam) for sedation and small doses of opioid (such as fentanyl) for analgesia. Even small doses of such drugs may result in loss of consciousness in some patients.

Intravenous anaesthetic agents must only be used by an appropriately trained medical or dental practitioner, and titrated in doses which do not allow intended loss of consciousness. Continuous monitoring of consciousness by whatever means must be established. These agents must not be administered by the proceduralist without the presence of an appropriately trained assistant whose sole duty is to monitor the level of consciousness of cardio-respiratory function of the patient (see 3.1).

8. Training in Sedation for Dental Procedures

An appropriately trained medical or dental practitioner should be present and be responsible for administration of sedation. The clinician is to be one of the following:

8.1 A dentist who has successfully completed relevant postgraduate training leading to an accredited qualification accepted by the relevant Health Authority. An example is the Diploma in Clinical

Dentistry (Sedation and Pain Control) from the University of Sydney, or an equivalent course (as defined by the relevant regulating authority).

8.2 A medical practitioner with formal training at least equivalent to the Diploma in Clinical Dentistry (Sedation and Pain Control) from the University of Sydney, or training in accordance with ANZCA current professional requirements.

8.3 A specialist anaesthetist.

9. Specialised Equipment for Nitrous Oxide Sedation

When nitrous oxide is being used to provide sedation, the following equipment requirements must be satisfied:

9.1 There must be a minimum oxygen flow of 2.5 litres/minute with a maximum flow of 10 litres/minute of nitrous oxide, or in machines so calibrated, a minimum of 30% oxygen. There must be the capacity for the administration of 100% oxygen.

9.2 The circuit must include an anti-hypoxic device which cuts off nitrous oxide flow in the event of an oxygen supply failure, and opens the system to allow the patient to breathe room air.

9.3 There must be a non-return valve to prevent re-breathing, and a reservoir bag.

9.4 The patient breathing circuit must provide low resistance to normal gas flows, and be of lightweight construction.

9.5 Installation and maintenance of any piped gas system must be according to appropriate standards.

9.6 Servicing of equipment and piped gases must occur on a regular basis and at least annually.

9.7 An appropriate method for scavenging of expired gases must be in use.

9.8 There must be a low gas flow alarm.

9.9 Risks of chronic exposure to nitrous oxide should be considered.

10. Discharge

The patient should be discharged only after an appropriate period of recovery and observation in the procedure room, or in an adjacent area which is adequately equipped and staffed. Oxygen must be available in any area used for patient recovery.

Discharge of the patient should be authorised by the practitioner who administered the drugs, or another appropriately qualified practitioner. The patient should be discharged into the care of a responsible adult to whom written instructions should be given. Transport should normally be by car.

Adequate staffing and facilities must be available in the Recovery Area for managing patients who have become unconscious or who have suffered some medical mishap. Should the need arise the patient must be transferred to appropriate medical care.

A number of ANZCA Professional Documents should be noted where appropriate, particularly the following:

PS1 *Recommendations on Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia*

PS2 *Recommendations on Privileges in Anaesthesia*

PS4 *Recommendations for the Post-Anaesthesia Recovery Room*

PS6 *Recommendations on Minimum Requirements for the Anaesthesia Record*

PS7 *Recommendations on The Pre-Anaesthesia Consultation*

PS15 *Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery*

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

PS18 *Recommendations on Monitoring During Anaesthesia*

T2 *Recommendations on Minimum Facilities for Safe Anaesthesia Practice Outside Operating Suites*

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

Appendix I

The American Society of Anesthesiologists' physical status classification system:

Class I: A normal, healthy patient.

Class II: A patient with mild systemic disease.

Class III: A patient with severe systemic disease.

Class IV: A patient with severe systemic disease that is a constant threat to life.

Class V : A moribund patient who is not expected to survive without the operation.

Excerpted from American Society of Anesthesiologists Manual for Anesthesia Department Organization and Management 2001. A copy of the full text can be obtained from ASA, 520 N Northwest Highway, Park Ridge, Illinois 60068-2573

Appendix II

Emergency drugs should include at least the following:
adrenaline
atropine
dextrose 50%
lignocaine
naloxone
flumazenil
portable emergency oxygen supply

ANZCA PROFESSIONAL DOCUMENTS

ANZCA 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 is intended to apply wherever anaesthesia is administered.

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

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

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

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and

Faculty of Pain Medicine

and

Joint Faculty of Intensive Care Medicine

Australian and New Zealand College of Anaesthetists and Royal Australasian College of Physicans

ABN 82 055 042 852

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Australasian College for Emergency Medicine

ABN 76 009 090 715

Review PS48 (2003)

STATEMENT ON CLINICAL PRINCIPLES FOR PROCEDURAL SEDATION

1. Introduction

The purpose of this paper is to outline the basic clinical principles underlying the practice of procedural sedation.

The specific application of these principles is a matter for policy development and determination by appropriate professional organisations.

2. Patient Assessment and Preparation

All patients should be assessed before sedation for a procedure. Assessment should include:

2.1 Medical history, including details of events leading to the current problem, co-existing medical conditions, past medical history, including anaesthesia and surgery, medications, recreational drugs, allergies, and fasting status (seriously ill or injured patients should be assumed to have a full stomach).

2.2 Examination, including that relevant to the current problem, airway, cardiovascular and respiratory status, other systems identified by the history.

2.3 Relevant investigations.

2.4 Identification of risk factors (eg co-morbidities, allergies, ASA classification).

2.5 Obtaining of informed consent for sedation and the procedure.

3. Staffing

Sedation and performance of a procedure requires at least two appropriately qualified staff:

3.1 One to perform the procedure.

3.2 One to be solely responsible for administration of medications, monitoring and care of the patient.

3.3 A medical specialist or advanced medical trainee or other appropriately credentialled medical practitioner with specific experience in airway management and resuscitation must be either directly involved in performance of the procedure or administration of the sedation.

3.4 If general anaesthesia is intended for the procedure, a medical practitioner trained in the use of anaesthetic agents and techniques must be present to care exclusively for the patient.

4. Facilities

The procedure must be performed in a suitable clinical area with facilities for monitoring, and advanced cardiorespiratory resuscitation.

There must be immediate and dedicated availability of equipment for oxygen administration and artificial ventilation, suction, and equipment and medications for cardiac resuscitation.

5. Monitoring

All patients undergoing intravenous sedation must be monitored continuously with pulse oximetry. There must be regular recording of pulse rate, oxygen saturation and blood pressure throughout the procedure. Other monitors such as ECG or capnometry may be required.

6. Medication

Doses of medications must be calculated, drawn up and labelled prior to the procedure.

Appropriate antagonists must be available.
Secure intravenous access is mandatory.
Oxygen must be given to every sedated patient.

7. Recovery

Close observation and monitoring by appropriately trained staff in a suitable clinical area with immediate availability of oxygen, suction, resuscitation drugs and equipment should continue until the patient returns to their pre-sedation state of consciousness and cardiorespiratory function.

8. Documentation

The clinical record should include the names of staff performing sedation and the procedure, with documentation of the history, examination, investigations, details of the medications and fluids administered (including time, dose, route) any resulting complications, as well as monitoring used, and data measured. Progress in the recovery phase should be similarly documented.

9. Discharge

The patient may leave the recovery area or be discharged when:

9.1 Vital signs and level of consciousness have returned to pre-sedation level.

9.2 An appropriate accompanying person and transport is available.

9.3 Appropriate further care has been arranged.

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

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Australian And New Zealand College Of Anaesthetists

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PROFESSIONAL DOCUMENTS

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

TE1	(2001)	Guidelines for Hospitals seeking College Approval of Posts for the First Four Years of Vocational Training in Anaesthesia *Bulletin June 2001, pg 92*
TE3	(1999)	Supervision of Clinical Experience for Trainees in Anaesthesia *Bulletin November 1999, pg 67*
TE4	(2002)	Policy on Duties of Regional Education Officers in Anaesthesia *Bulletin November 2002, pg 84*
TE5	(2002)	Policy for Supervisors of Training in Anaesthesia *Bulletin November 2002, pg 76*
TE6	(2000)	Guidelines on the Duties of an Anaesthetist *Bulletin July 2000, pg 86*
TE7	(1999)	Secretarial and Support Services to Departments of Anaesthesia *Bulletin November 1999, pg 69*
TE9	(1999)	Quality Assurance *Bulletin June 1999, pg 94*
TE11	(1999)	Formal Project Guidelines *Bulletin March 1999, pg 70*
TE13	(2001)	Guidelines for the Provisional Fellowship Year *Bulletin November 2001, pg 76*
TE14	(2001)	Policy for the In-Training Assessment of Trainees in Anaesthesia *Bulletin November 2001, pg 84*
TE17	(1999)	Advisors of Candidates for Anaesthesia Training *Bulletin November 1999, pg 66*
TE18	(2000)	Guidelines for Assisting Trainees with Difficulties *Bulletin March 2001, pg 76*
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 , pg 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	(1998)	The Pre-Anaesthesia Consultation *Bulletin March 1998, pg 73*
PS8	(1998)	The Assistant for the Anaesthetist *Bulletin March 1998, pg 75*
PS9	(2001)	Guidelines on Conscious Sedation for Diagnostic, Interventional Medical and Surgical Procedures *Bulletin June 2001, pg 88*
PS10	(1999)	The Handover of Responsibility During an Anaesthetic *Bulletin November 1999, pg 62*
P11	(1991)	Management of Cardiopulmonary Bypass *Bulletin May 1991, pg 43*
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*
P21	(2003)	Guidelines on Conscious Sedation for Dental Procedures *Bulletin June 2003, pg 93*
P24	(1997)	Sedation for Endoscopy *Bulletin May 1997, pg 78*
PS26	(1999)	Guidelines on Providing Information about the Services of an Anaesthetist *Bulletin November 1999, pg 63*
P27	(1994)	Standards of Practice for Major Extracorporeal Perfusion *Bulletin November 1994, pg 46*
P28	(1995)	Policy on Infection Control in Anaesthesia *Bulletin March 1995, pg 38*

PS29 (2002) Statement on Anaesthesia Care of Children in Healthcare Facilities without Dedicated Paediatric Facilities *Bulletin November 2002, pg 80*

PS31 (1997) Protocol for Checking the Anaesthetic Machine *Bulletin November 1997, pg 84*

PS37 (1998) Regional Anaesthesia and Allied Health Practitioners *Bulletin March 1998, pg 79*

PS38 (1999) Statement Relating to the Relief of Pain and Suffering and End of Life Decisions *Bulletin June 1999, pg 93*

PS39 (2003) Minimum Standards for Intrahospital Transport of Critically Ill Patients *Bulletin June 2003, pg 90*

PS40 (2000) Guidelines for the Relationship Between Fellows and the Healthcare Industry *Bulletin March 2000, pg 55*

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 (2002) Recommendations for Training and Practice of Diagnostic Perioperative Transoesophageal Echocardiography in Adults *Bulletin November 2002, pg 73*

PS47 (2002) Guidelines for Hospitals Seeking College Approval of Posts for Vocational Training in Diving and Hyperbaric Medicine *Bulletin November 2002, pg 82*

PS 48 (2003) Statement on Clinical Principles for Procedural Sedation *Bulletin June 2003, pg 97*

June 2003

Professional Documents – Erratum

Professional Documents PS39 "Minimum Standards for Intrahospital Transport of Critically Ill Patients and PS48 "Statement on Clinical Principles for Procedural Sedations" were printed in the March 2003 edition of the Bulletin with incorrect headings. Both documents are joint Professional Documents of the College, Joint Faculty of Intensive Care Medicine and the Australasian College for Emergency Medicine. These documents have been reprinted in this Bulletin with correct headings.