

bulletin



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JOINT FACULTY OF INTENSIVE CARE MEDICINE FACULTY OF PAIN MEDICINE

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New ANZCA Foundation

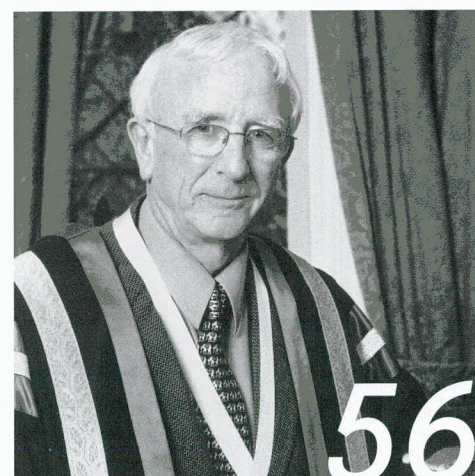
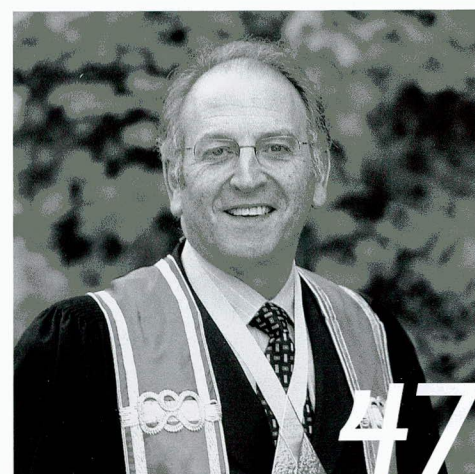
Rural Education Support Programs

***Jack Brockhoff Foundation Churchill
Fellowship***



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Editorial

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

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The Bulletin

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President's Message

It will be apparent from the Report of the Highlights of the Council Meeting of 8th and 9th of October, 2004, that some major events are occurring within ANZCA at the present time. I would like to highlight just a few of these.

Research and the standing of our speciality:

Fellows will be well aware that there are now many external forces operating which place Specialist Medical Colleges in a milieu that must be described as challenging. (eg. ACCC, AMC, OTS/AON, State Governments etc.) Indeed there has never been a time when public and government scrutiny of Medical Colleges has

"good news stories" which are easy to project to the general public, to healthcare administrators and to politicians. The same is beginning to occur with multicentre studies in anaesthesia and it is great to see that some of our Fellows are achieving success with NH&MRC funding in this area. In the field of Pain Medicine, we only are just beginning to be on the radar screen for major funding bodies such as the NH&MRC and others; however the potential is enormous.

In contrast, in the next decade or so Anaesthesia, Intensive Care Medicine and Pain Medicine will play a crucial role, if not the

indication that the Fellows support this activity. I now have a fairly long experience in raising funds from the community and business sector and I can assure Fellows that the Foundation will not be successful if there is a lack of initial support from Fellows. Another very important role of the Foundation will be to raise ANZCA's visibility and this will inevitably occur as a result of the Foundations interaction with the community, governments and business sector. So, now is the time for you to invest in the future of your speciality!

ANZCA Strategic Planning

It has become abundantly clear that not-for-profit organisations, such as Specialist Medical Colleges, are not exempt from the increasingly stringent rules that apply to Directors of Boards and Operations of organisations. Also, ANZCA has now grown to an organisation with close to 4000 Fellows and 1500 Trainees, with a total of 50 employees spread across a number of different regions and two countries. Thus it is high time that we reviewed the governance of this substantial organisation, the functions of the key Officers, Council/Executive, President, Vice President, CEO etc. In order to do this we have engaged Mr Henry Bosch AO, former Chair of the Australian Securities Investment Commission. Council will work with Mr Bosch for one full day in February and March 2005 with subsequent follow-up to implement all of the major recommendations of these two

"...in the next decade or so Anaesthesia, Intensive Care Medicine and Pain Medicine will play a crucial role, if not the dominant role, in the acute care activities that remain in our major hospitals."

been greater. In former times, it was not uncommon for patients and relatives to express appreciation for high quality medical care. This still occurs but sadly to a much lesser extent, and it is now more common to receive input concerning any perceived imperfections. Acknowledgment of highly reliable and excellent medical specialist services is rarely made by health administrators, with the focus being almost invariably on financial matters. None of this is fair to the large majority of our Fellows who provide a high quality clinical service as their major responsibility.

It is in this milieu that the research achievements of a speciality, and the emphasis that it places on the scientific foundations of clinical work, come in to sharper focus and tend to be a very powerful method of projecting a positive image of the speciality. The great success of multicentre studies in Intensive Care has been a very powerful method of showing this speciality in a good light and providing

dominant role, in the acute care activities that remain in our major hospitals. Thus both basic and clinical research in these three areas will be of enormous relevance to quality healthcare, of great interest to the public and politicians, and a powerful method of projecting these three important areas of specialist practice.

With this background, I urge all Fellows, to carefully consider the call for support of the new ANZCA Foundation that appears in the accompanying material in this Bulletin. For the large majority of Fellows who are not involved in research, I would encourage them to focus on the fact that they are investing in the standing of their speciality and its growth into a strong position in the coming years. This will be an investment that is well repaid in the future.

The role of the ANZCA Foundation will certainly be to raise substantial funds to promote research in all three areas of College activity. It will be difficult to do this unless there is a strong

"...I urge all Fellows, to carefully consider the call for support of the new ANZCA Foundation..."

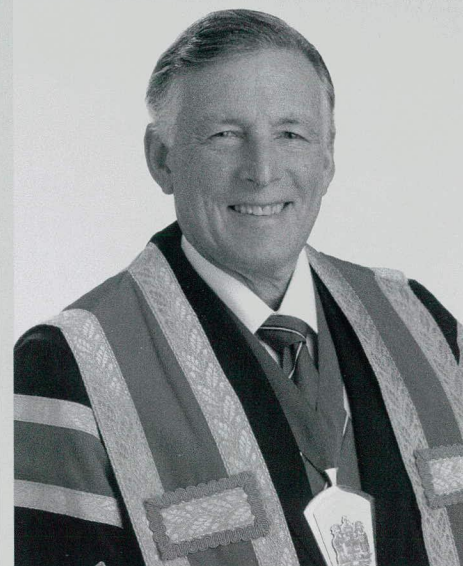
planning days. This will allow ANZCA to consolidate its current strong position and to be ready to meet the challenges of the next 10-15 years. As an initial part of this process, Council



has already requested a Human Resource Management company to review ANZCA employees and processes to ensure that the College meets best practice in all areas of Human Resource Management.

I will inform Fellows about the key recommendations from the two Strategic Planning Days, and the changes in the governance of the College that are approved by Council.

Finally, I wish all Fellows, trainees and staff a happy, relaxing and enjoyable Christmas and New Year and safe holiday period.



Michael J Cousins
President

NHMRC Success for ANZCA Fellows

The National Health and Medical Research Council (NHMRC) of Australia recently announced \$1.17M funding over 3 years for the ATACAS trial: a randomized controlled trial of aspirin and tranexamic acid in 4,600 patients undergoing coronary artery surgery. This trial will be undertaken in 2005-9 and will be one of the largest trials ever undertaken in cardiac surgery worldwide. The Chief Investigators of the trial are Paul Myles (Anaesthetist), Julian Smith (Cardiac surgeon), John McNeil (Epidemiologist), Jamie Cooper (Intensive Care Specialist) and Brendan Silbert (Anaesthetist). The success of this group in the highly-competitive NHMRC grant environment reflects their outstanding individual achievements as well as the strength of their collaboration. The ATACAS trial will be the first trial conducted through the new ANZCA Clinical Trials Group and will involve ANZCA and JFICM Fellows throughout our region. All Fellows who are involved with cardiac anaesthesia or intensive care are invited to contact the Clinical Trials Group for further information (email: jhorton@anzca.edu.au). Congratulations to the ATACAS trial investigators on their success and happy recruiting!



Law Report

Keeping up to Date - New Techniques

As part of professional and legal obligations, doctors must keep up to date in their practice.

As we know, medical knowledge is expanding and changing at a rapid rate. New techniques, new drugs and new procedures are being developed. New clinical trials report regularly on advances. Doctors must, in their practice, utilise the best available medical knowledge and techniques in the care of their patients.

However, when does a new technique become accepted and expected practice?

What are the obligations to explain to patients the risks of new or experimental practices - particularly when results may be exceptionally good?

A recent case in Western Australia highlights this dilemma. *Hall v Petros* (2004) WADC 87 (27 May 2004) involved the use of a relatively new procedure - intra vaginal sling plasty ("IVS"). Dr Petros was an advocate of IVS techniques. A small group of gynaecologists and surgeons

had been pioneering IVS. However, evidence presented during the case suggests that there were no independent studies on the IVS technique and that the more common "gold standard procedure" was different. The IVS procedure was not part of the training program for RANZCOG.

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



The case reflected on the situation where new techniques are emerging and the responsibilities of doctors involved. Cases have consistently confirmed that new techniques and new procedures should be utilised where there are proven successful results. There are even cases where it may be negligent not to adopt the new

"There are even cases where it may be negligent not to adopt the new procedure or new technique, even though it is not universally common practice within the medical profession."

The case is interesting given recent changes to the law of negligence resulting from the medical indemnity crisis.

The Ipp Report recommended that, in determining negligence, reference must be made to any generally accepted practice of the medical profession. The Ipp Report recommended that a defendant doctor should not be held liable where the conduct in question is in accordance with an opinion widely held by a significant number of respective practitioners in the relevant field. This test is now enacted in civil liability legislation in most states and territories.

One of the issues in *Hall v Petros* was whether the IVS technique was supported by a body of evidence of "respected practitioners".

However, more determinative in the case was the alleged failure by the doctor to provide sufficient information and advice to the patient, particularly to warn of material risks inherent in the IVS treatment and the risks and benefits of alternative treatments. It appeared concluded that the doctor did not adequately warn the patient as to the risks of tape rejection, or infection, relevant to IVS procedures. Accordingly, the case was more inherently an "informed consent" case, than case of negligent treatment.

procedure or new technique, even though it is not universally common practice within the medical profession. These cases are suggested as "negligent majority" cases, where the majority of doctors are not performing an otherwise successful, all be it new, procedure.

However, inherent in a new procedure is a heightened obligation to inform the patient - both of the risks involved in the new procedure and the alternative procedures available.

The decision in *Hall v Petros* should not deter doctors from exploring new techniques and new procedures. Indeed, where there are proven successful results, there may be an obligation to stress the value of new techniques and procedures. However, there is also a greater liability for doctors to inform patients that the techniques or procedures are new or experimental, and any particular risks inherent in the new procedures or techniques. Patients must also be given the choice of alternative procedures, and the benefits and risks of the alternatives with full information.

Honours and Appointments

Professor Alex Delilkan (Malaysia)
- Conferment of Emeritus Professorship
by the University of Malaya, Kuala Lumpur

Dr David M Scott (Vic)
- Associate Professor, Department of
Surgery, University of Melbourne at
St. Vincent's Hospital

Dr Peter Lillie (SA)
- Elected to Life Membership of the
Australian Society of Anaesthetists

Professor John Russell (SA)
- Elected to Life Membership of the
Australian Society of Anaesthetists

Dr Rod Westhorpe (Vic)
- Elected to Life Membership of the
Australian Society of Anaesthetists



The NEW ANZCA Foundation:

A call for support from Fellows

Strong research by Fellows is one of the vital factors in securing the future of our medical specialities in Australia and New Zealand. Our Fellows have produced some remarkable and influential research to date, in a wide variety of fields (see Box). However, now is the time that our research efforts need to redouble, in line

"If science dies, a specialty is one generation away from extinction"

with other medical specialties, and in response to increased demands for evidence-based clinical practice, education and management.

Since 1985, ANZCA research grants have been funded through subscriptions in advance. This allowed the College to establish an income-generating corpus from which to award grants. Careful management of College investments has allowed the Council to keep subscriptions constant for the last six years, and now, to rollback subscriptions in advance. Most Fellows will not be required to pay an ANZCA subscription until January 1, 2006.

The College now plans to enhance funding for research through the new ANZCA Foundation. The Foundation was recently established by Council to raise funds and distribute them to Fellows for research in anaesthesia, intensive care medicine and pain medicine. The Patron of the Foundation is the Governor-General of Australia, Major-General Michael Jeffrey, and we are currently recruiting a Board of prominent people to guide our fund-raising activities. The Foundation will be launched officially early in 2005 and will then approach the wider community for support.

Fellows responded with great generosity to our last call for donations in 1985 (19 years ago!)

We would like to take this opportunity to invite Fellows to, once again, take the lead by supporting the new Foundation. We are asking

you to consider a donation to the Foundation at the time of your annual subscription. With a substantial initial corpus in the Foundation, the wider community can be confident that the Foundation has the support of ANZCA Fellows and will be encouraged to provide generous support. All donations will

be publicly acknowledged by the College.

Many thanks for considering this important new initiative. Remember *"If science dies, a specialty is one generation away from extinction"*.

Michael Cousins
President
Kate Leslie
Treasurer



Examples of the varied research in anaesthesia, intensive care medicine, pain medicine and simulation supported by ANZCA

| | | |
|--|------------------|-------------------|
| Regional anaesthesia and cognitive deficits in the elderly | Brendan Silbert | Victoria |
| Optimal duration of antibiotic therapy in critical illness | Bala Ventakesh | Queensland |
| General anaesthesia and local anaesthetic cardiotoxicity | Laurie Mather | New South Wales |
| Genetic mutations and MH | Neil Pollock | New Zealand |
| Safety of tramadol in breast-feeding | Michael Paech | Western Australia |
| Surfactant proteins and ARDS | Andrew Bersten | South Australia |
| Safer intravenous drug administration in anaesthesia | Alan Merry | New Zealand |
| The ENIGMA Trial: nitrous oxide and hospital stay | Paul Myles | Victoria |
| Cannabinoids and neuropathic pain | Paul Wrigley | New South Wales |
| Improving teaching of airway skills to medical students | Harry Owen | South Australia |
| Neuropeptides and changes in injured neurons | Suellen Walker | New South Wales |
| The B-Aware Trial: BIS monitoring and awareness | Kate Leslie | Victoria |
| Fatigue and anaesthetists' performance | Alexander Garden | New Zealand |
| The MASTER Trial: epidural analgesia and outcome | John Rigg | Western Australia |



Education Report

Effective Teaching Strategies that have Stood the Test of Time



Russell W. Jones
Director of Education, ANZCA

Both the words "doctor" and "teacher" share the same Latin origin. Both are derived from the Latin *docere* which literally means "to teach". This dual derivation is not a coincidence. All anaesthetists are engaged in teaching to a greater or lesser extent¹. On a daily basis anaesthetists broaden and extend the knowledge, skills and attitudes of their colleagues, other health care professionals, patients and their families. Increasingly anaesthetists are being required to adopt formal teaching roles whereas teaching via less formal techniques, such as role-modelling and apprenticeship, has long been established.

Therefore teaching can be seen as an integral part of the anaesthetist's role. Indeed the Hippocratic Oath includes reference to teaching²:

"I swear by Apollo the physician ... to teach others this art without fee and covenant; to give a share of precepts and oral instruction and all the other learning to those who have taken this oath under medical law."

Hence, if we accept that the roles of teacher and anaesthetist are inseparable, what must we do in order to ensure that this teaching is most effective? Interestingly little has changed over the last several thousand years. By and large many of the educational issues faced today have been faced by all great teachers through the ages.

This report reviews key approaches of 11 great teachers through the ages from Confucius and Socrates through to contemporary times. The report identifies key characteristics of the strategies used by these eminent teachers that have proven most effective. Specifically those that have stood the test of time and are applicable now.

Confucius 551 – 479 BC

The first recorded professional adult educator was Confucius. Born in China, during his 72 years he founded a system of philosophical and ethical teachings that survives to this day. Three of his sayings that concern teaching are:

"A jade stone is useless before it is processed; a man is good for nothing until he is educated."

"Learning is a treasure that will follow its owner everywhere."

*"When planning for a year, plant corn.
When planning for a decade, plant trees.
When planning for life, educate people."*

What can we learn from these teachings? For us, we should demonstrate that we truly value education. This means our Trainees will be more likely to value our teaching and also their own learning.

Socrates 470 – 399 BC

Perhaps the most famous teacher of all time was the Athenian teacher Socrates. Born shortly after the death of Confucius, Socrates required the teacher to ask stimulating and challenging questions to motivate learners to think critically and reflectively. What strategy can you and I adopt to ensure we stimulate and challenge our Trainees? We should endeavour to take our Trainees out of their comfort zone and to teach them to think critically and reflectively.

Socrates also popularised a teaching strategy now known as "Socratic Irony". Here the teacher feigns ignorance in order to entice others into making statements that can be challenged. This is a very useful teaching strategy, though it risks our Trainees coming to believe that we are not as bright as we really are.

The Death of Socrates

The death of Socrates also offers us a lesson. In 399 BC Socrates' questioning of the prevailing authority and opinion caused him to be accused of impiety to the gods and the corruption of the youth of Athens. Consequently he was tried, convicted and sentenced to death by the Athenian court. He was sentenced to take his own life by drinking hemlock and, although he had the opportunity to save himself, he chose death to remain true to his ideas. Socrates' trial was one of the earliest in a long line of cases

involving academic freedom; the right of a teacher to teach and of a learner to learn without arbitrary interference from authorities or a countervailing public opinion. Perhaps the lesson we can learn from this is not to make our employers too uncomfortable with too many revolutionary teaching ideas too quickly.

Plato 427 – 347 BC

Perhaps the most famous student of Socrates was Plato. When Plato was 22 years old he met Socrates and became his great friend and mentee. Following the death of Socrates, Plato left Athens and journeyed to the cultural centres of the Aegean and Mediterranean worlds. During this time he studied with many greats including Pythagoras and Euclid. Probably as a result of the incredible education he acquired from these masters, combined with the wisdom that is afforded by travel, Plato was able to grasp a truly global view of education. As a consequence he founded the Academy; a school of higher education. Most notably he established a rigorous curriculum which all his students were required to follow. What strategy can we learn from Plato? The need to organise teaching into a curriculum. That is, the need to bring structure and planning to education. Incidentally, as with all good teachers, Plato was persecuted for his educational innovations and, at one time, he was sold into slavery. Fortunately, he had a wealthy friend who eventually purchased his freedom.

Aristotle 384 – 322 BC

Aristotle is significant as a founding father of Western education and philosophy. He was born in Macedonia where his father was court physician to King Amyntas II. From his father Aristotle developed a lifelong interest in medicine and science and at 17 he journeyed to Athens, the then centre of European intellectual life. For the next 20 years he was a student at Plato's Academy. Aristotle's educational life gave us at least two pearls of wisdom. First, he emphasised that human choice is based upon reason. Thus developing and guiding the clinical reasoning of our Trainees is one of the most powerful



strategies we can adopt. Second, he emphasised that teaching is the highest form of understanding. Thus for our own education, if we really want to learn something, then we should teach it. All of us who have ever attempted to teach something outside our comfort zone, know this to be true.

Quintilian 35 – 95 AD

Marcus Fabius Quintilianus, aka Quintilian, is significant as a prominent Roman rhetorician. Born in Callagurris, a Roman city located in modern day Spain, Quintilian's educational theory integrated the Greek and Roman concepts of oratorical education that have become an essential part of the Western educational heritage. Quintilian broadened the somewhat simplistic idea of orator from being a skilled and persuasive public speaker to a person who was broadly educated, ethical and committed to public service. Most notably for us he was the first educator to emphasise that a teacher is responsible for developing all aspects of human nature. Thus teaching of knowledge should be combined with the teaching of values, ethics, behaviours and attitudes.

Plutarch 45 – 125 AD

In the first century AD, the seat of learning had moved from Athens to Rome. However, following the horrors of Nero and Domitian, Rome was ready for some gentle enlightenment and looked to the former seat of learning, Greece. In particular, to the temple of Apollo at Delphi. This, of course, is the site of the Delphic Oracle brought to recent fame thanks to Harry Potter. The priests of the Delphic Oracle had tremendous influence on events of the early part of the first millennium. One of their legacies is the well known advice "Know Thyself". Plutarch was a priest who rose to prominence due to his writings and rhetoric. He also had a tremendous influence on education and approached education with a particularly inspirational strategy that believed:

"A mind is fire to be kindled, not a vessel to be filled."

To us this strategy means that to be most effective we need to inspire our Trainees. And in this regard the teacher is the single greatest influence on a Trainee.

Jane Addams 1860 – 1935 AD

The industrial revolution resulted in enormous societal changes with, of course, significant effects upon education. A Nobel Prize winner, Jane Addams was born in Illinois during the industrial revolution and was an advocate of education until her death in 1935. She was a champion of educational and curricular reform and much of her success rested

On a daily basis anaesthetists broaden and extend the knowledge, skills and attitudes of their colleagues, other health care professionals, patients and their families

upon her strategy that education should be applied to the problems of society. What can we learn from Jane Addams' strategy? If education is to be optimally successful it should focus on current problems of interest to our Trainees.

John Dewey 1859 – 1952 AD

John Dewey was arguably the most influential thinker on education in the 20th Century. He contributed much but perhaps his greatest strategy was the iterative approach to education. The approach that education was a gradual process and, although quantum leaps are occasionally made, for most teachers it is simply continual hard work and striving for perfection within our Trainees. In Dewey's words:

"Not perfection as a final goal, but the ever enduring process of perfecting, maturing and refining...."

Dewey also emphasised that education is about life-long learning. Again, in his words:

"Education is not preparation for life, education is life itself."

Albert Einstein 1879 – 1955 AD

We are all familiar with the achievements and reputation of Albert Einstein. Few of us, however, know that early in his career he failed an entrance examination to undertake studies to become an electrical engineer. Following this failure he suffered several more setbacks in both Germany and Switzerland and failed to impress some of his key superiors. Eventually, however, he qualified as a science and mathematics teacher and then went from strength to strength to ultimately achieve numerous accolades and honours including the Nobel Prize. What can we, as teachers, learn from

this? Never give up on our Trainees, no matter how much they may appear to struggle. Einstein also believed in the value of the example demonstrated by a teacher. He once wrote:

"Setting an example is not the main means of influencing another, it is the only means."

Benjamin Bloom – present day

Benjamin Bloom developed Bloom's Taxonomy. This was the first taxonomy of learning to formalise the existence of multiple levels of learning including knowledge, comprehension, application, analysis, synthesis and evaluation. He also believed that it was important to both teach and assess each of these levels. Bloom suggested that the ability of environmental factors to influence change in human characteristics decreases as the characteristics become more stable. In his words:

"There is a 'window of opportunity' in which powerful environmental interventions are most likely to be successful."



Bloom also understood that a competent teacher is able to teach a gifted Trainee, but that a truly successful teacher is able to teach almost all Trainees.

"Talent is not something to be found in the few; it is to be developed in the many."

K. Patricia Cross – present day

K Patricia Cross is one of the most influential present day adult educators and a prolific writer. The David Pierpont Gardner Professor of Higher Education at the University of California, Berkeley she is former Professor and Chair at the Harvard Graduate School of Education and was named "American Adult Educator of the Year". She is a proponent of the strategy that views learning as not so much an additive process with new learning simply piling on top of existing knowledge, but rather as an active, dynamic process in which connections within the mind are constantly changing and the mind's structure reformatting. The implications for us are that our strategies must include:

- Identifying the current state of knowledge within a Trainee and building upon that knowledge.
- Identifying and correcting misconceptions.

- Not attempting to build new knowledge in the absence of necessary pre-requisite learning.

Conclusion

So as teachers, we are all in great company. What can we learn from these 11 historical masters whose educational strategies have stood the test of time?

- Confucius – education is to be highly valued
- Socrates – the need to stimulate and challenge Trainees
- Plato – teaching should be organised
- Aristotle – teaching is the highest form of understanding
- Quintilian – humans are multifaceted and teachers must cater for all facets
- Plutarch – teachers should inspire their Trainees
- Addams – successful teaching focuses upon real problems
- Dewey – an iterative approach is best
- Einstein – set the example we want our Trainees to follow
- Bloom – there are multiple levels of education
- Cross – appreciate that knowledge, behaviours and attitudes are changeable and incorrect

knowledge, behaviours and attitudes are usually based on incorrect learning

These are some of the strategies from 11 of the educational greats over the last 2,500 years. A final pearl of wisdom we can learn from them is that good teaching is immortal. Though not all of us will be remembered by name, such as Confucius or Socrates, the legacy of our good teaching will live on.



Series on Past Deans and Presidents

James Fishbourne McCulloch

James F McCulloch was the fourth Dean of the Faculty of Anaesthetists, Royal Australasian College of Surgeons, from 1961-1964, having served as Vice Dean from 1956-1961. He followed Dr Lennard Travers and was succeeded by Dr Len Shea.

Jim McCulloch was born on the 1st of June 1901 in Urana, New South Wales, and died in Sydney at the age of 83 years on the 26th June 1984. He was the eldest of six children, and was brought up in a small Riverina township. He was extensively tutored by his mother and, despite limited opportunities, completed his schooling in Albury and entered Medicine at Melbourne University, graduating in 1924.

After hospital posts he proceeded to England and became a Resident Medical Officer at Lambeth Hospital in 1930. There he met Dr Robert Macintosh, later the first Nuffield Professor of Anaesthetics at Oxford University and they became firm friends. He was amongst the first Australian doctors to commence his basic anaesthetic training overseas.

He returned to Australia in 1934, committed to a career in anaesthesia. He first obtained a post as an Honorary Anaesthetist at St Vincent's Hospital Sydney. It was here that he met Drs Harry Daly and Stuart Marshall, who were both to have major influences on his career, as well as on the development of anaesthesia as a speciality in Australia. In 1935 he was also appointed to the honorary anaesthetic staff of the Royal North Shore Hospital. As was usual at that time he also continued a career in general practice to supplement his income. In 1935, Jim McCulloch also joined the Australian Society of Anaesthetists, a group that he would later lead.

Jim remained in general practice until 1939 when he joined the A.I.F. He was posted to Gaza in 1940 with the 1st Australian General Hospital, and then to postings in Palestine. At this time he worked as an anaesthetist. He was posted back to Australia for six months in 1942 before joining the 5th Australian General Hospital in Port Moresby, Papua New Guinea, and then the

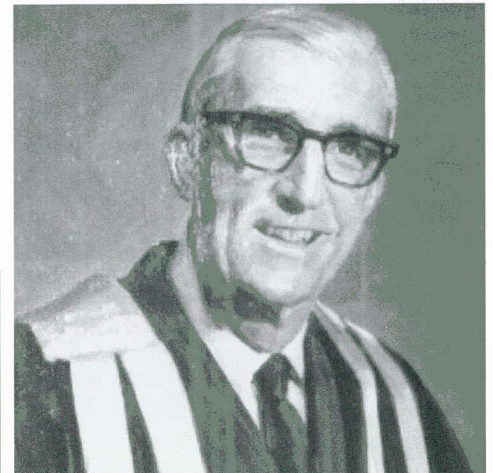
103rd Australian General Hospital. He had vast experience in anaesthesia under wartime conditions, exhibiting considerable ingenuity and fortitude in those primitive conditions, and kept records of over 5000 administrations. He recounted these at the AGM of the ASA in 1947⁽¹⁾.

One comment that reveals the difficulties faced is "The 2/1 Australian General Hospital arrived in Palestine with almost enough 1:1,500 Nupercaine to bathe the Sixth Division, not a great deal of ether and very little else"⁽²⁾.

Upon return to civilian life in 1946 he entered specialist practice in a group partnership with Drs Harry Daly and Stuart Marshall. He had gained Membership of the Royal Australasian College of Physicians in 1945, probably one of the first anaesthetists to do so. At that time he resigned from St Vincent's Hospital and took up the position of Honorary Anaesthetist at Sydney Hospital, whilst continuing his post at Royal North Shore Hospital. He brought to these roles his extensive experience gained through the war years, particularly in the field of peri-operative resuscitation and the administration of intravenous fluids and blood.

At the first post war AGM of the ASA in 1946, Jim was elected Honorary Secretary to succeed Geoffrey Kaye, who had held the post since the formation of the ASA and had reinvigorated the Society in the aftermath of the Second World War. Jim held this post for two years and was later elected President of the Society from 1954-1955. It was whilst President in 1955 that a proposal was supported by the Executive to produce an anaesthetic journal in Australia and Jim was appointed putative editor. Members did not subsequently support this proposal and it was not until 1972 that a journal of anaesthesia was produced in Australia, although the ASA Newsletter filled this void during the period. He was honoured with Life Membership of the Society in 1972.

Having gained the Diploma in Anaesthesia of the University of Sydney in 1950, he was a Foundation Fellow of the Faculty of Anaesthetists,



RACS in 1952. He was elected to the Board in 1956, appointed an examiner and served as Vice Dean from 1959 until 1961 to Dean, Len Travers. He was Dean from 1961-1964. In 1973 he was granted Honorary Fellowship of the Australasian Faculty and elected to the Court of Honour of the Royal Australasian College of Surgeons in 1980. The English Faculty had previously honoured him with election to Fellowship in 1954.

It might be best to finish with a direct quotation from Douglas Joseph who held the role of Dean himself and who was directly encouraged to enter a career in anaesthesia by Jim McCulloch "If one had to choose from amongst many outstanding personal attributes, it would be his amazing ability to encourage young aspirants into anaesthesia without any hint of coercion or false representation of the speciality. He, himself was a living example of the complete anaesthetist and many a Fellow owe their position today to the early inspiration given by James."

I would like to acknowledge that this article is derived from two sources. One, the book by Gwen Wilson (*Fifty years: The Australian Society of Anaesthetists*), and the Obituary written by Douglas Joseph in the July 1984 Bulletin of the Faculty of Anaesthetists, Royal Australasian College of Surgeons. Both of these anaesthetists were personal friends and colleagues of Jim McCulloch.

Terry Loughnan

(1) Daly, J.H., An Address: Retiring President of the Australian Society of Anaesthetists (British Medical Association), *Med J Aust* 1947, Vol 2, No 9, pp. 253-255

(2) McCulloch J.F., Anaesthesia in the Australian Imperial Force, *Med J Aust* 1947, Vol 2, No 9, pp. 261-265

(3) British Medical Association News, Annual General Meeting, *Med J Aust* 1947, Vol 2, No 9, pp. 276 - 278



ANZCA Trainee Committee



Annabel Orr
Chair, Trainee Committee

The Trainee Committee is continuing to develop after almost a year of being in place. In fact, the time is approaching where we will be looking for new members to take us through 2005 and hopefully pursue some more developments and initiatives to help trainees.

In order to improve communication between trainees, we now have an email address at which we can be contacted. This is traineecommittee@anzca.edu.au and anyone wishing to liaise with us should feel free to use this email. In addition the College is on the brink of launching its e-communities. This will effectively be a website that can be accessed via password where information can be posted, and questions can be asked and answered. It will be broadly divided into the discussion groups of

FANZCA, exams and general issues, and there will be one for each state or country under the mantle of ANZCA. All trainees will be able to access these e-communities, and we encourage you to use them.

*“...we now have an email address at...
traineecommittee@anzca.edu.au”*

The Regional Trainee Committees will be looking to recruit new members, and elect a new Chair for their Committee in November of this year. A National Chair is elected from the Chairs of the Regional Trainee Committees. If you have any interest in being involved with how the College addresses education and trainee issues, in

developing some of the policy documents relevant to trainees, or have some other opinions to offer, you will be very welcome on your Trainee Committee. Hopefully we will be represented by a broad range of training years, and a broad range of hospitals – both city and rural. It is essential

for the continuing development of these committees that we get as many people involved as possible. If you have any interest, please email us at the above address, or contact the current Chair of your Regional Trainee Committee directly. To remind you, they are:

- Dr Mark Adams (NZ)
- Dr Rowena Knoesen (WA)
- Dr Bronwyn Avard (ACT)
- Dr Timothy Stavrakis (NSW)
- Dr Savas Totonidis (TAS)
- Dr Kathleen Cooke (QLD)
- Dr Charles Clegg (SA/NT)
- Dr Libby Lee (Hong Kong)
- Dr Annabel Orr (VIC), Chair

Finally, to everyone, I wish you a lovely Christmas and best wishes for the New Year.



Hospital Accreditation Committee

Hong Kong Hospitals Inspection



Leona Wilson
Chair, Hospital Accreditation Committee

The Hospital Accreditation Committee recently undertook a major inspection of all the hospitals in Hong Kong SAR that are either approved or requesting approval for training for FANZCA, as part of the usual seven year cycle of hospital inspections. The ANZCA team was led by the Vice President, Dr Wally Thompson, and consisted of Dr Steuart Henderson, A/Prof Kate Leslie, A/Prof Tony Weeks, Dr Richard Willis and myself, with local inspectors nominated by the Hong Kong Regional Training Committee – Dr Y F Chow, Dr C T Hung, Dr W Chiu, Dr C K Chan, Dr Joseph Lui, Professor Tony Gin, A/Professor K F Ng, Dr Joyce Wong, Dr Simon Chan, Dr T W Lee, Dr John Liu, Dr Edward Ho and Dr Jacqueline Yap. Prospectively it looked a mammoth undertaking; we had three teams working concurrently for a whole week, each team consisting of two Councillors and one member of the Hong Kong Regional Training Committee, and each team inspecting one to two hospitals a day; in total eighteen hospitals.

However, with the extremely able assistance of the Hong Kong Regional Training Committee, especially their Chair Dr YF Chow and Honorary Secretary Dr Jackie Yap, and the fantastic preparation by all the hospitals, the inspection ran like clockwork. The Hong Kong College of

Hong Kong College of Anaesthesiologists, and noted that the inspectors were impressed by the physical facilities in the hospitals and the manner in which members of the health professions in Hong Kong had coped with the dreadful challenge of SARS. We then discussed

“...inspectors were impressed by... the manner in which members of the health professions... had coped with the dreadful challenge of SARS.”

Anaesthesiologists fully supported us, for which we were very grateful, and assisted us with our understanding of local issues.

matters of relevance to all the hospitals in the Hong Kong SAR in an atmosphere of extreme cordiality.

We met with representatives of the Hong Kong Hospital Authority, who welcomed us to the Hong Kong SAR and spoke of the value to them of links with the medical profession outside Hong Kong. In reply, Dr Thompson spoke of the long and valued association between ANZCA and the

Back Row: C T Hung, Tony Gin, Joseph Lui, P T Chui, Anne Kwan, Matthew Chan, Y F Chow, Tony Weeks, Edward Ho, Simon Chan, Theresa Hui, Dick Willis.
Front Row: Leona Wilson, Kate Leslie, Steuart Henderson, T W Lee, Wally Thompson





Obituary

David Cullingford FFARACS 1969, FANZCA 1992

1922 - 2004

Dr David Cullingford was born in 1922 at Leigh-on-Sea, Essex England.

As a teenager he developed a love of music. When the Second World War broke out David's school was evacuated to Derbyshire. He completed his final year of school there and started to learn the organ, a love he had for the rest of his life.

He was accepted into medical school and moved to London in 1941 around the time of the blitz. He graduated from Guy's Hospital, London University in 1946. Sadly, most of his school friends were killed in the war.

Study was difficult, but despite this he passed his exams in 1946. His first house job was in Orpington.

From his diary: 'My surgical experience was limited by two Australians who returned from the war and wanted to do all the surgery. I was enlisted to give anaesthetics for them and this was my first experience of anaesthesia. Evipan was still the standard induction agent prior to the introduction of thiopentone. Maintenance for years was with diethyl ether in nitrous oxide and oxygen. As a student I had received a reasonable grounding in the use of ether and sometimes chloroform. I was sufficiently scared of chloroform to let others use it, as it had hepatotoxic as well as cardiotoxic effects. We experimented with divinyl ether (Vinesthene) as well as cyclopropane. We had to learn to pass endotracheal tubes and use the new muscle relaxant curare. It was reversed by prostigmine (neostigmine). I remember being worried one night by a patient whose pulse had dropped below 40. When I asked for advice the next morning, none of my chiefs could advise me. The effect of atropine which I should have used had not been published. I was one of the first to combine them in the same syringe. I then went to Southend Municipal Hospital and was taught by Dr. J. Alfred Lee. He taught me to use cuffed tubes. Prior to that, endotracheal anaesthesia had been by insufflation catheter. Laryngoscopes

all had straight blades. The Macintosh blade was not invented until later when I was with the RAF. Alfred Lee was then writing his book, 'Synopsis of Anaesthesia'. My call up to the RAF had been deferred to allow me some more training, and I enrolled in October 1947'.

After training he was commissioned as a Flight Lieutenant. He was sent to Egypt as Hospital Anaesthetist between 1948-1949, and after his return he was appointed anaesthetic resident

"His work in India has been highly spoken of by others. In addition he published a number of papers in Indian medical journals."

at Guy's Hospital and commenced his formal training in anaesthesia. There he met Avery his future wife and they were married in 1953. After passing his Fellowship he was appointed anaesthetist to the Birmingham group of Hospitals. His main interest at this stage was thoracic anaesthesia. He wrote on the development of his oesophageal stethoscope which he developed into a clever useful monitor.

In 1962, David, Avery and their eldest son Graham went to the Christian Medical College Hospital, at Vellore in India. His work in India has been highly spoken of by others. In addition he published a number of papers in Indian medical journals. He returned to England in 1963 where their second son was born in 1965.

David found the English climate very depressing and saw an advertisement for the Director of Anaesthetics at Fremantle Hospital, Western Australia. He applied, and they moved there in 1967. David worked fulltime at Fremantle until 1970 during which time he started an ICU and ran it himself.

He was appointed as a visiting anaesthetist at Royal Perth Hospital, Fremantle and Hollywood Hospitals in 1971. It was then he developed an interest in sailing with his sons, graduating from

a 'Mirror' to a 'Red Witch'. Meantime both his sons graduated in medicine.

David joined the University Choral Society, sang at the opening of the Concert Hall and sang the Messiah many times.

Following his retirement in 1992 he joined Rotary Nedlands and was active in collecting medical equipment and medications to send to third world countries. In 1994 he worked for a few

months in Nepal where he taught the administration of anaesthetics to Nepalese doctors. His new interests in retirement were caravanning and computing which were sadly interrupted by a car accident which left him with chronic pain, which he bore stoically.

He became ill in June of 2004 and died on 7th July. He is survived by his wife Avery, his two sons, Graham and Robert and eight grandchildren.



Report

Highlights from the Council Meeting

October 2004

Welcome

The President welcomed Dr Michael Beem and Dr Lynne Rainey, Chairs of the Queensland and South Australian and Northern Territory Regional Committees respectively, to their first Council Meeting and Dr Peter Cooke, Chair of the NZ National Committee.

Education

ANZCA Certificate in Diving and Hyperbaric Medicine

Council resolved that for the purposes of the Regulations governing the ANZCA Certificate in Diving and Hyperbaric Medicine, Fellowship of the Royal Australian College of General Practitioners and Royal New Zealand College of General Practitioners be recognised as acceptable qualifications in order to pursue training and present for the examination.

Recognition of Modules

Council has resolved that for trainees who have completed 48 months of training prior to the commencement of the 2004 hospital employment year, that date will be deemed to be the completion date for validation of the modules.

Recognition of Intensive Care Training towards FANZCA

Up to six months training time may be approved, under Regulation 15.6.3, in Intensive Care Units not accredited for Core IC Training but identified by JFICM as offering suitable experience for anaesthetic trainees.

EMAC Accreditation - CASMS, Perth

The Centre for Anaesthesia Skills and Medical Simulations (CASMS) was granted accreditation as an EMAC provider for five years from February 2004.

Accreditation of Retrospective Training

Regulation 15.3.2 has been amended to permit retrospective training to be accredited for 2003 provided support from the Supervisor of Training is submitted stating such training was equivalent to

that undertaken by approved anaesthesia trainees. This training may be approved as time within the compulsory period of 33 months anaesthesia.

Other training may be accredited retrospectively as part of the compulsory period of 24 months as outlined in Regulation 15.4.6.3 only.

Finance

College Fees for 2005

All fees will remain at the current rate for 2005 except the fee for Non Fellows' participation in the College MOPS Program. This will be A\$300+GST. There has been no change in other fees for five years.

Internal Affairs

Human Resources Management

Council has appointed CapH Consulting on a part-time basis to review the Human Resource services in the College and Faculties and report to the November Executive.

Electronic Agenda and Document Access System

Council approved the trial of online access for the Executive and Council Meetings including a discussion forum. This process will increase security and efficiency of the College Committees. A security clearance will be required to access the e-community via an internet connection anywhere in the world including ANZCA House.

It is anticipated that following the pilot all College Committees agendas will be available in this form.

ANZCA House – Foyer

A mural depicting the various activities of Fellows working in Anaesthesia, Intensive Care and Pain Medicine is to be erected in the Foyer at ANZCA House.

Definition of Anaesthesia

Council agreed that *Anaesthesia is a provision of peri operative care, anaesthetics, intensive care and pain management to patients and can include the*

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

Asia Pacific

Council agreed to support anaesthesia education and training program in Papua New Guinea by funding two visits of FANZCAs for two one-week visits per annum.

Dr Kenny Aaron currently working in the Port Moresby General Hospital was awarded the International Scholarship for 2005.

The Scholarship covers travel expenses between the home country and Australia or New Zealand and may include the Scholar's spouse and children under 16 years. A living allowance will be provided. During the scholarship it is anticipated that the appointee will attend the Annual Scientific Meeting of the College.

Council Strategic Planning Day – February 2005

Mr Henry Bosch, AO, former Chair of the National Companies and Securities Commission and a Director of several major companies and organisations, has agreed to assist the President in the conduct of a College Strategic Planning Day prior to the February Council.

Topics to be discussed on this Strategic Planning Day include:

- Functions of Council
- Functions of Executive
- Role of the President
- Role of the Vice President
- Role of the Director of Professional Affairs
- Role of the position of the CEO – into the next 10-15 years
- Interrelationship of associated Executive Officer positions
- Confidentiality



- Conflict of Interest
- Development of Strategies to continue to attract a wide range of individuals to Council and to the Office of President, including the election process for Vice President and President
- Long Term Goals for ANZCA
- Ensuring Continuity of ANZCA Leadership and Goals
- Communication with Fellows
- Addressing Needs of Fellows
- Orientation of New Fellows
- Language and Culture of the College
- Core Business of the College
- Where is Anaesthesia going?

Professional Affairs

Acute Pain Management Guidelines

A large working party led by Dr Pam Macintyre has reviewed and updated the Acute Pain Management Guidelines which it is anticipated will be published by the end of the year. The review of these guidelines represents a joint College/Faculty of Pain Medicine initiative.

Nurse Practitioners

Scope of Practice of Anaesthesia – New Zealand

On the 15th September 2004, New Zealand Government Gazette published:

2. Scope of Practice – Nurse Practitioner

Nurse Practitioners are expert nurses who work within a specific area of practice incorporating advanced knowledge and skills. They practise both independently and in collaboration with other health care professionals to promote health, prevent disease and to diagnose, assess and manage people's health needs. They provide a wide range of assessment and treatment interventions, including differential diagnoses, ordering, conducting and interpreting diagnostic and laboratory tests and administering therapies for the management of potential or actual health needs. They work in partnership with individuals, families, whanau and communities across a range of settings. Nurse Practitioners may choose to prescribe

medicines within their specific area of practice.

Nurse Practitioners also demonstrate leadership as consultants, educators, managers and researchers and actively participate in professional activities, and in local and national policy development.

The Nursing Council competencies for Nurse Practitioners describe the skills, knowledge and activities of Nurse Practitioners.

Qualifications

- a) *Registration with the Nursing Council of New Zealand in the Registered Nurse Scope of Practice, AND*
 - b) *A minimum of four years of experience in a specific area of practice, AND*
 - c) *Successful completion of a clinically focused Masters Degree programme approved by the Nursing Council of New Zealand, or equivalent qualification, AND*
 - d) *A pass in a Nursing Council assessment of Nurse Practitioner competencies and criteria.*
- Nurse Practitioners seeking registration with prescribing rights are required to have an additional qualification:
- e) *Successful completion of an approved prescribing component of the clinically-focused Masters' programme relevant to their specific area of practice.*

Continuing Education and Quality Assurance

Welfare of Anaesthetists SIG

Resource Document RD11 – After a Major Mishap was approved for promulgation and is annexed.

New Fellows' Conference

Dr Colin King, New Zealand Representative for the 2004 New Fellows' Conference reported to Council.

The following Recommendations from the New Fellows Conference were referred to the relevant College Committees for consideration:

1. That the following year's New Fellows' Conference Convenor be asked to attend the meeting, with funding allocated as it is to the delegates.
2. That the previous years New Fellows' Representative be asked to attend the meeting, with funding allocated as it is to the delegates. He/she would be a resource person, and able to inform the New Fellows about the election and role of the New Fellows' representative.
3. That some form of voluntary incident reporting system be established, or AIMS re-established, as a priority, to enhance the quality of anaesthesia in Australasia and the Pacific Region. The conference noted the loss of a vitally important reporting system that was a world leader. A system of incident reporting, such as AIMS, is important for understanding, analysis and prevention of errors. It is also important in the detection and highlighting of errors in a way that single institutions are unable to achieve.
4. That the College pursues qualified privilege for QA activities.
5. The Conference supported College guidelines for fatigue minimisation, and for allocation of protected non-clinical time.
6. If Nurse Anaesthetists become a reality, then the College should be involved in their training and the setting of standards.
7. The Conference proposed that the College develop a document on clinical risk management.
8. The Conference supported the development of a New Zealand system similar to the Australian JCCA in the event that GP Anaesthetists were to be reconsidered as option for expanding the anaesthetic workforce.

Professional Documents

The following Professional Documents were approved for promulgation:

- PS10 – Handover of Responsibility during an Anaesthetic
- PS38 – Statement Relating to the Relief of Pain and Suffering and End of Life Decisions



The Geoffrey Kave Museum of Anaesthetic History Report

Behind the Scenes

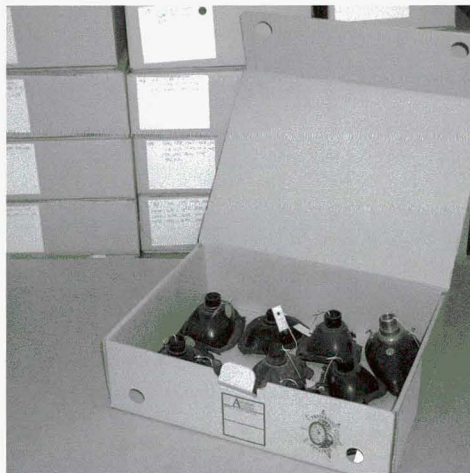


Ms Elizabeth Triarico
Museum Curator



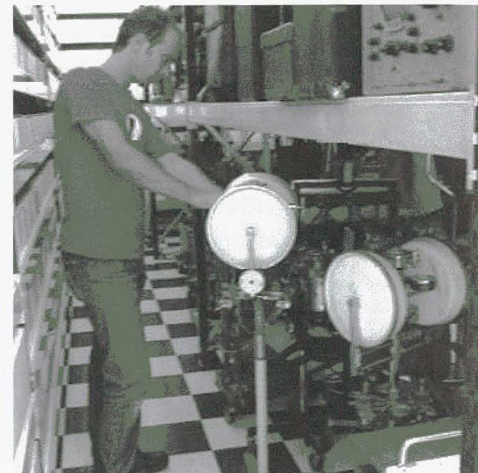
Museum store prior to November 2003

Over the past 18 months a great deal of work has been undertaken "behind the scenes" to develop this highly significant collection into a vibrant, accessible modern museum. All aspects of museum management are being reviewed and



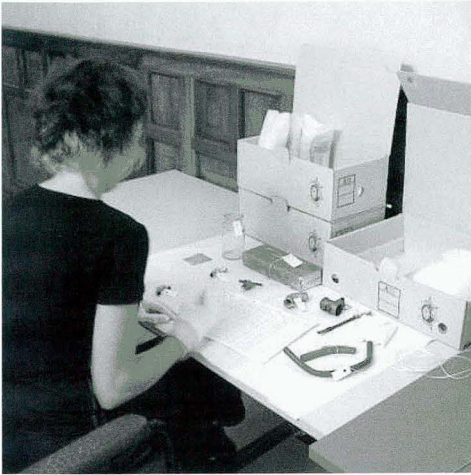
Repacked Small Objects

improved. This has resulted in the development of formal policies and procedures, a major upgrade of the museum storage area and the implementation of a collection inventory.



Museum Store December 2003
Mr Tom In'pen (POD Museum and Art Services)

Like all museums, only a small percentage of the museum collection is on display at any given time. The majority of the collection is in storage and includes approximately 8,000 objects, ranging in size from small items such as rubber



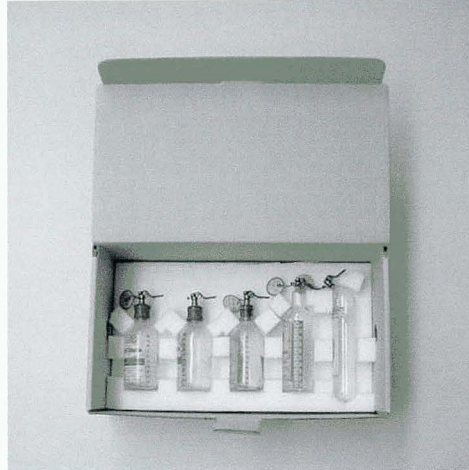
Working on the Collection Inventory
Ms Sarah Parker (Pod Museum and Art Services)

masks to much larger items such as Boyles machines. It is extremely important that these objects are documented accurately and stored appropriately so that they can be used in future displays and research.

The Museum Storage Upgrade and Collection Inventory Project which commenced in November 2003, (and undertaken with the assistance of POD Museum and Art Services), was developed to address these issues. The Project is based on museum best practice standards and is aimed at making the Collection more accessible and ensuring its long term preservation.

The storage upgrade component of the Project is due to be completed at the end of November 2004 and has involved: the relocation of objects, the installation of an appropriate racking system and repacking of small objects into museum acid free storage boxes. This has resulted in an efficient and effective museum collection storage area and dramatically improved access to the Collection.

The Collection Inventory is a complex task which involves: documenting the collection, tracking and matching objects to associated information, research, numbering and tagging of objects, basic condition assessment, conservation cleaning and inputting information onto an Access Database.



Example of Priority Repacking

A number of significant and/or fragile items have been selected for priority repacking. These items are a very important part of the Collection and therefore require a more specialised standard of storage.

The Collection Inventory is the first stage in improving access to objects and associated information. Once the Inventory is completed the information will be transferred to an appropriate museum collection database. Full cataloguing will then commence which will improve access by providing more detailed information and images of the objects.

The successful development of the Museum is a long term commitment and is being made possible due to the on-going support, assistance and foresight of ANZCA. The improved management of the Museum will ensure that the Collection will be used to its full potential and will assist in establishing it as a highly professional and respected museum.

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



Conservation Cleaning
Ms Sarah Parker (Pod Museum and Art Services)



Rural Specialist and Trainee Educational Support Programs



Garry Phillips
Director of Professional Affairs

Australian Government funding for a number of programs aimed at providing educational support for rural specialists and trainees in Australia completes its second year of operation at the end of this year.

SSRS

■ 1. The Support Scheme for Rural Specialists has been funded via the Committee of Presidents of Medical Colleges, and ANZCA has been involved in three projects. The flagship has been the Clinical Resource Management travelling roadshow, with the Simulator Centre, Southern Health, Monash Medical Centre taking a team of instructors and equipment to Orange and Cairns in 2003 and to Launceston, Darwin and Albury/Wodonga in 2004. The two, two day courses in each location were able to accommodate 40 specialists, including anaesthetists, intensive care and emergency medicine physicians, general practitioners, physicians, surgeons and obstetricians from near and far. Feedback was excellent, and external evaluation very positive. A review of this and other programs funded will be determined by the review, by the recent budget, and probably by the election results.

■ 2. A joint RANZCOG/ANZCA project on Assessing Risk in Obstetrics and Maternity Anaesthesia, managed by RANZCOG was delivered by videoconference to rural obstetricians and anaesthetists in 2003 and 2004.

■ 3. A second joint RANZCOG/ANZCA project on Informed Consent for Epidural and Emergency Caesarean Section is being delivered by videoconference to rural obstetricians and anaesthetists this year.

The interest in both of these projects by anaesthetists was considerable.

RASTS

A series of videoconferences for Rural Advanced Specialist Trainees Support ran in 2003 and 2004, funded by the Australian Government. Feedback from trainees, Fellows and presenters was such that ANZCA is considering ways in which videoconferences of this type could benefit Fellows, trainees, Overseas Trained Specialists and Area of Need Specialists in Australia and New Zealand.

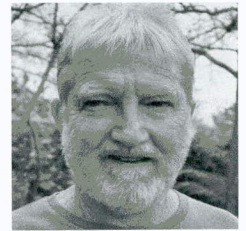
Other Educational Projects Funded by Government

While not restricted to rural specialists, the Australian Government funded RANZCOG in 2003 to develop a generic Continuing Professional Development (CPD) Program. Funding has continued in 2004 to pilot this project, targeting specialists of most Colleges who are prepared to trial a "MOPS variant". Apart from broadening participants' knowledge and skills in this area of practice, feedback from those involved will contribute to ANZCA's review of MOPS, due to be completed by the end of 2005.

Information on any of the above projects is available from Helen Morris (hmorris@anzca.edu.au) or Juliette Mullumby (jmullumby@anzca.edu.au).



Travelling North



Gerald J. Flynn, FANZCA

Fellows will be interested to hear of a new project to provide "specialists –in-residence" at remote Northern Territory Hospitals.

The brainchild of Mr Peter Macneil OAM FRACS, the scheme is designed to take clinical skills and continuing medical education support to the medical and nursing staff of hospitals in remote areas of the Northern Territory.

The project currently includes an orthopaedic surgeon, an obstetrician and gynaecologist, a plastic surgeon, a general surgeon and an anaesthetist. All of us are retired specialists who see our experience and academic background of value in remote hospitals where "live-in" consultants do not exist.

The current pilot scheme is funded by the Federal Government through its Support Scheme for Rural Specialists (SSRS), co-ordinated by officers of The Royal Australasian College of Surgeons. Visiting specialists organise their own travel arrangements and a moderate emolument is paid. Once the visit is complete, the clinician bills the RACS offices and a financial settlement is made.

Most visitors spend two weeks in the Northern Territory hospitals at Nhulunbuy (Gove) and Katherine. Before commencing hospital activities it is necessary to apply for temporary registration with the Northern Territory Registration Board, which is not a difficult matter and involves no cost.

The duties of the visitor are largely those familiar to all teaching and major hospitals down south.

As an anaesthetist I spent most of my time in the operating theatre at each hospital. I would work with the nominated intern/registrar seconded from the Darwin Hospital. Each day there would be a certain number of elective cases. A visiting surgeon (paediatric, gynaecological or general) would fly from Darwin for the day, operate in the morning, consult in the afternoon and fly home that evening.

The hospitals are of approximately 70 beds, and both excellently equipped. All advanced anaesthetic

equipment and drugs were available and the nursing staff, first class. Medical libraries were very good, with recent publications and of course, full internet access. The emergency cases were naturally most demanding. Victims would arrive at anytime either by motor vehicle, road ambulance transport and rarely by industrial helicopter (Gove is the site of the immense bauxite mining facility and industrial accidents must be dealt with).

Severe injuries or patients with profound surgical illness are stabilised by the on-site medical staff before being shipped off to Darwin by air evacuation teams. It takes about three hours to fly a patient from Nhulunbuy (Gove) to Darwin.

"The anaesthetic intern at Katherine Hospital personally gave seventy two caesarean section anaesthetics in one twelve month period..."

Other patients including obstetric emergencies, must be dealt with at once. The anaesthetic intern at Katherine Hospital personally gave seventy two caesarean section anaesthetics in one twelve month period, most of them for indigenous Australian mothers who presented without having any antenatal care.

In addition to operating theatre attendances, visiting specialists are encouraged to deliver a number of tutorials/discussion groups on matters of general interest to house officers. The tutorials are held at lunchtime, and usually five to nine interns attend. At each hospital I spoke on the following subjects:

- Hyponatraemia presenting as post operative encephalopathy
- Malignant hyperpyrexia
- Anterior spinal artery syndrome following epidural anaesthesia
- Historical development of anaesthesia techniques

Incidentally, as we visitors merely advise, teach and encourage interns, we are not required by the Northern Territory Health Service to have

personal medical liability insurance.

The Katherine Gove Project for me continues on 8th October 2004, when I return for my second stint at the "Top End" It is a stimulating challenge for a retired anaesthetist, though of course practising anaesthetists will, in the future, be more involved.

The reception of the visiting specialist has been most pleasant. The young men and women doctors who staff these hospitals find that the presence of an experienced clinician is a great opportunity to ask questions, evaluate another opinion, receive an alternative view and so on.

Their greatest anxiety is working alone often a thousand kilometres from a consultant. A phone call to Darwin is readily available (to speak to another anaesthetist) but to have a visitor on hand, so to speak is much superior.

As I write, the spectre of terrorist attacks on Darwin are being freely ventilated by both political parties leading up to 9th October 2004 Australian Elections. Already the Prime Minister, John Howard has promised \$10 Million to upgrade health facilities at Royal Darwin Hospital.

In an age of terrorism, the Northern Territory has become Australia's Defensive Frontline. With respect, I think that our College and the Councils of other Colleges, should move to increase their efforts of support and continuing education, on the ground, where health care and emergency services might sadly, in the future, be most needed.

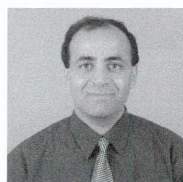
Our own small Katherine Gove Project would benefit by the vigorous support of my College and that of its sister Colleges. Funding of this scheme by the Federal Government will be essential for its continuance. Council's forceful support could be crucial in obtaining federal funds.



Awards

2005 Research Grant Awards

The following *Research Grants for 2005*, recommended by the Research Committee, were awarded by Council at the October Council Meeting:


A/Professor Bala Venkatesh (QLD)

\$20,000 Optimal duration of antibiotic therapy in critical illness: a prospective study.

\$29,871 Assessing quality of, and identifying gaps in information handover during ICU ward rounds.

\$42,900 Optimal antibiotic dosing in burns: Fluid dynamics and drug tissue pharmacokinetics.


Professor Laurence Mather (NSW)

\$59,000 Pharmacological consequences of general anaesthesia on local anaesthesia cardiotoxicity.


Dr Ross Kennedy (NZ)

AUD\$15,000 Grant in Aid Development and evaluation of effect site target control for inhalational anaesthesia.


A/Professor Kate Leslie (VIC)

\$24,010 Patient-controlled sedation in patients undergoing colonoscopy.

\$27,334 Quantifying the effect of nitrous oxide on the depth of anaesthesia using theoretically based time series modelling.


Dr Marianne Chapman (SA)

\$40,000 Effect of sedation on upper GI motility, CCK levels and glucose absorption in ICU patients.


Dr Phillip Siddall (NSW)

\$40,000 The role of ascending nociceptive neurons in pain processing.


A/Professor Michael Paech (WA)

\$41,653 Nasal versus epidural Fentanyl for patient-controlled analgesia after caesarean section.


Professor Stephan Schug (WA)

\$15,000 Grant in Aid Predicting outcomes in chronic pain patients attending a multi disciplinary Pain Medicine Centre.

\$20,000 Botulinum toxin in the treatment of pain associated with upper limb burns.


Dr Mathew Zacharias (NZ)

AUD\$25,000 A randomised, crossover dose-effect trial of paracetamol 60 and 90mg/kg in third molar surgery.


Dr Tony Chow (VIC)

\$24,000 A multi-centre randomised controlled trial to prevent chronic post-amputation pain.


Dr Robyn Gillies (VIC)

\$15,000 Grant in Aid Characterisation of genetic mutations in Australian malignant hyperthermia families.


Dr Brendan Silbert (VIC)

\$45,927 Is regional anaesthesia associated with postoperative cognitive deficit in the elderly? A prospective randomised controlled trial.


Dr Peregrine Osborne (NSW)

\$63,500 Cellular mechanisms of tolerance to opioid analgesics in sensory dorsal root ganglia neurons.

The **Harry Daly Research Award** was awarded to **Dr Brendan Silbert** for his project "Is regional anaesthesia associated with postoperative cognitive deficit in the elderly? A prospective randomised controlled trial".

The **Organon Research Award** was awarded to **Professor Laurence Mather** for his project "Pharmacological consequences of general anaesthesia on local anaesthesia cardiotoxicity".

The **John Boyd Craig Bursary** was awarded to **Associate Professor Michael Paech** for his project "Nasal versus epidural Fentanyl for patient-controlled analgesia after caesarean section."



College Honours and Awards

The Robert Orton Medal was awarded to
Dr Graham C Fisk (NSW) and
Associate Professor John R Rigg (WA)

The ANZCA Medal was awarded to
Dr John A Williamson (SA)

College Citation was awarded to
Professor John M Gibbs (QLD)

2004 Academic Enhancement Grant

The 2004 Academic Enhancement Grant of \$90,000 was awarded to the Department of Anaesthesia, Alfred Hospital, Melbourne.



2005 Simulation/Education Grant Awards

The following Simulation/Education Grant award for 2005, recommended by the Research Committee, was awarded by Council at the October Council Meeting:

Dr Jennifer Weller (NZ)

AUD\$35,000 *The impact of trained anaesthetic assistance on patient safety*



Undergraduate Prize in Anaesthesia

The recipient of the 2003 ANZCA/ASA Gilbert Troup Prize for The University of Western Australia was **Ms Kavitha Subramaniam**. Kavitha's award was presented to her during the University Awards Ceremony held in March this year.

Admission to Fellowship by Examination

| | | | |
|--------------------------------|-----|------------------------------|-----|
| Mogalla Amitha ABEYSEKERA | NZ | Michael Bruce LUKINS | VIC |
| Anne-Maree ADERS | NSW | Jeremy MACFARLANE | WA |
| Stephanie Clare APLIN | NSW | Todd William MADDOCK | SA |
| James Lyndon BEIT | QLD | Kwan Yin MAN | HK |
| Matthew Lawrence Norman BOWMAN | VIC | Helen Frances NICOL | NSW |
| Sam CAVALLARO | NSW | Subita Marie NOBRE | NZ |
| Mark Edward CHADDOCK | VIC | Adam Alexander OSOMANSKI | NSW |
| Brian Owen CHAN | WA | Andrew James OTTAWAY | TAS |
| Wei-Ping CHAN | NSW | Elizabeth Kate PRENTICE | NZ |
| CHEUNG Wing Wai Rochelle | HK | Roslyn Maree PURCELL | QLD |
| Gordon Yuk Sang CHOI | HK | Christopher Allan RICHARDSON | NSW |
| Tony Chung Hay CHU | NSW | Orysia Christine SANDRY | TAS |
| Michael Peter CLIFFORD | VIC | Fiona Catherine SHARP | UK |
| Bryce John CURRAN | NZ | Heather Jane STEVENS | SA |
| Peter DZENDROWSKYJ | NZ | Lac TRUONG | SA |
| Ian Coulter FORSYTH | VIC | Rachel Mary VASSILIADIS | NSW |
| Simon James HANNING | NSW | Aruntha VINAYAGAMOORTHY | NZ |
| Michael John HEYTMAN | QLD | Brian Joseph WARDEN | QLD |
| Sarah Shirley KURIAN | WA | David Andrew WRIGHT | WA |
| Anna Kam Suen LEE | HK | Chen WU | QLD |
| Philip Seng Loong LEE | SA | Vivian Man-Ying YUEN | HK |
| John Charles William LEYDEN | VIC | | |

Admission to Fellowship via OTS Performance Assessment Process

| | |
|------------------------|-----|
| Alistair Brian BOYCE | NSW |
| Ines Christina BOYNE | QLD |
| Fiona Dawne CHADWICK | NSW |
| Tomy GEORGE | SA |
| Sarah Louise GREEN | NSW |
| Mahmadhanief HASSAN | WA |
| Nicolas Francois LERCH | VIC |
| Llewellyn LLOYD | NSW |
| Charles MASHONGANYIKA | QLD |
| N Ram Mohan REDDY | NSW |
| Richard Arne SEMENOV | SA |
| Alka Rani SINGH | SA |
| Michael Paul STEYN | QLD |
| Joseph TARPEY | QLD |



DJ Professorship

Douglas Joseph Professor of Anaesthetics 2005

Associate Professor Leslie *MBBS, MD, M Epi, FANZCA*, has been awarded the Douglas Joseph Professor of Anaesthetics for 2005. The Professorship is awarded quadrennially at the discretion of the College Council, to Fellows who are making an outstanding contribution to the advancement of the specialty to pursue scholarship and research in human anaesthesia in Australia and/or New Zealand.

Kate Leslie is a Staff Anaesthetist and Head of Research in the Department of Anaesthesia and Pain Management at the Royal Melbourne Hospital, and Honorary Principal Fellow in the Department of Pharmacology at the University of Melbourne. Following her training in the Royal Melbourne Hospital anaesthesia rotation, Kate worked in San Francisco, in clinical neuroanaesthesia, and thermoregulation and depth of anaesthesia research. Since her return to the Royal Melbourne Hospital, Kate has continued her interest in research conducting studies in the areas of intravenous anaesthesia, neuroanaesthesia and awareness. Her work is funded by NHMRC and ANZCA. She was a chief investigator of the B-Aware Trial, a large multicentre trial on BIS monitoring to

prevent awareness in high-risk patients. This work has attracted international academic and media attention, and is one of the studies that has formed the basis of the new ANZCA Clinical Trials group, of which Kate is an Executive Member. Other ANZCA activities include her work as a College Councillor and Primary Examiner.

During her appointment as the Douglas Joseph Professor, Kate will undertake research on the relationship between dreaming during anaesthesia and anaesthetic depth. This research will be presented at the ANZCA Annual Scientific Meeting in Adelaide at which Kate will be the Australasian Visitor. Kate Leslie is the first woman to be awarded the Douglas Joseph Professorship. She hopes to inspire other female Fellows and Trainees, and other "young-ish (!)" anaesthetists to participate in anaesthesia research.



Rural Specialists Establishment Grant

Near the completion of my PFY at the Royal Melbourne Hospital I responded to a hand written advert (they do things a little differently in the country!!) on our notice board for an anaesthetist to join an already well established practice with six other specialists in regional NSW. As my wife and I had always wanted to move to a non-metropolitan area to raise our family and to enjoy a county lifestyle, information contained in the advert seemed to 'fit the bill'. After coming up to Nowra with my family to check the place out and do a week of locuming I was pretty sure that we had 'hit gold'. I feel that we were very fortunate to find such a great spot. Nowra lies only 150 km south of Sydney, on the beautiful south coast of New South Wales. It has an area population of 90,000 and is rapidly growing. To cater to our love of the outdoors we have the beauty of bush, river, the coast, great climate and...



Mr Robert Cook presenting the grant to Dr Erfan Hedayati

I am able to ride my bike to work and the 25 minute ride in the morning wakes me up and gives me a free work-out. This, plus the local magpie that is out to get me, keeps me on my toes. I'd rather have my daily encounter with him than navigate the clogged and busy roads of the city. While there are some sacrifices moving away from city life, the benefits of a county life far outweigh these. Nowra is a very friendly place; we have been welcomed by the community and feel very at home. The medical community is well represented by a friendly team of all medical and surgical subspecialties, and we share all

the workload in town, which is practically everything except cardiac and neurosurgery!

"...look for the advert for the next Grant in this Bulletin and consider leaving the city for the great country life, you won't regret it..."

Having heard about the Rural Specialists Establishment Grant offered by Affinity Health, I decided to apply for it. This grant is an innovative initiative offered by Affinity Health to encourage specialists to move to non-metropolitan areas. I was very fortunate to be the recipient of this grant and commend Affinity Health on their progressive initiative. This generous support offered by Affinity Health assists greatly in meeting the costs involved in establishing a medical practice in a regional area and I am very appreciative. My big thanks also go to our College for selecting my application.

So look for the advert for the next Grant in this Bulletin and consider leaving the city for the great country life, you won't regret it for a minute.

Erfan Hedayati FANZCA
hedayati@optusnet.com.au



Dr Erfan Hedayati, Dr Clive Wellington, Dr Susan Rundle, Mr Robert Cooke



Special Interest Groups

Annual Reports 2003/2004

Anaesthetists in Management

SIG Executive

The current interim SIG Executive comprises:

| | |
|------------------------------------|-----|
| Prof Barry Baker | NSW |
| Dr Vanessa Beavis (<i>Chair</i>) | NZ |
| Dr David Chamley | NZ |
| Dr Patricia Goonetilleke | Qld |
| Dr Martin Lum | NSW |

Administration

The first Annual General Meeting of the AIM SIG was held on 4 May 2004 during the ANZCA ASM in Perth. Minutes have been circulated.

The key points discussed and agreed included:

- Purpose of the SIG
- The objectives of the group
- Formal elections of the Executive to be conducted
- Future activities
- Membership as of May 2004 is 117

Continuing Education

The SIG contributed to the ANZCA ASM in a dedicated session on management for the first time in May 2004. The session was well attended and feedback was very positive.

The SIG is committed to organising sessions at the ASM 2005 and will be contributing to the October 2004 combined Medical Education, Welfare of Anaesthetists and Simulation and Skills Training Special Interest Group meeting at the Gold Coast.

Plans for Next Year

- Formal Executive to be elected (process underway at present)
- Development of the website
- Continued development of educational resources and a network of support for Members.

I would like to thank Helen Morris of ANZCA for her invaluable help with administrative matters and again would welcome comments from Members as to the future direction of the group.

Vanessa Beavis

Chair

Critical Care in Unusual Environments

SIG Executive

The current SIG Executive comprises:

| | |
|--------------------|-----|
| Dr Bruce Lister | Qld |
| Dr Allan MacKillop | Qld |
| Dr Blair Munford | NSW |

Unfortunately, until recently, the Critical Care in Unusual Environments Special Interest Group (CCUE SIG) has been in virtual hibernation since the ANZCA 2003 meeting in Hobart. The 2003 AGM of this SIG was scheduled to be held at the Hobart meeting but failed to attract a quorum. (An unofficial meeting of those interested in anaesthesia and critical care in disasters, field environments and transport was held following one of the scientific sessions, which confirmed that there was still widespread interest in this field.)

Elections for the Executive of the SIG were held in advance of the proposed AGM. Three nominations only were received. As the number of nominations received did not exceed the number of positions vacant, the three nominees were declared duly elected. Unfortunately, due to a misunderstanding, this was not fully appreciated by the appointees until recently. This accounts for the prolonged period of inactivity. Once this glitch had been resolved, the three Executive members held a virtual meeting by email and Blair Munford was elected Chairman.

The Executive identified four major areas of practice that would fall under the auspices of the CCUE SIG:

1. Military anaesthesia.
2. 3rd world/developing country anaesthesia.
3. Retrieval/Critical care transport.
4. Disaster response: resuscitation and anaesthesia aspects.

Recent history such as the Bali bombing, increased Australian military commitments abroad, and disasters such as the Waterfall train crash have emphasized the relevance of this SIG. Some of the potential areas for the CCUE SIG to initiate or become involved in include:

- Developing a contact list of anaesthetists/intensivists in each region who have CCUE experience who may be available for deployment in case of disasters.
- Educational courses in the principles of anaesthesia with limited facilities - for anaesthetists proposing to work as part of aid teams or similar. These may be able to be integrated with introductory courses in military anaesthesia.
- Further development of standards, training, and system development for critical care transport/retrieval, especially the development of regional/rural retrieval teams with prehospital capabilities.

One point that arises out of this is that each region (Australian states and territories, NZ and possibly SE Asia) should be represented on the Executive, as well as each of the areas of practice above. This is obviously not the case at present. It is planned to co-opt SIG Members to the Executive to achieve this. The formation of a fully representative Executive for the SIG will allow the above initiatives to proceed much more rapidly and smoothly.

It is planned to hold an AGM for the SIG during the ANZCA 2005 in Auckland. There is to be a session on retrieval/disasters and related topics in the Intensive Care program, and it is planned at this stage for the AGM to follow.

Blair Munford

Chair



Day Care Anaesthesia

SIG Executive

The current SIG Executive comprises:

| | |
|---------------------------------|-------------------|
| Dr Steve Watts (<i>Chair</i>) | WA |
| Dr Michael Fong | Qld |
| Dr Colleen Kane | NSW |
| Dr Elliot Rubinstein | Vic |
| Dr Rowan Thomas | Vic |
| Dr Carolyn Fowler | NZ |
| Dr Robin Limb | SA |
| Dr Carmel McInerney | ACT |
| Dr Ruth Matters | Tas |
| Ms Helen Morris | ANZCA Secretariat |

The SIG Executive meets via teleconference four to six times annually.

SIG Mission

To promote and encourage quality initiatives in the provision of Day Care Anaesthesia through the coordination of medical education activities, the support of relevant research and a contribution towards guidelines and minimum standards for patient care.

Continuing Medical Education Activities

ANZCA Hobart May 03

"Outside Area Day Care"

Day Care is increasingly being provided away from the traditional operating suite environment. Anaesthesia support for some therapeutic and many diagnostic procedures is delivered in a range of potentially unfamiliar environments. This session covered issues of minimum standards of care in "outside areas" and included aspects of anaesthesia for ECT and local anaesthesia for eye surgery.

A review and discussion of the literature surrounding assessment of fitness to drive after ambulatory anaesthesia was also presented. The SIG thanks all contributors.

ASA National Scientific Congress Melbourne October 03

"The Day After Day Surgery"

This session was coordinated and chaired by Dr Rowan Thomas and centered on issues related to patient care after discharge from a Day Care facility. Speakers were Dr David Scott, Dr Steve Watts and Dr Carmel McInerney.

Rupert Hornabrook Prize

The Hornabrook Prize is awarded by the Executive of the SIG for excellence in research in the field of day care anaesthesia as presented at one of the major anaesthesia meetings. The Prize (consisting of a certificate and book voucher) was awarded to Dr Mathew Zacharias from Dunedin, NZ for a paper entitled "Comparison of Tenoxicam and Rofecoxib after Dental Surgery", presented at the Melbourne ASA meeting.

6th Australasian Day Surgery Conference Sydney Sept 04

"Controversies and Emergencies in Day Surgery"

The SIG has resolved this year to combine our bi-annual single-theme meeting with the Australasian Day Surgery Council's annual conference. The aim has been to provide a single forum for topics related to Day Surgery and Anaesthesia in an effort to generate a robust and exciting scientific program. This aim has been achieved. The SIG is grateful to Dr Glenda Rudkin for coordinating this Program.

Prof Alain Borgeat (Switzerland) is the SIG's International Visitor and will be speaking on aspects of care related to local and regional anaesthesia.

The ADSC Conference will be held as a satellite meeting preceding this year's ASA National Scientific Congress.

The SIG has agreed to a 25% share of costs/surpluses associated with this conference.

Future Meetings

The SIG has committed to support for a Day Care Anaesthesia Session at ANZCA ASM to be held in Auckland May 05. Dr Carolyn Fowler is coordinating speakers for this session. Themes and topics will be announced shortly.

Clinical Indicators Working Party

The SIG was associated with the College Clinical Indicators Working Party. This group have undertaken a review of the traditional anaesthesia Clinical Indicators with a view to making them more meaningful. Input from a number of SIGs was sought with multiple, discipline-specific Indicators being generated. The Day Care Indicators submitted for approval are:

- Cancellation by the anaesthetist on the day of surgery
- Unplanned admission of day surgery patient for anaesthesia-related reason
- Unexpected delay in home-readiness

It was expected that each Unit would apply their own specific sub-classes to further breakdown these main indicators.

As yet the SIG has had no official notification of the take-up of the proposed changes.

Day Surgery Fellowship

Development of a Fellowship program for Senior Trainees in Ambulatory Anaesthesia has been an ongoing project of the Day Care SIG. Generic requirements have been produced for Units considering offering such a position. Sir Charles Gairdner Hospital will be offering 2 six month Fellowships from the start of the '05 academic year, combining regional and day surgery sub-specialties. The course content has been modelled on similar programs offered at Duke University and the University of Florida.

Steve Watts
Chairman



Diving and Hyperbaric Medicine

SIG Executive

The current SIG Executive comprises:

| | |
|-------------------------------------|-----|
| Dr Chris Acott | SA |
| Dr Mike Bennett | NSW |
| Dr Alistair Gibson | NZ |
| Dr David Smart | Tas |
| Dr Brian Spain | NT |
| Dr Margaret Walker (<i>Chair</i>) | Tas |
| Dr Robert Webb | Qld |
| Dr David Wilkinson | SA |
| Dr Robert Wong | WA |

Co-opted Members

Dr Simon Mitchell (South Pacific Underwater Medicine Society)

A vacancy exists for the position of ANZ Hyperbaric Medicine Group Representative. Three names have been proposed and the nominees will be contacted regarding their willingness to accept the position.

An election was held in 2004, Executive Members having served their three year term. After serving as a member of the Executive Committee since the SIG's inception, Dr David Griffiths has resigned from the Committee. Dr Bob Webb was elected as his successor.

At the first teleconference meeting of the SIG Executive following the AGM, Dr Margaret Walker was elected as the new Chair.

Dr R M Wong, who initiated the formation of the Diving and Hyperbaric Medicine SIG in 1998, has formally completed his term as Chairman but remains a member of the Executive Committee.

ANZCA Council Citations

The ANZCA Council Citation was established in December 2000 to recognise individuals who have made significant contributions to particular activities of the College. At the AGM in 2003, individuals were nominated for their outstanding contributions to diving and hyperbaric medicine; Dr Carl Edmonds of Sydney and Dr Peter McCartney of Hobart were awarded the ANZCA Council Citation at the Conference Dinner of the Undersea and Hyperbaric Medical Society, held in Sydney in May 2004. Dr John Williamson of

Adelaide received the award at a Regional Committee Meeting in South Australia.

Formal Qualification in Diving and Hyperbaric Medicine

The Certificate in Diving and Hyperbaric Medicine has finally been established, with seventeen candidates being awarded the Foundation Certificate in October 2003, four of whom applied for and were appointed to the Court of Examiners for the new Certificate. Two more applications have been received by the College and are currently being processed.

The inaugural Certificate Examination will take place on 11th October 2004 (written) and 29th October 2004 (oral). Three candidates have applied to present.

Accreditation of Facilities

Accreditation of facilities seeking approval for Vocational Training in Diving and Hyperbaric Medicine took place in May 2003. The Royal Hobart Hospital was the first to be accredited. Subsequently the Prince of Wales Hospital and Fremantle Hospital have been approved for training. The Royal Adelaide Hospital has also applied and will be inspected in August 2004. Alfred Hospital is in the process of applying for accreditation.

Introductory Diving and Hyperbaric Medicine Course

The two-week full-time course continues into its fifth year in 2004. After two years in Melbourne, it was held again at the Prince of Wales Hospital in Randwick, NSW. This is one of the two requisite courses for training in the Certificate in Diving and Hyperbaric Medicine. This year, there were 19 candidates including representatives from South East Asia. The UHMS accreditation currently held by this course is due for review, and as no UHMS members have attended this course, it is debatable whether the process of re-accreditation is warranted.

Annual General Meeting

Due to the small number of members of the SIG who usually attend the ANZCA ASM and the ASM of UHMS, and in view of the close proximity of the two meetings, it was decided to hold the AGM during the UHMS in May 2004. This was combined with the AGM of the Australian and New Zealand Hyperbaric Medicine Group (ANZHMG).

The Undersea and Hyperbaric Medical Society of the US usually holds their scientific meeting in continental US, Canada or Mexico and every three to four years, a meeting is held overseas, usually in Europe. For the first time in its history, the meeting was held in Australia, which was due to the enormous effort put in by Dr Mike Bennett and his organising committee - Dr J Lehm, Dr Robyn Walker, Gabrielle Janik, Peter Barr (HTNA), Dr Simon Mitchell (scientific committee), Prof Des Gorman (scientific committee) and Dr D Doolette (scientific committee) to make this a reality. The Chairman and its Executive Members congratulate their effort and contributions. It was one of the most successful UHMS Meetings ever held.

Scientific Meetings

Members again actively contributed to national and international scientific meetings during the year, e.g. meetings of the Undersea and Hyperbaric Medical Society (UHMS); South Pacific Underwater Medicine Society (SPUMS); European Underwater and Baromedical Society (EUBS) and the Australasian Hyperbaric Meeting hosted by the Hyperbaric Technicians and Nurses Association (HTNA).

Dr C Acott was invited as guest lecturer at the Diving Medicine Course and Workshop on "Triage and retrieval of diving casualties in remote areas" in Patong, Phuket in Thailand in November 2003. Dr R Wong was also a participant at the workshop.

SIG Constitution

With the amended SIG Constitution, SIG Associate Members holding the ANZCA Certificate of Diving and Hyperbaric Medicine can now be invited by the SIG Executive to become full members.

Article 5.5 of the Constitution currently stipulates that co-opted members can serve a maximum aggregate period of three years. However, due to the small number of members of this SIG, and the ongoing development of an examination process for the ANZCA Certificate in Diving and Hyperbaric Medicine, Dr Wong has written to the Chairman of ACECC requesting that this three year term be extended to a maximum of six years. It is envisaged that this item will be discussed at the September Meeting.



Retirement

Dr David Griffiths who has contributed tirelessly to the SIG, has relinquished his post in the Executive Committee. Dr David Doolette, who has performed a tremendous job in his role as the Education Officer of SPUMS has resigned his post, he is replaced by Dr Chris Acott. The Chairman and the Executive Committee thank Drs Griffiths and Doolette for their enormous contributions over the years.

Publications

Members of the SIG have been active in writing papers for publications.

Dr Mike Bennett has again been very active in this area and has contributed personally and with co-authors to fifteen publications during the year 2003.

Dr David Smart also contributed to numerous publications with papers and abstracts.

Dr Mike Davis has two papers published. Others who have made contributions to various publications include Dr David Doolette, Dr Simon Mitchell, Dr J Lehm, Dr B Trytko, Dr Margaret Walker and Dr R Wong.

Honours, Awards and Appointments

The Chairman and the SIG Executive Members extend their congratulations to those members who have received awards or have been honoured/ appointed to the various academic positions and in diving and hyperbaric organisations.

ANZCA Council Citations were awarded to Drs Carl Edmonds, Peter McCartney and John Williamson.

Dr Chris Acott continues his post as Vice President of UHMS in 2003 - 2004. He has also been appointed to a lectureship at the University of Auckland.

Dr Robyn Walker remains in her role as President of South Pacific Underwater Medicine Society.

Dr David Smart was honoured with the award of the Order of the International Federation of Emergency Medicine at the ICEM in June 2004 in Cairns. He was also awarded the "Foundation 20" – a medal from the Australasian College for Emergency Medicine for his contribution to the College over its first 20 years.

Dr Mike Davis of Christchurch was appointed Associate Professor, Occupational Medicine Unit, Department of Medicine, University of Auckland in February 2004. He continues as the Editor of the SPUMS Journal. Under his leadership, the journal has made vast progress and improvements.

Dr Robert Wong was appointed as an External Examiner in the Faculty of Medicine at the University of Technology, Trondheim, Norway.

Dr Simon Mitchell remains a member of the Editorial Board of the Journal of Undersea and Hyperbaric Medicine. He is also the Member at Large of the Executive Committee of the Undersea and Hyperbaric Medical Society Inc USA and continues to be a member of the Adjunctive Therapy Committee of the same organisation.

Dr Mike Bennett continues to serve on the Hyperbaric Oxygen Therapy and Education Committees of that organisation.

Dr David Smart continues to serve as Chairman of the Australian and New Zealand Hyperbaric Medicine Group (ANZHMG) and Dr Barbara Trytko as Vice-Chairman. Dr David Wilkinson is the Honorary Secretary.

Robert M Wong

Chairman

Neuroanaesthesia

SIG Executive

The current Interim SIG Executive comprises:

| | |
|--------------------------------------|-----|
| Dr Kerry Brandis | Qld |
| Dr Winifred Burnett (<i>Chair</i>) | Vic |
| Dr Doug Campbell | NZ |
| Dr Ray Cook | ACT |
| Prof Tony Gin | HK |
| Dr Stephen Swallow | Tas |
| Dr Elizabeth Tham | SA |
| Dr Wally Thompson | WA |
| Dr Neil Warwick | NSW |

SIG Annual General Meeting 2004

The next AGM of the Neuroanaesthesia Special Interest Group (NeuroSIG) will be held during the CME Meeting at Lindeman Island, September 2004.

Meetings 2003

The NeuroSIG held a very successful one day meeting in October as a Satellite meeting to the ASA NSC entitled "An Update on the Anaesthetic Management of Head Injury" with Prof Mike Todd, Editor in Chief of Anesthesiology as the key note speaker.

The NeuroSIG session at the NSC was very well attended and had a superb line-up of international speakers including Mike Todd, James Cottrell and Adrian Gelb.

Meetings 2004

This year we are attempting to repeat the success of the 1998 Lindeman Island meeting and currently have almost 100 registrants for the meeting entitled "Anaesthesia Problems and the CNS".

AGM 2003 Hobart

Unfortunately the AGM in Hobart did not reach quorum and served merely as a handover meeting of the previous Chair, Stephen Swallow, to the incoming Chair Winifred Burnett. The 2004 AGM will be held at Lindeman Island, where it is anticipated a greater number of members will be in attendance.

Winifred Burnett

Chair



Obstetric Anaesthesia

SIG Executive

The current SIG Executive comprises:

| | |
|---------------------------------------|-----|
| Dr David Elliott | NSW |
| Dr Alison Lilley | Vic |
| A/Prof Michael Paech (<i>Chair</i>) | WA |
| Dr Andrew Ross | Vic |
| Dr Graham Sharpe | NZ |
| Dr Scott Simmons | SA |
| Dr Steven Katz | NSW |
| Prof Warwick Ngan Kee | HK |

Co-opted Members

| | |
|-----------------------|-----|
| Dr David Crooke | NSW |
| A/Prof Stephen Gatt | NSW |
| Dr Genevieve Goulding | Qld |

Administration

1. The current Executive's three-year term of office expires in 2004 and a new Executive will be elected through due process, with announcement of results at the Annual General Meeting during the Blenheim SIG scientific congress in November 2004. It should be noted that

currently the ACT, Tasmania and NT do not have representation on the Executive.

2. A meeting of the SIG was held at the Perth ANZCA Annual Scientific Meeting in May 2004 and the Minutes have been circulated previously. Another meeting is planned during the ASA National Scientific Congress in Sydney in September 2004.
3. The SIG Membership continues to increase and currently stands at 662. The financial position is a little stronger, with a balance of at 31/12/02 of \$5,197.24.

Activities

Matters of interest arising this year:

1. The SIG initiative in obtaining ANZCA representation, since August 2003, on the AIHW National Perinatal Statistics Maternal Mortality Committee. Michael Paech has been involved in the preparation of the 1997-99 triennial report, which is due for release in August 2004, and work has commenced on the 2000-2002 report.

2. Through ANZCA, Members of the SIG Executive (Alison Lilley, Michael Paech, Graham Sharpe) contributed to a joint RANZCOG/ANZCA/RACGP/ACRRM working party that prepared a position statement on the provision of obstetric anaesthetic services. This is due for release following ratification by all colleges involved.
3. ANZCA has formed a Clinical Trials Group Chaired by A/Prof Paul Myles. This group will conduct and support multicentre clinical trials and provides an avenue for assistance for SIG Members considering multicentre research.
4. A request was made to the ANZCA librarian to have the International Journal of Obstetric Anesthesia included as an on-line journal and this is now available.
5. The newsletter reporting on presentations from the Hobart ANZCA 2003 ASM was prepared and distributed, thanks to David Elliott of the Executive.
6. Scott Simmons of the Executive has represented the SIG on an ANZCA Clinical Indicators Working Party. This group has prepared a draft proposal, which when ratified will result in audit templates placed on the ANZCA/MOPS/ACECC websites.
7. David Crooke has commenced working toward an expansion of the SIG website.
8. Some Members of the SIG, Chaired by Genevieve Goulding of the Executive, are forming a working group to develop a position statement on "Aseptic technique for the insertion of epidural catheters". Input is welcomed.

Continuing Education

1. The SIG has continued to support the major national meetings, the ANZCA ASM and ASA NSC. Well-attended and received plenary sessions were held at the Melbourne and Perth congresses in 2003/2004 and another session has been organised for the forthcoming Sydney ASA congress. I have already committed the SIG to the planning of a plenary session at the Auckland ANZCA ASM in 2005. My thanks to those who have helped

OTS Performance Assessment September 2004

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

| | | | |
|----------------|-----|-----------------|----|
| Fiona Chadwick | NSW | Richard Semenov | SA |
| Joseph Tarpey | QLD | | |

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

| | | | |
|--------------------------|-----|------------------|-----|
| Mirjam Bar | VIC | Gerard Booy | NSW |
| Alma Cohadzic-Djurdoevic | NSW | Beverley Correia | NSW |
| Patrick Eakins | WA | Tomoko Hara | NZ |
| Jonathan Hopkinson | SA | Mohua Jain | NZ |
| Heike Koelzow | NSW | Mazhar Mahmood | QLD |
| Melrex Malan | QLD | James Musson | QLD |
| Frances Page | NSW | John Prickett | NSW |
| Neena Singh | NSW | Helge Suhr | VIC |
| Roelof van Wijk | SA | Charlotte Wilsey | NSW |

Certificate of Excellence

Dr Jonathan Hopkinson was awarded a Certificate of Excellence at the September 2004 Overseas Trained Specialist Performance Assessment.



conceive and implement these scientific programs.

2. A number of well-subscribed one-day meetings were held in which obstetric anaesthesia was the theme. A SIG meeting was organised by Victorian Members, with special thanks to Maggie Wong of the Royal Women's Hospital, and was held in Melbourne in June 2003. This is likely to be repeated in 2005. Other meetings in 2004 included a OA Workshop in Brisbane in February; the Jobson symposium in Sydney in March and a combined ASA/ANZCA Victorian meeting in July 2004.

3. The forthcoming SIG single-theme scientific conference in Blenheim, NZ from November 13-15, is being convened by Graham Sharpe, the NZ representative on the Executive. This meeting has an outstanding faculty, including the overseas invited lecturer Dr David Bogod from the UK, many well-known speakers from Australasia and Hong Kong, and prominent non-medical speakers. The social program focuses on the highlights of the region, both visual and gastronomic. Registration brochures are in circulation and on the SIG website. Many thanks to Graham, and Helen Morris of ANZCA, in anticipation of an exciting event.

Acknowledgements

Cassandra Hargreaves of the ASA and in particular, Helen Morris of ANZCA, deserve praise for their invaluable contribution to the activities of the SIG. As I come to the end of my term as Chair, I would also like to express my appreciation to the Executive for their guidance and to the Members for their involvement in the growth of the group and the enrichment of obstetric anaesthesia in this region.

Michael Paech
Chairman

Simulation and Skills Training

The role of this SIG is to discuss academic issues including assistance in the formulation of training syllabuses of Simulation and Skills Training courses; maintenance of standards, quality

assurance, and research and teaching. Copies of the Special Interest Group's Constitution are available through the College.

The Executive of the Simulation and Skills Training SIG comprises:

| | |
|-----------------------------|-----|
| Dr Stephen Bignell | Qld |
| Dr Brendan Flanagan (Chair) | Vic |
| Dr Richard Morris | NSW |
| A/Prof Kwok Fu Jacobus Ng | HK |
| Prof Harry Owen | SA |
| Dr Richard Riley | WA |
| Dr Richard Waldron | Tas |
| Dr Jennifer Weller | NZ |

Satellite meeting to Melbourne ASA NSC, 2003

The major event on the SAST SIG calendar in the past twelve months was the SIG's 2nd Continuing Education Meeting, "Advancing Education through Human Patient Simulation", held at the Sebel Lodge, in Victoria's Yarra Valley, from 29th September – 1st October 2003.

The meeting was a very successful satellite to the ASA NSC in a picturesque setting. A multidisciplinary theme was proposed which encompassed the educational aspects of the use of simulation, how and why people learn, and whether retention is improved and the role of the debriefing process. A small (55 registrants) but enthusiastic group from a number of medical, nursing and allied health disciplines attended the meeting and grappled with the generic challenges of simulation-based education. The meeting was supported by industry which included an opportunity to peruse the latest mannequins available from Laerdal and METI. It was proposed that a similar meeting be held in twelve months time to maintain the momentum of this group (see below).

EMAC Course

The past twelve months has seen continued rollout of the Effective Management of Anaesthetic Crises (EMAC) course with the simulation centres at CASMS in Perth and St Vincent's in Melbourne now accredited to conduct the course. Although the development of this course does not fall directly under the responsibility of the SIG – it continues to develop under the guidance of the ANZCA Courses Subcommittee chaired by Dr Wally Thompson -

the establishment of the course reflects the College's interest in formalising the prospect of simulation and skills based training. The College will undertake an evaluation of the course towards the end of 2004.

Future Meetings

A combined meeting of the Medical Education SIG, Simulation and Skills Training SIG, Welfare of Anaesthetists SIG and Anaesthetists in Management SIG will be held in Surfers Paradise on October 1-3, 2004. The Annual General Meeting of the SIG will be held during this meeting. Election of a new Executive for the SIG is underway at the time of writing.

Planning is underway for a Simulation SIG session at the ANZCA ASM in Auckland in May 2005.

Membership

Enquiries regarding membership to the SIG can be made through Helen Morris at the College. Membership of this SIG is open to Fellows, Members of the ASA and NZSA. Fellows of other Colleges, practitioners and allied health professionals will also be encouraged to participate as Associate Members.

Brendan Flanagan
Chairman

Welfare of Anaesthetists

SIG Executive

The SIG Executive currently comprises:

| | |
|--|----------|
| Dr Rob Burrell | NZ |
| Dr Mary Cardosa | Malaysia |
| Dr Margie Cowling | SA |
| Dr Genevieve Goulding (<i>Chair</i>) | Qld |
| Dr Diana Khursandi | Qld |
| Dr Greg Purcell | NSW |
| Dr Lindy Roberts | WA |
| Dr Maurice Vialle | Tas |
| Dr Jack Warhaft | Vic |

Co-opted Executive Members:

| | |
|-----------------------|--------|
| Prof George Mendelson | RANZCP |
| Not yet notified | GASACT |



Administration

The current Executive is due for re-election in 2005.

Membership of the SIG is 346, including 1 Associate Member

The WOA SIG AGM was held in Perth on 2/5/04. Minutes of that meeting will be circulated prior to the next AGM in 2005.

Activities

- The Welfare of Anaesthetists SIG has developed its Mission, Vision and Goals, and these are now on the SIG website.
- ANZCA requested that the Action Plans (which were revised in 2003) be revised again, reference lists updated and that they be scrutinized by Mr Michael Gorton, College solicitor, prior to the documents becoming formal resources for the FANZCA curriculum.

The documents have now been re-named Resource Documents. They have been reviewed by Mr Gorton and the ANZCA Regional Committees, and are currently under review by the ASA and NZSA. Once all parties have considered them satisfactory, they will replace the current Action Plans on the SIG web pages on ANZCA, ASA and NZSA websites.

In particular, the documents on Impairment and After a Major Mishap (which now includes Critical Incident Support) have been modified, and a new document, 'Breaking Bad News' has been added.

Dr Di Khursandi has been a major force in achieving this task and the Chair acknowledges her indefatigable efforts.

- At a state level, most states have included some Welfare issues into their FANZCA Part II long or short courses and some have had welfare topics at state CME meetings.
- Dr Di Khursandi was invited by Dr Mary Cardosa on behalf of the Malaysian Society of Anaesthesiologists to give a series of lectures on Welfare Issues. Di made three presentations on a diverse number of topics including Doctors' Health, Breaking Bad News, Mentoring, Critical Incident Support and Stress.

Continuing Medical Education

- ASA NSC Adelaide October 2002: Session on Retirement, with talks on the ageing anaesthetist by Prof Barry Baker, a personal perspective by Dr Des O'Brien and a panel discussion on mentoring.
- ANZCA ASM Hobart May 2003: Dr Tracey Tay led a workshop and discussion on Mentoring of Trainees, from both a theoretical as well as a practical viewpoint.
- ASA NSC Melbourne October 2003: A session on Medical Marriage. A lecture by Dr David Barton, a Melbourne psychiatrist followed by some interactive discussion of case histories, assisted by his wife, psychologist Celia Brenchley. This session is to be repeated at a combined SIG meeting in October 2004.
- ANZCA ASM Perth May 2004: Dr Lindy Roberts organized a session led by Dr Jean Foster, a GP, speaking on Doctors' Health, followed by Dr Martin Chapman, psychiatrist, on medical relationships from a spouse perspective and lastly Mr Milos Supljegav, a family lawyer, with some practical advice on one's rights and responsibilities and structuring one's finances and assets in the event of a marital breakdown.

- October 2004, Gold Coast Joint SIG meeting: Welfare of Anaesthetists, Medical Education, Simulation and Skills Training, Anaesthetists in Management.

This is a pioneer effort, convened by Dr Rod Tayler. There is considerable overlap in the activities and interests of all these SIGs and there will be topics of common interest as well as some opportunity for each group to pursue some topics of special interest.

- Dr Rob Burrell is overseeing the WOA session for the ANZCA ASM (Auckland) in May 2005.

Projects still outstanding

On reviewing a list from a previous Annual Report of Outstanding projects and Future Directions, we have achieved five of eight tasks.

- We have yet to find representatives from Hong Kong and GASACT, the ASA's trainee group.
- The survey on Professional Diversity has not yet been implemented but plans are underway.

- Di Khursandi and I have a few 'generic lectures' prepared which could be used by Departments to assist with tutorials on welfare topics. This project could be expanded as the FANZCA modules develop.

Genevieve Goulding

Chair



Examinations

Primary Examination

July/August 2004

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

The viva examination was held at College Headquarters, Melbourne.

Successful Candidates

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

| | |
|---------------------------------|-----|
| <i>Ikhwan Naser Abdul Rahim</i> | QLD |
| <i>Joseph Ajaka</i> | NSW |
| <i>Kara Jane Allen</i> | VIC |
| <i>Lance David Anderson</i> | NSW |
| <i>Viktor Avramov</i> | SA |
| <i>Remesh Kumar Balasingam</i> | MAL |
| <i>Erez Ben-Menachem</i> | NSW |
| <i>Paul David Bent</i> | VIC |
| <i>Jennifer Gay Blackshaw</i> | QLD |
| <i>David Charles Brown</i> | NZ |
| <i>Shanel Lei Cameron</i> | NSW |
| <i>Paula Jane Carter</i> | NZ |
| <i>Carmel Laurelie Cassar</i> | QLD |
| <i>Giresh Chandran</i> | NT |
| <i>Mui Khoon Chang</i> | NZ |
| <i>Karen Chee</i> | NSW |
| <i>Lyndon Chee</i> | NSW |
| <i>Kenneth Ngee-Ken Chin</i> | SA |



Retiring Primary Examiner Dr. Renald Portelli with Assoc. Prof. David Cottee (Chairman, Primary Examination Committee)

| | | | |
|----------------------------------|-----|--------------------------------|-----|
| <i>Chui Chin Chong</i> | WA | <i>Alison Jane Davies</i> | NZ |
| <i>Michael Kok Foong Choo</i> | NZ | <i>Sharon Dempsey</i> | NZ |
| <i>Chee Yong Choo</i> | SIN | <i>Trudia Disney</i> | TAS |
| <i>Peter Clapham</i> | NSW | <i>Michael Francis Dobbie</i> | NSW |
| <i>Steven Patrick Cook</i> | NSW | <i>Felicity Ann Doherty</i> | NSW |
| <i>Astley Mark Cottrell</i> | QLD | <i>Rowan Marsh Drayton</i> | WA |
| <i>Geoffrey Stephen Crawford</i> | QLD | <i>Erika Petra Dutz</i> | VIC |
| <i>Daniel Dallimore</i> | NZ | <i>Christine Maria Edmonds</i> | NSW |
| | | <i>Michael James Edwards</i> | QLD |
| | | <i>Robert James Edwards</i> | QLD |
| | | <i>Tamara Eichel</i> | NSW |
| | | <i>Robert James Elliott</i> | QLD |
| | | <i>Michael John Farr</i> | SA |
| | | <i>Fung Chi Sum Winnie</i> | HKG |
| | | <i>Robert Gotmaker</i> | VIC |
| | | <i>Madeleine Louise Ho</i> | VIC |
| | | <i>James Philip Houghton</i> | NZ |
| | | <i>Andrew James Howard</i> | NSW |
| | | <i>Sanaa M Ali Ismail</i> | NSW |
| | | <i>William Thomas Jordan</i> | QLD |
| | | <i>Kylie Adelle Julian</i> | NZ |
| | | <i>Patricia Kan Kwok Yee</i> | HKG |
| | | <i>Charles Chul-Han Kim</i> | VIC |
| | | <i>Nani Indriati Kuswanto</i> | VIC |
| | | <i>Hai Yen Lam</i> | NSW |
| | | <i>Lam Kit Ying Sandy</i> | HKG |

Examinations

OTS Performance – Certificate of Excellence

A Certificate of Excellence has been approved to be awarded to candidates undertaking the OTS Performance Assessment from the July/September 2004 Examination.

Candidates sitting the OTS Performance Assessment may be awarded a Certificate of Excellence if they satisfy the Court of Examiners as having demonstrated a consistently high performance in all three sections of the examination.

Final Examination

From the July/September 2004 Final Examination, candidates results will be available listed by successful candidates number and by letter, to be handed to the individual candidates, within a particular timeframe.

Primary Examination

The Syllabus for the Basic Sciences in Anaesthesia and Intensive Care for introduction from March 2005 Examinations was approved for distribution to all trainees.



| | |
|--------------------------------|-----|
| Lam Tat Shing Ernest | HKG |
| Stephen Peter Lamb | WA |
| Samuel Hoi-Sing Lau | VIC |
| Emily Mary Lee | TAS |
| Richard Michael Lees | NSW |
| Heather Loane | VIC |
| Maria Mackintosh | NSW |
| Julian Robert Mahood | VIC |
| Thomas James Main | NZ |
| Daniel John McGlone | TAS |
| Rebecca Edgeworth McIntyre | VIC |
| Hamish Douglas Devenish Meares | NSW |
| Phillip Melksham | QLD |
| Andrew Robert Middleton | VIC |
| Simon John Mitchell | NZ |
| Christopher George Munns | NZ |
| Pedram Naderi | SA |
| Parag Dattaprasad Nalavade | QLD |
| Sagy Jacob Nathan | NSW |
| Njo Kui Hung Anthony | HKG |
| Poh Loong Sharon Ong | VIC |
| Caroline Padget | NSW |
| Robert Malcolm Palmer | QLD |
| Andrew William Potter | NT |
| Murali Rajaratnam | QLD |
| Vanessa Jane Rich | QLD |
| Elizabeth Ranjana Richards | QLD |
| Paul Harold Martin Sadleir | VIC |
| Mark Andrew Sandy | VIC |
| Jason Matthew Schoutrop | QLD |
| Tanya Selak | NZ |
| John Ronald Sestan | NSW |
| Mark Shulman | VIC |
| Karl Hans Smolka | NSW |
| Subhapiya Sreedharan | QLD |
| Anthony James Stark | VIC |
| Kate Louise Stephens | SA |
| Richard Paul Sullivan | NZ |
| Frank Yung-Tai Sun | NSW |
| Lionel Kee-Hau Tan | QLD |
| Tong Kam Chiu | HKG |
| Yvonne Unger | VIC |
| Andrew John van der Poll | NZ |
| Arlon William Van Niekerk | NZ |
| Diana Webster | QLD |
| Laurence Weinberg | VIC |
| Gary Lee Willis | NSW |
| Charles Harold Allan Willmott | QLD |



Primary Examination July/August 2004 - Court of Examiners

Back Row: Drs. Harry Prevedoros, Geoff Gordon, Stephen Barratt, Noel Roberts and Prof. Tony Gin

Front Row: Drs. Tim Short, Brad Smith, Renald Portelli, Yahya Shehabi, Helen Kolawole, Assoc. Prof. David Cottee (Chairman) and Dr. Andrew Patrick

| | |
|--------------------------|-----|
| John Campbell Wilson | NZ |
| Grace Lai Sze Wong | HKG |
| Gerald Laurence Wong | NZ |
| Hannah Wai Man Wong | NSW |
| Lai Yee Belinda Wong | HKG |
| Chor Hoaw James Yu | NSW |
| Alexander Michael Zoszak | NSW |

Renton Prize

The Court of Examiners recommended that the Renton Prize for the half year ended 31 December 2004 not be awarded.

Merit List

The following candidates were awarded Merit Certificates for their performance at the July/August 2004 Primary Examination.

| | |
|--------------------|-----|
| Kara Jane Allen | VIC |
| Stephen Peter Lamb | WA |
| Maria Mackintosh | NSW |
| Caroline Padget | NSW |
| Lionel Kee-Hau Tan | QLD |



Examinations

Final Examination

September 2004

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.

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

Successful Candidates

| | |
|--------------------------|-----|
| Matthew Acheson | VIC |
| Imran Ali | WA |
| Glenn Arnold | NZ |
| Maria Balenovich-Kordich | NZ |
| Shrina Beğg | NSW |
| Emma Bendall | VIC |
| David Bertholini | QLD |
| Gregg Best | SA |
| Derrick Brown | QLD |
| James Cameron | NSW |
| Katarzyna Charbucinska | QLD |
| Chu Suk Yi | HK |
| Anne Craig | NZ |
| Paul Dalley | VIC |
| Mihaela Diacon | VIC |
| Tamsin Dovell | NZ |



Court of Examiners, Final Examination September 2004

| | |
|-----------------|-----|
| Marie Dreux | NSW |
| David Duke | NSW |
| Philip Eames | NZ |
| William Egerton | ACT |
| James French | NSW |
| Kathryn Fry | QLD |
| Kylie Hall | QLD |
| Gareth Harris | NZ |
| Elizabeth Holt | WA |



Dr Michele Joseph with retiring Final Examination Committee Chairman, A/Prof Tony Weeks

| | |
|--------------------|-----|
| Vinh Hua | NSW |
| Nicholas Ireland | NZ |
| Andrew Jackson | NSW |
| Clint Johnson | NSW |
| Lisa Khoo | WA |
| Kylie King | NSW |
| Jamie Knuckey | WA |
| Kerstin Krueger | NZ |
| Mark Krumrey | NZ |
| Irina Kurowski | WA |
| Angeline Lee | WA |
| Bernard Lising | NSW |
| Rachelle Lumsden | NZ |
| Sharon Maconachie | QLD |
| Jules Maussen | QLD |
| Simon McPherson | VIC |
| Andrew Mitchell | NZ |
| Andrew Muncaster | SA |
| Michelle Olsen | QLD |
| Leo O'Shea | QLD |
| Ashley Padayachee | NZ |
| Stephen Pickering | NSW |
| Arun Ratnavadivel | NZ |
| Tomasz Rawdanowicz | VIC |
| Anthony Ringuet | QLD |
| Mark Robertson | QLD |
| John Rotherham | NZ |
| Margot Rumball | NZ |
| Shamani Singham | NSW |
| Michelle Soh | VIC |
| Lanie Stephens | ACT |

| | |
|-----------------------|------|
| Nickolas Stradwick | NSW |
| Wen Tien JamesTan | SING |
| Tung Ong John Tang | VIC |
| Tay Kwang Hui | SING |
| Katherine Todd-Menzel | SA |
| Gerald Toh | SA |
| Praveen Vats | VIC |
| Justine White | WA |
| Joseph Williams | QLD |
| Neil Wylie | NZ |
| Haytham Yousif | NZ |
| Man Alexandra Yip | HK |
| Peggy Yip | NZ |

Renton Prize

The Court of Examiners recommended that the Cecil Gray Prize for the half year ended 31 December 2004 be awarded to Dr Paul Dalley, Victoria.

Merit List

The following candidates were awarded a Merit Certificate for their performance at the September 2004 Final Examination:

| |
|-----------------------|
| Andrew Jackson, NSW |
| Jules Maussen, QLD |
| Andrew Mitchell, NZ |
| Ashley Padayachee, NZ |
| Margot Rumball, NZ |



Professional Documents Under Review

In line with College policy, the following Professional Documents are due for review in 2005:

PS4 – Recommendations for the Post-Anaesthesia Recovery Room

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

PS18 – Recommendations on Monitoring During Anaesthesia

PS40 – Guidelines for the Relationship Between Fellows and the Healthcare Industry

PS41 – Guidelines on Acute Pain Management

PS42 – Recommendations for Staffing of Departments of Anaesthesia

T1 – Recommendations on Minimum Facilities for Safe Anaesthesia Practice in Operating Suites

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

TE6 – Guidelines on the Duties of an Anaesthetist

TE18 – Guidelines for Assisting Trainees with Difficulties

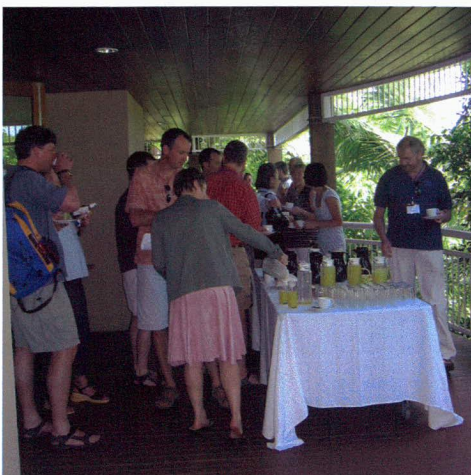
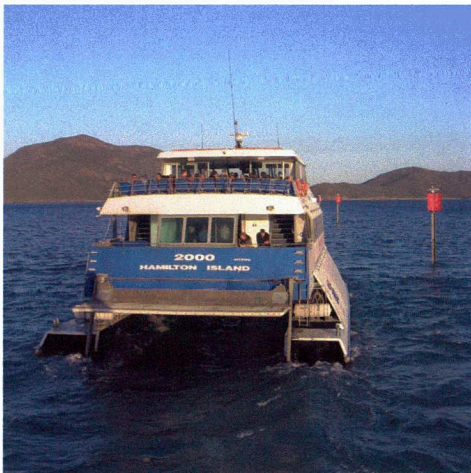
The Executive will welcome any input or suggestions relating to these documents which will be considered during the review.



Neuroanaesthesia Special Interest Group Meeting "Anaesthesia Problems and the C.N.S."

The Neuroanaesthesia Special Interest Group held its 3rd Continuing Education Meeting at Club Med Lindeman Island from 10-14 September. The meeting was very successful with 96 registered participants, both available sponsorships taken up and an excellent scientific program.

The Overseas Invited Speaker, Dr Basil Matta, Cambridge, UK presented on Hypothermia – An Update, Inotropic Support in the Neuro-Critical Care and Anaesthesia for Extra Cranial Surgery in Patients with Traumatic Brain Injury as well as contributing to the ASA NSC scientific program. Local Invited Speakers, Professors Guy Ludbrook, Adelaide and Tony Gin, Hong Kong also contributed greatly to the program. Feedback from delegates has been very positive. Thanks were expressed to Dr Ray Cook, Convenor, for his energy, enthusiasm and excellent choice of venue, Dr Winifred Burnett, Scientific



Convenor, for a great program and Ms Helen Morris for her administrative and negotiating skills.

It was generally agreed that the venue was ideal for this type of program and consideration is being given to repeating the meeting in a similar format at this venue on a regular biennial or triennial basis.

Left: Tea Break on the veranda
Top: Sunset Cruise
Above: Major Sponsor – Pfizer Dynastat
Upper Right: Sessions
Right Centre: Scientific Convenor (Winifred Burnett), Convenor (Ray Cook), Overseas Invited Speaker (Basil Matta), Local Invited Speaker (Tony Gin)
Right: Prof Tony Gin, Prof Basil Matta, Prof Guy Ludbrook





"Human Factors in Anaesthesia Education, Simulation, Welfare and Management"



The Medical Education, Simulation and Skills Training, Welfare of Anaesthetists and Anaesthetists in Management Special Interest Groups held a combined meeting at the Marriott Hotel Surfers Paradise from the 1st – 3rd October. The 95 registrants were able to attend a broad range of workshops and interactive lectures from a total of 19 presenters. The overseas guest lecturer was Dr David Greaves from the UK who presented on The UK Non-Medical Anaesthetist Program, The UK Certificate in Anaesthesia Education, Anaesthesia Non Technical Skills (ANTS), and The Trainee / Specialist with Difficulties. The Australasian guest lecturer was Dr David Barton who presented on Relationships and Professional Life. The evaluation of the meeting by the participants was most positive. Another combined SIG meeting is planned for Noosa Heads in October 2005.



Left: Conference Dinner at Ristorante Fellini
Centre (Left and Above): Industry Display
Top Left: Chairs (Rod Tayler, Genevieve Goulding, Brendan Flanagan and Vanesa Beavis) with Overseas Invited Speaker, Dr David Greaves
Above: Panel (David Greaves, Jennifer Weller, Di Khursandi and Vanesa Beavis)



Western Australia Regional Committee

Anaesthesia WA Winter Scientific Meeting



Dr Simon Maclaurin, WA Regional Committee Chair, presents the 2003 ANZCA / ASA Gilbert Troup prize to Dr Kavitha Subramaniam. The prize is awarded to the final year medical student with highest marks in anaesthesia.



Dr Lukas Tan receives the Nerida Dilworth Registrar Prize from Dr Dilworth



Dr Wally Thompson and Professor Teik Oh following the unveiling of the portrait by local artist, Ben Joel

Anaesthesia WA held its Annual Winter Scientific Meeting on Saturday 7th August at the St John of God Conference Centre, Subiaco.

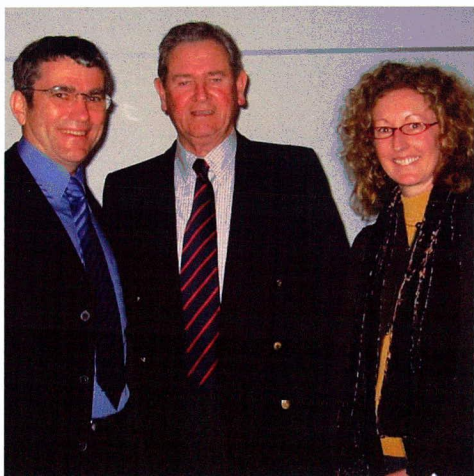
Professor Alan Merry, the 2004 Anaesthesia WA "Dr Maxwell T Sloss" visiting lecturer, presented two very enjoyable and thought provoking addresses: "Making Advances in Anaesthesia" and "Death at Duke". These were the first in the current three-year series of named lectureships which were inaugurated in 1998 by the Anaesthesia WA Education Liaison Committee to honour outstanding Western Australian Anaesthetists.

The day began with the Annual General Meeting of WA Fellows concurrent with the Trainees' Annual Meeting convened by the WA Trainee Committee representative, Dr Rowena Knoesen. Fergus Matthews, a relationship counsellor, led an interactive workshop session focussing on overcoming problems encountered during training.

Dr Rob Storer, ASA WA Committee of Management Chairman, introduced the Awards Ceremony. Dr Simon Maclaurin, ANZCA WA Regional Committee Chairman, presented the 2003 ANZCA/ASA Gilbert Troup Prize for a final year medical student to

Dr Kavitha Subramaniam; Dr Lukas Tan received the Nerida Dilworth Registrar Prize from Dr Dilworth for his 2003 WSM presentation "Comparison of hypnotic state monitoring between clinical assessment and bispectral index"; and Dr Andrew Gardner, REO, commended Dr Jay Bruce for her contribution to training at Fremantle Hospital on her award of the ANZCA Supervisor of Training Certificate of Recognition.

Central to the proceedings was the tribute paid to Professor Teik Oh by Dr Wally Thompson, who outlined Professor Oh's formidable career before unveiling a portrait by local artist, Ben Joel. The portrait



Professor Alan Merry, Visiting Maxwell T Sloss Lecturer, with Dr Sloss and Dr Jenny Fabling, WA Continuing Education Officer and WSM Convenor



Dr Andrew Gardner, WA Regional Education Officer, presents Dr Jay Bruce, Fremantle Hospital SOT, with the ANZCA Supervisor of Training Certificate of Recognition.



Simon Maclaurin, Patricia Luxford and Rob Storer, ASA WA



Trainee Meeting with presenter, Fergus Matthews (far right) and Trainee Committee representative, Dr Rowena Knoesen (centre front)

will eventually join those of other Past Presidents at ANZCA House. A welcome was extended to invited guests Mrs Lala Oh, Stefan and Kazia; Mr and Mrs Brian Oh; Ms Peta Gjedsted, former WA Administrative Officer; and staff from Royal Perth Hospital.

Dr Andrew Gardner and Dr Michael Veltman chaired the sessions at which the following Free Papers were presented:

Dr Per Flisberg:

Physiological and metabolic adaptability among anesthesiologists after on call duty

Dr Elaine Christiansen:

A comparison of morphine and tramadol in children undergoing adenotonsillectomy for obstructive sleep apnoea

Dr Sarah Berridge:

Brachial Plexus Neuropathy - It's not always our fault!

Dr Sarah Martindale:

Anaesthesia for ERCP

Dr Jenny Fabling, Convenor, closed the proceedings with thanks to Boots Healthcare for their generous sponsorship.



Faculty of Pain Medicine

Dean's Message

Hidden in the press releases from the IASP which no doubt many Fellows received for the Global Day Against Pain held on 11 October last was a call from the European Federation of IASP Chapters (EFIC) for "specialisation (or subspecialisation) in pain medicine...". The Global Day itself was half a world and several time zones away and, in Australia, fell immediately after a federal election, which made it a challenge to bring our media to focus on that burden of distress which is the *raison d'être* of our Faculty. This call reminded me of a recent Editorial in the journal of the World Institute of Pain entitled "Pain Medicine: a Medical Specialty?" [Day M. *Pain Practice* 2004;4:1-10]. We believe that it is, as our negotiations for recognition as such with the Australian Medical Council will attest. However it is worthwhile to reflect just how far ahead in this process are we in Australia and New Zealand, with our small populations, compared with the northern hemisphere.

EFIC advocates, among other things: (i) Creation of a core curriculum of basic and applied medical knowledge on pain; (ii) Creation of [uniform] standards of training and certification for pain specialists; (iii) Institution of subspecialty training, leading to recognised professional certification in Pain Medicine, the typical duration of such a program being two years; (iv) Candidates entering the program to have already obtained accreditation in an appropriate medical specialty. Finally, they state that, after a few years and having created a body of trained professionals qualified to provide guidance and leadership, Pain Medicine should be instituted as a medical specialty.

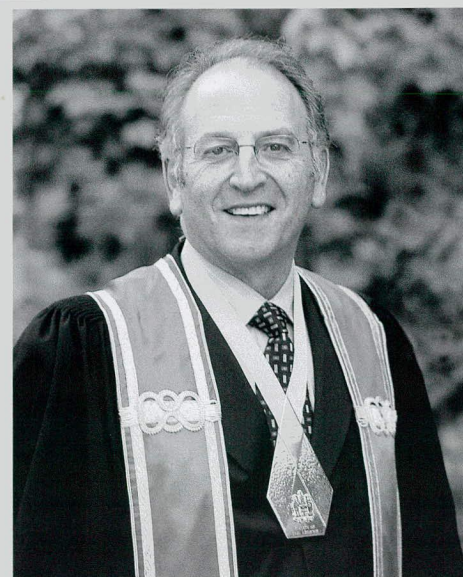
Meanwhile in the United States there is, unsurprisingly, competition between four different bodies to offer certification in pain medicine: the American Board of Anaesthesiology, the American Board of Pain Medicine, the American Academy of Pain Medicine and the World Institute of Pain. The criteria for a "new" specialty Board in that

country include: (a) "...the differentiation of a new specialty which must be based on major new concepts in medical science"; (b) "...a distinct and well-defined field of medical practice... [which] may entail special concern with the problems of patients according to age, sex or organ systems or with the interaction between patients and their environment. ... The needed training must be sufficiently complex or extended that it is not feasible to include it in established training programs"; (c) "A specialty board must require evidence that its diplomates have acquired capability in a stated area of medicine and will demonstrate special knowledge in that field". (There are four other criteria which are not central to this theme.)

"...Our examination process is demanding and rigorous, with an emphasis on superior clinical skills as well as knowledge..."

The editorialist argues that in the United States criteria (a) and (b) are satisfied but that criterion (c) is currently frustrated by the four credentialing entities. None of them has a training and examination program comparable with ours.

Perhaps then we in Australia and New Zealand might allow ourselves some sanguine but not smug satisfaction in the achievements of the Faculty in less than six years. We have articulated a comprehensive curriculum which not only defines the scope of pain medicine but also provides a framework for setting and maintaining standards of knowledge and practice. Our criteria for entry into Pain Medicine training have always included the requirement for Fellowship in an established medical specialty. We have established what our training units must be able to provide to trainees over the two years of required pain medicine training. Our examination process is demanding and rigorous, with an emphasis on superior clinical skills as well as knowledge,



as would be expected in an "add-on" Fellowship. We can argue that we fit the final EFIC criterion: as the number of our Fellows approaches 200, the Faculty does exist as "a body of trained professionals qualified to provide guidance and leadership".

Whether or not the Europeans or the Americans follow the example we have set, it remains for all of us in the Faculty to maintain and build on this sound basis. All Faculty committees – Education, Examination, Unit Accreditation and Research – are working innovatively under strong leadership and the fruits of those labours will be shared in future Bulletins, Synopses and scientific meetings. Each of us is the profile of Pain Medicine at our clinical coalfaces, no matter whether that is in a tertiary institution or a provincial centre, whether we have access to all treatment modalities or have to cut according to our cloth. Who said Pain Medicine is not seductive?

Milton Cohen
Dean



Report

Highlights from the Board Meeting

A/Professor Milton Cohen welcomed the Board and in particular A/Professor Ben Marosszeky who has been co-opted to the Board following the resignation of Professor Michael Cousins and Dr Mike Martyn co-opted member representing ANZCA Council. Dr Carolyn Arnold, President of the Australian Pain Society was also welcomed as a visitor to the Board Meeting.

Honours and Appointments

The following awards in the Queen's Birthday Honours List were noted:

A/Professor Leigh Atkinson AO, Order of Australia in the General Division

Professor Richard Vaughan AM, Member in the General Division

Education

The Board supports the Education Committee's goal to have pain medicine questions included in the participating Colleges' examinations. The Committee will pursue this initiative. There are many items on the Education Committee agenda including developing a Supervisor of Training Manual, revision of the Prospectus and developing white papers.

Regional Education Meetings

It was agreed that meetings initially be held in Queensland and New South Wales. The Faculty now runs joint meetings with the Victorian Pain Management Group.

American Academy of Pain Medicine Pain Medicine Journal

The Dean reported that negotiations are progressing regarding a closer association between the AAPM and the Faculty. AAPM is offering the Faculty:

- To nominate a Fellow of the Faculty to the Senior Editorial Board
- A discounted subscription rate of AUD\$150.00 per annum to Faculty Fellows

- The Faculty name be added to the cover with that of the AAPM name.

It is recognised that most Fellows can receive free access however the more important issue is that it will be the official journal of the Faculty.

The Board proposed that this subscription fee be added to each Fellow's annual Fellowship subscription.

Pain Orientated Physical Examination (POPE)

The DVD was presented for the first time at the Refresher Course Day and will be shown to the trainees at the pre-examination short course in September. Negotiations regarding production costs and artwork are continuing with the production house.

Finance

It was agreed that the Fellowship subscription for 2005/06 not increase.

Executive Committee

The Dean reported on the Executive Committee meetings held on April 21, May 31 and June 30. It was agreed that the minutes of these meetings be circulated to the Board following each meeting.

Library

R Goucke reported on his attendance at a recent meeting of the Library Committee and was pleased to advise that the Committee agreed to continue the subscriptions to the Clinical Journal of Pain and Spine.

Examination Committee

P Briscoe reported that the Examination Committee is meeting on July 30. The first component will be a business meeting followed by preparing the 2005 examination to be held October 27 to 29 at Royal Adelaide Hospital. Issues to be raised at the business meeting will be a proposal for a more formal process for the re-appointment and appointment of examiner.

There will be a pre-examination short course at the Pain Unit, Royal Adelaide Hospital, on September 9 and 10.

Intercollegiate Working Party

The Dean commented that this working party is as a result of the Intercollegiate Pain Medicine forum. The brief for the working party will be to develop collaboration with the participating Colleges, particularly in relation to education, exchanging of minutes, to identify career paths and hold pain medicine sessions at the annual scientific meetings.

2005 Annual Scientific Meeting and Refresher Course Day

Programs have been developed for both meetings.

Administrative Staff

Ms Mary Silvestro has commenced as the Faculty's Administrative Assistant on a part-time basis.

Admission to Fellowship of the Faculty of Pain Medicine by election:

David Manohar NSW



Admission to Fellowship of the Faculty of Pain Medicine *by the Alternate Pathway*

Persons who are registered medical specialists in Australia or New Zealand may be admitted to Fellowship using the following criteria:

1. Have not had formal training in Pain Medicine during their primary specialty training, and
2. Are not in a position to enrol prospectively in the Faculty Training Program, but
3. Have been actively engaged in Pain Medicine practice since obtaining their primary specialty Fellowship –

Will not be required to undertake the full Faculty of Pain Medicine Training Program as outlined in Faculty Professional Document PM1 Guidelines for Trainees and Departments Seeking Faculty Approval of Posts for Training in Pain Medicine. However, they will be required to:

4. Have been actively engaged in Pain Medicine practice for at least two years full-time equivalent since obtaining their primary Fellowship.

5. It will be the role of the Assistant Censor to assess applications for admission to Fellowship by Election in accordance with the Faculty's Administrative Instructions 4.3.1 to 4.3.5 to determine whether the criteria have been met or whether this alternate pathway may be offered.

6. Should the applicant be offered this alternate pathway, they will be additionally required to:

- 6.1 Be registered as a trainee for six months prior to registering for the examination. Such trainees must pay the registration fee but are exempt from the annual training fee.

- 6.2 Satisfy the following Summative Assessment criteria:

- 6.2.1 A case report as outlined in the Training Manual.
- 6.2.2 Examination pass as specified in the Training Manual.

7. Administrative Instructions in relation to the election to Fellowship process will be followed.

8. This alternate pathway for admission to Fellowship will cease following the 2005 examination.

Please contact the Executive Officer, Faculty of Pain Medicine for further details on +61 3 8517 5337 or painmed@anzca.edu.au



The 2003 Jack Brockhoff Foundation Churchill Fellowship



Jane Munro
Faculty of Pain Medicine
Trainee

Paediatric Pain Management— We can do it better!

This year I had the wonderful opportunity to travel to a number of different hospitals internationally on a Churchill Fellowship to evaluate and compare different models of multidisciplinary paediatric pain units in Canada, USA, Sweden and the United Kingdom with a view to discovering best practice and improving local Victorian paediatric pain services.

I had the opportunity to discuss many aspects of caring for children with painful conditions with leaders in this field and benefit from their experience and insights. During my Churchill Fellowship I endeavoured to learn from and reflect upon excellence in practice and consider the difficulties and barriers of getting research evidence into clinical practice in large organisational settings. The Fellowship helped conceive a practical and implementable plan for improving paediatric pain management at the RCH in Victoria.

What is a Churchill Fellowship?

The Winston Churchill Memorial Trust was established in 1965, the year in which Sir Winston Churchill died. The principal object of the Trust is to perpetuate and honour the memory of Sir Winston Churchill by the award of Memorial Fellowships known as "Churchill Fellowships". The Trust's aim is to reward proven achievement with further opportunity in the pursuit of excellence, for the enrichment of Australian society. The Churchill Trust gives opportunity, by the provision of financial support, to enable Australian's from all walks of life to undertake overseas study, or an investigative project, of a kind that is not fully available in Australia.

Acknowledgements

I would like to acknowledge the ongoing support I have received from the Royal Children's Hospital in Melbourne both for my training in Paediatric Rheumatology and in Pain Medicine;

the generous and energetic support from each of the six hospitals I visited; and lastly (but most importantly, huge thank yous to both the Winston Churchill Memorial Trust and the Jack Brockhoff Foundation for the support of and enthusiasm towards my Fellowship; I have been impressed by the vision and energy of all involved.

Background on Paediatric Pain Medicine

The management of pain in infants, children and adolescents has often been ignored in the evolution of medical care. It is only over the past half century that both health professionals and society have begun to prioritise this common, feared and imminently treatable symptom of illness as an integral factor to address when caring for children. The evolution in this change in attitude has sadly been slow in coming to fruition. In the not so distant past children routinely had surgery without post-operative pain relief; still today many children, in a range of health care settings, are routinely held down screaming for procedures without the appropriate simple and effective preventative steps taken to minimise this trauma.

There are a number of barriers and misconceptions that impede optimal pain relief in children. For instance, previously pain has been falsely believed to be "character building" for children or even they in fact do not feel pain. Fortunately, there is an evolving research and evidence base, an escalating awareness of the harm done to infants, children and adolescents whose pain is under-treated, as well as the identification of a number of medical cultural barriers and knowledge deficits that are now beginning to be addressed.

The 1960's saw adult pain management services established in a number of international centres of excellence. However, multidisciplinary paediatric pain teams, particularly in Australia, have been established relatively recently over the past ten to fifteen years, with several large centres still without a service. In Victoria the

Royal Children's Hospital pain team was established in 1993. Currently within the hospital itself there are over forty medical, nursing, psychology, allied health and play therapy staff involved in pain research, clinical practice and education on a daily basis (on top of the many other staff involved in the direct care of children in pain). This is a dramatic change in a short period of time. The challenge is to integrate this energy, passion and experience within the organisational structure to ensure optimal progress and clinical care for the children we look after.

In Australia Governmental hospital accreditation practices could be strengthened in relation to pain management requirements. However, the subspecialty of pain medicine is unique given the Faculty of Pain Medicine comprises input from multiple medical Colleges. Paediatric pain education, advocacy, collaborative research, training and policy development are all areas where Australia lags behind our international peers.

What did I do? The Churchill Fellowship program and highlights

In May-June 2004 I visited six hospitals in four countries over six weeks. The itinerary was busy, however allowed for a variety of models of pain units to be examined within the setting of differing health care systems. I am happy to be contacted to discuss specific details of any of the visits in more detail.

During the Churchill Fellowship I was actively involved in the day to day work of the pain teams at a number of the centres; participated in acute pain ward rounds, conscious sedations, procedures and chronic pain clinics; I formally and informally interviewed most members of the different teams; I attended team meetings, case conferences and education sessions and also visited with other relevant staff members, units and areas of the hospitals. Subsequently, I have had extensive feedback from a variety of staff at the centres I visited who felt the chance to be



introspective about their own practice and team's work as well as being able to discuss other approaches to paediatric pain management was very useful and will lead to improvements in their own institution.

Canada:

■ **Vancouver:**

- Visit with Dr Leora Kuttner, clinical psychologist and author.
- Attend the 4th Paediatric Pain Meeting ("Changing the face of pediatric pain" at the American Pain Society Annual Scientific Meeting).
- Visit the Paediatric Rheumatology Unit at the British Columbia Children's Hospital, Vancouver, Canada.
- Palliative care film "When every moment counts" screening
- Interview the Paediatric Pain Team from the British Columbia Children's Hospital, Vancouver, Canada

USA:

■ **San Francisco:**

- Visit the Pain Unit at Lucille Packard Children's Hospital, Stanford University, Palo Alto, California, USA.
- Observing the Lucille Packard Children's Hospital at Stanford University, acute pain team in action, particularly the role of nurse practitioner in acute pain ward rounds (Chris Almgren) and the Child Life Specialist at procedures as well as seeing the structure and organisation of the chronic pain clinic.

■ **Los Angeles:**

- Visit Pediatric Pain Program (for chronic pain) at Mattel Children's Hospital, University of California of Los Angeles, California, USA.
- Attending the truly multidisciplinary team meeting for the chronic pain Pediatric Pain Program at Mattel Children's Hospital and spending time discussing their work and research projects with Dr Brenda Bursch.

"...previously pain has been falsely believed to be "character building" for children or even they in fact do not feel pain..."

■ **Milwaukee:**

- Visit the Pediatric Pain and Palliative Care Unit at the Children's Hospital of Wisconsin, Milwaukee, Wisconsin, USA. Observing at their work in pain management within the setting of the organization-wide approach to pain management (under the banner of "The Comfort Zone"). The impressive teamwork and the enthusiastic leadership of Dr Steve Weisman, the organisational structure of Pain and Palliative Care together, the role and competence of their chronic and acute pain nurse practitioners, the working environment, well resourced funding, and leading research base were all highlights to learn from.

Sweden:

■ **Stockholm:**

- Visit the Pain Treatment Unit at the Astrid Lindgren Children's Hospital, Karolinska Institute, Stockholm, Sweden.
- An alternate health care system structure lead to interesting differences to observe both between funding and clinical approaches from previous Fellowship visits. The team at the Astrid Lindgren Children's Hospital had an impressive organisational structure, excellent teamwork, a commitment to research (particularly psychological), a well run Sedation Service and very energetic leadership from Dr Gunnar Olsson.

United Kingdom:

■ **Bath:**

- Visit the Pain Management Unit at the Royal National Hospital for Rheumatic Diseases, Bath, United Kingdom
- It was fascinating to observe the unique inpatient rehabilitation program for treatment of refractory chronic pain conditions in adolescents and adults at the Pain Management

Unit. The program's strengths were the excellent teamwork, the strong research base, and innovative clinical approaches to managing patients with chronic pain.

General Comments and important themes from the Fellowship

The need for leadership and excellence in communication

Excellence in pain management within an organization requires the recognition and prioritisation of this as an important issue. Every department and all staff need to feel this is a priority and that good pain management is also their responsibility and that they are committed to improving the situation. This often requires behaviour change within a framework of organisational change. For this to be successful it was perceived leadership was the key to integrating the pain team within the whole institution as "mainstream" (rather than seen as a peri-operative only pain team). This should occur from the CEO down, with the leader of the pain team and other opinion leaders actively pushing improvements in pain management. It was perceived in the USA that the JCAHO hospital accreditation process had helped garner support and resources for this process. There was widespread acknowledgement of the many barriers such as medical cultural factors and "territory wars" that can impede the improvement of pain management within an institution. Having a hospital wide program with a recognisable logo and philosophy such as "The Comfort Zone" (Milwaukee) was seen as one way to address the problem at an organisational level although this was not perceived to be the panacea to overcome all barriers or problems.



The organisational structure of the Pain Team

The challenge for this predominantly anaesthetic driven speciality to be fully successful in the paediatric hospital setting is mainstream integration within the structure of the institution. Acceptance by the paediatric physicians and breaking down of traditional barriers within certain subspecialties can be challenging as can the integration of Palliative Care (a specialty with extensive overlap with Pain Medicine). One method is to engage more broadly within the hospital context; one such model is the unit in Milwaukee (and additionally Westmead Children's Hospital in Sydney has a similar model) where the Pain and Palliative Care unit is an integrated stand alone unit that incorporates anaesthetists and physicians within an interdisciplinary and multidisciplinary team structure.

All teams were multidisciplinary and this was thought to be optimal by all I met with. The use of play therapists, psychologists and complementary therapists is an area that could be expanded.

Involving physicians from other sub-specialties was seen to be useful for integrating within the hospital structure. The role of the advance practice nurse, nurse educator or nurse practitioner were a strength for the pain teams that had them.

“...Educational activities provided by the pain teams for hospital staff and clinicians working with children and adolescents were seen as critical to improving patient care...”

The "Wish-lists" of the teams

When interviewing team members I always asked for their "wishlist" for their team and work. I included them in detail in my formal Churchill Report (and am happy to be contacted for more details) and some units already were doing what others wished for.

Major recurrent themes are presented below:

- More integration within the main hospital structure

- More resources – both financial and human to appropriate support the important work done in this area.
- A more holistic approach to all aspects pain management; the use of non-pharmacological therapies needed to be increased especially in procedural pain management.
- For chronic pain: a healing centre integrating Western and Eastern medicine with a focus on health rather than illness
- Organisation-wide education programs reaching those "in the frontline" at the patient bedside
- The development of a Paediatric Pain Interest Group within the organisation or local paediatric health professional community.
- Access to inpatient paediatric pain services, especially inpatient rehabilitation services.

Team Meetings and Educational Activities

Every team had a team meeting of some description, although the purpose and frequency varied. Staff reported meetings have important roles in building teamwork, improving communication lines, and accessing education with peers. The meetings I felt functioned well had set timelines and purpose, seemed to lack hierarchy with all team member's opinions sought and valued.

Educational activities occurred variably for pain team members and ranged from journal club or case discussions to presentations from visiting speakers. Some centres had formal clinical supervision (particularly in psychology), however many physicians did not have this. Educational activities provided by the pain teams for hospital staff and clinicians working with children and adolescents were seen as critical to improving patient care; for example most centres provided orientation educational sessions to new staff when commencing at the

institution. More in depth education was offered sporadically and was limited by a number of factors (both pain team and recipient related).

Research / Database

Protected research time was variable between centres but perceived by staff as absolutely necessary to the development of a successful service, new initiatives, to maximise job satisfaction and improve patient care (e.g. through management of a patient information database).

Space, equipment and administrative support

Several centres were purpose designed and had excellent clinical and non-clinical spaces that optimised patient care. Access to a seminar room for educational activities and team meetings was seen as essential. A non-clinical area where most of the pain team staff had offices together meant improved communication, effective informal discussions, better time management, shared resources (equipment, administrative, journals), and a feeling of unity and teamwork. An impressive example was Milwaukee, which had stand-alone offices with ample conference, administrative and clinical spaces.

Access to the appropriate tools to manage pain (such as toys and distraction boxes) through to adequate staff computer access, as well as appropriate administrative support, were seen as key issues to improve the function of a pain team and were perceived by staff as suboptimal in a number of centres.

Website Development

The development of a unit website for both intra and internet access was a useful tool. Information both clinical and about the team were on websites and accessible to patients. Information for nursing staff and doctors about common paediatric pain problems was also as useful. The web-based competencies of the RCH were seen as excellent by staff I visited with.

Recommendations

- Culture change within organizations remains the premier barrier to effective pain management. Leadership and excellent communication to support individual clinician



behaviour change in a framework of organisational change is needed. Strategies will need to address changing beliefs, medical territorial disputes and how to engender a change in professionals thinking around pain.

- Team work, leadership and effective communication are essential.
- There is no one "perfect" system at any hospital and any system developed needs to be specifically adapted to the institution's and patient's needs
- We are on the brink of an exciting movement forward at RCH (and within Australia) in relation to pain management for our paediatric patients Careful strategic planning, appropriate resourcing, integration of all staff, maximising non-pharmacologic therapies, integrating pain management into the mainstream hospital culture and improvements in communication are all required for success. We still have a lot to learn and to put into practice in relation to paediatric pain medicine!
- A critical look at the current barriers to effective pain management would be useful (and once identified we can effectively tackle them!).
- The development of a multi-faceted program along the lines of "The Comfort Zone" to improve organization wide pain management and support initiatives to improve patient care by getting evidence into practice. This would involve teaching staff and parents how to be "coaches" at procedures, and skilling our patients in non-pharmacological techniques. The ethos should be of patient and family centred care and children with chronic illnesses should be targeted.
- An emphasis on integration of non-pharmacological approaches to pain management. These techniques are usually cheap, simple, acceptable and can be used in all other areas of the child's life as coping skills.
- The role of play therapists should be expanded within RCH.
- The role of nurse practitioner in both acute and chronic pain should be developed.
- The possibility of a stand-alone Department integrating Pain Management and Palliative Care should be considered. Continue a service that tackles acute and chronic pain, but expand that to more broadly include procedural and

cancer pain management with a closer relationship with the Palliative Care and oncology teams.

- Inpatient Rehabilitation Services are also desperately needed in Victoria.
- Sedation service provision including education and training is needed and should be integrated within a procedural pain framework.
- None of the above recommendations can be achieved without appropriate staffing, space, equipment, and administrative support. Protected research time and database management assistance is also essential
- Increased hospital funding and philanthropic support will be necessary to achieve these aims with adequate resourcing of the pain team for the above core business activities.
- The information gained from this Fellowship will be disseminated locally at the Royal Children's Hospital and more broadly within the paediatric physician and trainees, paediatric pain and rheumatology networks, as well as via the media and other professional communities.

Conclusion

The conclusion I made from the Fellowship was that there is no one "perfect" system at any hospital and any system needs to be specifically adapted to the institution and patient's needs. We are on the brink of an exciting movement further forward in Victoria in relation to pain management for our patients; careful strategic planning, appropriate resourcing, integration of all involved, maximising non-pharmacologic therapies, the move to make pain management mainstream and improvements in communication are all required for success. We still have a lot to learn! We can do better! The challenge is to take hold of the growing momentum and interest regarding painful conditions in children and take this opportunity to drive widespread changes in opinions, beliefs, thinking and the practices of those caring for children.

These two months were filled with space to think, much laughter, amazing travels, exponential learnings, fascinating discoveries and discussions, shared experiences, but most of all many opportunities! I have had an inspiring time and

I hope the many ideas that have sprung from this Fellowship will result in improvements in the care of children and adolescents with painful conditions. I would encourage you (or your staff, friends and others) to consider applying for a Churchill Fellowship – it is a wonderful opportunity!

Jane Munro
2003 Jack Brockhoff Foundation Winston Churchill Memorial Trust Fellow
Pain Medicine trainee, Paediatric Rheumatology Fellow, General Medical Fellow and
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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 (2003) Requirements for Multidisciplinary Pain Centres Offering Training in Pain Medicine *Bulletin March 2002, Pg 52*
- PM3 (2002) Lumbar Epidural Administration of Corticosteroids *Bulletin November 2002, pg 63*
- PS3 (2003) Guidelines for the Management of Major Regional Analgesia *Bulletin March 2003 , pg 70*
- PS38 (2004) Statement Relating to the Relief of Pain and Suffering and End of Life Decisions *Bulletin November 2004, pg 80*
- PS40 (2000) Guidelines for the Relationship Between Fellows and the Healthcare Industry *Bulletin November 2000, pg 80*
- 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 *Bulletin June 2003, pg 97*
- PS49 (2003) Statement on the Health of Specialists and Trainees *Despatched with August 2003 Bulletin*

College Professional Documents Adopted by the Faculty:

- 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 (*Adopted May 2002*)
- PS10 (2004) Guidelines on the Handover of Responsibility During an Anaesthetic (*Adopted February 2001*)
- PS15 (2000) Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery with amendment to the title to read Recommendations for the Perioperative Care of Patients Selected for Day Care Procedures (*Adopted February 2001*)
- PS18 (2000) Recommendations on Monitoring During Anaesthesia (*Adopted February 2001*)
- PS20 (2001) Recommendations for Responsibilities of the Anaesthetist in the Post-Operative Period (*Adopted February 2001*)
- PS31 (2003) Recommendations on Checking Anaesthetic Delivery Systems (*Adopted July 2003*)

Joint Faculty of Intensive Care Medicine

Deans Message

KIA ORA (Greetings),

I have just returned home from a very busy JFICM Board meeting. The capability of our present Board is impressive, and the new members have added significant strength. Board Members work extremely hard at times (in addition to their clinical responsibilities) and some have very demanding portfolios that require many hours each month. Added to this is the large contribution from the panel of examiners and the work of State Regional Committees and the NZ National Committee, especially the Chairpersons. Without exception the present Board members are a very committed and talented group of professionals who are easy to work with. As "conductor of the orchestra" this makes my duties as Dean a pleasure.

Our paid staff of three, including Carol Cunningham-Browne (Executive Officer), Andrew Coghill and Megan Freeth all work to an extremely high standard and we are very fortunate to have them working for us. Under the leadership of Carol these three support the Board Members, the Trainees and the Committees. I cannot speak too highly of their contributions.

At our October Board meeting, Rob Boots (Queensland) and John Gowardman (Tasmania) joined us. By co-opting Fellows from States not

are also encouraged to write with views and suggestions, even if they are "robust". Without exception, all communications are considered seriously and some excellent suggestions have been forthcoming.

Future Scientific Meetings

After extensive discussion, far reaching decisions have been made:

We will be holding a yearly "stand alone" JFICM scientific meeting. However, we will continue to participate in a variable fashion at the meetings of our parent bodies, ANZCA and RACP. The style for the latter will be a minimum of a half day ICM refresher course, but depending on the liaison with the regional ANZICS committees, there may be more. The main responsibility for the "refresher courses" will rest on the local JFICM Committee, with the background guidance of the Board ASM Officer. After the meeting in Auckland (May 2005 and shaping up well), the ICM content of ANZCA meetings will almost certainly reduce because of the difficulty in trying to facilitate three meetings a year, let alone involvement in ANZICS meetings.

Those who wish to be presented as Graduands may do so at any of the JFICM, ANZCA or RACP meetings. However, at the "stand alone" 2005 JFICM meeting in Sydney there will be

Committee, and the Trainee Committee and received almost universal support to allow graduands to present for their Diploma at the new JFICM meeting. However, the Board also wanted to leave the option for Graduands to present at the alternative ANZCA or RACP ASMs if they wish. Some may have a particular reason to do this especially when they may have an additional diploma such as FANZCA or FRACP. Also we are cognisant of the mixture of disciplines staffing our ICUs including many anaesthetists and physicians. However it was considered that many of our graduates have simply not presented at all in the past, because their primary interest is in ICM and their attendance has been at the relevant intensive care meetings.

ADAPT Workshops

The Medical ADAPT (Australasian Donor Awareness Program) workshops have been in existence for some years now and attendees have produced excellent feedback. The content fits within what we would regard as core curriculum material for ICM including issues around brain death, organ donation and grief. Depending on some assurances such as ease of access, and increased participation from the JFICM, we have now agreed that the Workshop should be a compulsory training requirement before the Fellowship is granted. This rule will apply prospectively to new JFICM registrants, but we would encourage all trainees (and seniors) to attend these courses as they are excellent and have been described by some as having changed their practice in a major way. The Workshop content and suitability will be reviewed regularly by the JFICM Board.

Medals

I am pleased to announce that the Board resolved to establish the "Felicity Hawker Medal" that will be awarded to a Trainee, or a Fellow within 1 year of award of the Fellowship, and who is judged to make the best contribution at the Formal Project Session held

"...the present Board members are a very committed and talented group of professionals who are easy to work with. As "conductor of the orchestra" this makes my duties ...a pleasure."

represented, we try to achieve a more useful Board. We also invite a Regional Chairman in rotation, and this time Ross Freebairn from NZ was able to attend. Most of our Regional Committees are well and active, and the Board appreciates the regular responses. Individuals

a graduation ceremony for the first time outside of the ASMs of our parent bodies. Graduands within two years of passing their Fellowship by examination are eligible for free basic registration. The Board canvassed the opinion of Regional Committees, the NZ National



as part of the JFICM Annual Scientific Meeting. There is a monetary prize attached. Dr Hawker has contributed a large amount to the Faculty affairs and this award will recognise this in a tangible way.

The Board is also looking at creating a further medal for major contributions from Fellows to JFICM affairs.

Withholding and Withdrawal of Treatment

The Board has agreed to a Joint Statement with ANZICS on this subject. The content is based on the excellent work that developed the previous ANZICS statement. It is useful to have a joint statement from the whole intensive care community and we hope that this may help when intensive care specialists have to deal with the media and official agencies. The issues around this are sometimes confusing and clearly misunderstood by many of the public including politicians. There is room for a lot of education and development of understanding within the wider community.

Christmas Greetings

In conclusion, I send Christmas and New Year greetings to all Fellows and Trainees, and thank you for your support and contributions to the affairs of the wider Fellowship.

Jack Havill

Dean

“...the "Felicity Hawker Medal" ...will be awarded to a Trainee, or a Fellow within one year of award of the Fellowship, and who is judged to make the best contribution...”





Trainee Survey

Who wants to be an Intensivist?

A synopsis of the presentation given at the ANZICS ASM in Melbourne, October 2004.

Introduction

Despite a growing number of trainees, workforce issues remain a problem for intensive care. The demand for intensive care specialists continues to outstrip supply, with the specialty being identified as undersupplied by the Australian Medical Workforce Advisory Committee (AMWAC)¹. Addressing the workforce issues in light of community and government focus on the provision of quality health care is increasingly important, with the aim of providing essential services in both major cities and regional centres.

Accordingly, the capacity to attract trainees to the specialty is of major interest. Trainees' issues in other specialties have been infrequently addressed in the past, with little information having been previously collected regarding the perceptions of our specialty by those undergoing intensive care training.

The result of recent surveys published by the Australian Medical Association (AMA)² and AMWAC³ investigating the reasons why medical graduates choose a particular specialist training program failed to adequately gauge the motives behind choosing a career in intensive care. An opportunity to assess this formally arose with the introduction of prospective registration of trainees of the Joint Faculty of Intensive Care Medicine in 2003.

Method

The plan for a survey was supported by the NSW Regional Committee, and submitted to the Board of the Joint Faculty for approval. An anonymous postal survey was compiled and distributed to all registered intensive care trainees in November 2003. Demographic information was sought. Trainees were asked to rate the influence of various factors in their reasoning behind pursuing a career in intensive care and their level of satisfaction or dissatisfaction with their training program and workplace conditions. A section for free text comments by trainees was included.

Results

372 surveys distributed yielded 190 responses (51%). The median age of respondents was 33 years (interquartile range 31-35 years). Among trainees completing the survey, a greater proportion were male (76%) and this is comparable to the total trainees' pool as at May 2004.

52% of trainees obtained their basic medical degree in Australia, 10% in New Zealand, 22% in the United Kingdom or Ireland, 7% in India, 2% in Hong Kong. 7% of trainees were from a country other than those listed.

Nearly half of all trainees (49%) had their first exposure to ICU as an RMO. Although most universities include exposure to Intensive Care Medicine in the current curricula, only 19% of current trainees recalled their first ICU exposure being at undergraduate level. 23% of trainees did not have exposure to the specialty until Registrar level.

The decision to undertake intensive care training was made as a Registrar by 49% of trainees, 31% making this decision as an RMO. Only 7% of trainees had decided on ICU as a specialty for training at undergraduate level, or in the first postgraduate year, and 11% of trainees decided to train in Intensive Care Medicine as a Senior Registrar or Fellow.

More than half of all registered trainees who responded were training in other specialties in addition to Intensive Care (53%). The majority were training in Anaesthesia (43% of trainees). 10% of trainees were also undertaking training in Emergency Medicine, and 6% through the Royal Australasian College of Physicians. A number of trainees were undertaking training in more than two specialties.

At the stage of completing the survey, 64% of trainees were "definitely intending" to complete their intensive care training, but 30% were unsure. 10 trainees did not answer the question, and 1 trainee was "definitely not" intending to complete intensive care training.

Trainees were then asked to rate their level of agreement or disagreement with a range of factors which may have influenced them to choose to train in intensive care medicine in 2003.

Factors influential in choosing to train in intensive care included:

- positive experiences during previous rotations through ICU;
- a high regard for consultants previously worked with;
- perceived standards of excellence in the practice of intensive care;
- the variety of diseases treated;
- the intellectual content of the specialty;
- the procedural aspects of the work; and
- a team approach to patient management.

Trainees were also asked about their current education and training program.

Responses indicated that trainees were, in an overall sense, satisfied with their education and training programs, particularly with respect to formal supervision, procedural teaching, and the teaching of communication skills. Where they were relatively dissatisfied with their training and education was due to lack of teaching opportunities within the same city (ie. a long course program), especially in comparison to trainees of other specialties, and the lack of time & support to develop skills in research & teaching.

The final section of the survey concerned the trainees' working environment. Trainees appeared moderately satisfied with this in an overall sense. Factors with which trainees were very satisfied included support from the medical staff of their department, as well as the nursing and allied health staff of the unit. In the workplace, trainees were dissatisfied with their level of remuneration and time available for recreational activities.



Conclusion

This is the first formal assessment of what motivates and frustrates intensive care trainees in this region. It demonstrates that training and workplace reforms are required to attract trainees more effectively to the specialty and retain them through to completion of training. Changes to training in other specialties have resulted in an increase in teaching time during working hours. This is generally not seen to be available for intensive care trainees.

Trainees made reference to comparing their teaching and training opportunities with that of other specialist trainees. Many comments were received regarding the lack of formal structured long courses available for trainees.

As for time available for social, family and recreational activities, trainees in intensive care commented upon the onerous hours of their rosters. Remuneration levels for the work they do, especially with the degree of night and after-hours work, were regarded as unsatisfactory by almost a quarter of the respondents. Many commented about the unfavorable onerous hours worked by consultants, a third of trainees regarding the working hours of consultants as being too long.

It is recognised that in 2004 the demand for intensive care services is continuing to grow. In the absence of requisite changes in the way trainees and consultants work and are remunerated relative to their peers in other specialties, the community will likely find itself without the required expertise to supervise the treatment of all critically ill patients.

E Stachowski, E Fugaccia

NSW Regional Committee, Joint Faculty of Intensive Care Medicine, Sydney, NSW, Australia

References:

1. Australian Medical Workforce Advisory Committee 1999: The Intensive Care Workforce in Australia, AMWAC Report 1999.1, Sydney.
2. Australian Medical Association 2001: Training And Workplace Flexibility Report.
3. Australian Medical Workforce Advisory Committee (2003): Career Decision Making By Doctors In Vocational Training, AMWAC Report 2003.2, Sydney.

Joint Faculty Fellowship Examinations 2005

General Examinations

| <i>April/May</i> | <i>Location</i> | <i>Date</i> |
|------------------|-------------------|-----------------|
| WRITTEN SECTION | All Major Centres | 4th April |
| ORAL SECTION | Sydney | 18th – 20th May |
| CLOSING DATE | | 7th February |

| <i>August/September</i> | <i>Location</i> | <i>Date</i> |
|-------------------------|-------------------|-----------------------|
| WRITTEN SECTION | All Major Centres | 1st August |
| ORAL SECTION | Melbourne | 14th – 16th September |
| CLOSING DATE | | 6th June |

Paediatric Intensive Care Examination

| <i>August/September</i> | <i>Location</i> | <i>Date</i> |
|-------------------------|-------------------|----------------|
| WRITTEN SECTION | All Major Centres | 1st August |
| ORAL SECTION | Sydney | 12th September |
| CLOSING DATE | | 6th June |

Closing Date for Applications

Please note that late applications to present for a Faculty Examination after the closing date for that examination will not be accepted. This ruling must also apply to documentation in support of the application. For this reason, trainees are urged to send documented evidence of training to the Faculty Executive Officer early, even before the application to present for the examination, so that any problems in documentation can be clarified before the relevant examination closing date.

LATE APPLICATION AND LATE DOCUMENTATION WILL NOT BE ACCEPTED AFTER THE CLOSING DATE FOR AN EXAMINATION

ENTRY FEE: \$1900

The examination fee is to be remitted in Australian dollars by BANK DRAFT or CREDIT CARD directly to the Faculty Office by the examination closing date together with completed Form 'G'

Please take into consideration postage delays when sending applications near to the closing date. Overseas candidates should allow extra time for applications to arrive by the closing date.



Joint Faculty of Intensive Care Medicine

Highlights From the October Board Meeting

Honour

The Board noted the award to A/Professor Tom Buckley of the Bronze Bauhinia Star in the Chief Executive Officers Honours List.

Co-option to the Board

The Board welcomed Dr Rob Boots of Queensland and Dr John Gowardman of Tasmania as co-opted representatives to the Board. Dr Ross Freebairn was present as an invited observer.

Examinations

The G.A. (Don) Harrison Medal for 2004

The Board congratulates Dr Carole Foot, of Queensland, on her award of the G.A. (Don) Harrison Medal for 2004.

Changes to the Fellowship Examination

A number of changes to the Fellowship Examination were agreed to. These include:

1. As from 2005, Fellowship Examination candidates will be permitted to directly enter the Oral Sections of the Examination at the next two scheduled examinations if they have previously passed the Written Section but failed the Examination overall. Failure at their third attempt will require that candidate to re-sit the entire examination (including the written section at their next sitting).
2. As from 2005, the format of the Fellowship Examination will be amended as follows:
 - (a) Revising the written section to two 150 minute SAQ examinations involving 15 questions in each session.
 - (b) Moving the Clinical Cold cases to the OSCE to now include 2 cold case stations and 8 other stations.
 - (c) Increasing the Hot Cases to two 20 minute sessions.
 - (d) Increasing the OSCE marks from 20 to 24.
 - (e) Increasing the Clinical Hot cases marks from 15 to 20.

- (f) Reducing the Clinical Cold cases marks from 15 to 6.
 - (g) Revising the Clinical pass mark from 15 out of 30 to 13 out of 26.
 - (h) Reducing the poor failure mark from 9 out of 30 to 8 out of 26.
3. Thus from 2005, the JFICM Fellowship Examination will consist of the following four sections:
 - (a) Written Section comprising two 150 minute SAQ examinations involving 15 questions in each session.
 - (b) Clinical section comprising two 20 minute Hot cases and two 10 minute Cold cases.
 - (c) Cross Table Viva section comprising six 10 minute tables.
 - (d) Objective Structured Clinical Examination (OSCE) section comprising ten 10 minute stations, including the two Clinical Cold cases.

Education and Training

Victorian Long Course

The Board noted that a Registrars' Lecture Series has commenced in Victoria. This course runs from exam to exam and covers major topics over a 12-15 week period at ANZCA House. A Practical Skills series is to be run conjointly.

Guidelines for the Selection of Trainees

The Board revised its policy on this issue which promotes a best practice framework to selection standards in a transparent and consistent manner.

Developing a Comprehensive Curriculum

The Education Committee is establishing a working group which will commence the development of a curriculum, expanding on the current Objectives of Training.

Trainee Survey

The Education Committee also noted the results of the recent Trainee Survey, a summary of which is published elsewhere in the Bulletin.

Representation of Trainees on Regional and National Committees

The Regulations were amended to allow Regional and National Committees to have the power to co-opt a trainee representative.

Training Committee

The Training Committee has approved a number of diagrams which outline the minimum requirements for completing conjoint training in intensive care and anaesthesia, medicine or emergency medicine. These will be available on the website. The Committee has also approved a revised registration form and basic training form. A 'Notice of Assessment' will also be implemented, which will be an automatic summary of training available to trainees.

Medical ADAPT Course

The Board resolved that all trainees registering with the training program from 1st November 2004, will be required to complete the Medical ADAPT Course before being eligible for admission to Fellowship. This course covers issues surrounding brain death, donor management and grief.

The Felicity Hawker Medal

The Board agreed to award a prize to the Trainee, or Fellow within one year of award of the Diploma of Fellowship, who is judged to make the best contribution at the Formal Project session held as part of the JFICM Annual Scientific Meeting. The Prize will take the form of a Medal and be entitled the Felicity Hawker Medal.

Units accredited for anaesthesia training

Following discussions with ANZCA, anaesthesia trainees will be able to undertake 'other' training in Units that are not accredited for core training, but which are suitable for training if approved by the Censor. This will not count however towards the three month compulsory requirement for intensive care, which must be undertaken in a core unit. Basic training may also be permitted for intensive care trainees. It is thought that some rural units may be appropriate for this kind of training.



Assessment of Overseas Trained Specialists

The Board has approved a revision of this document to include the changes to the training program and exam, and the ability for an OTS with a primary medical degree from Australia or New Zealand to utilise the assessment process.

Professional

Policy Documents

The Board approved and endorsed the following new and existing policy documents and joint statements:

PS-38 Statement relating to the Relief of Pain and Suffering and End of Life Decisions

IC-14 Joint Statement (with ANZICS) on Withholding and Withdrawing Treatment

IC-15 Recommendations on Practice Re-entry for an Intensive Care Specialist

Rural Intensive Care

The Board reviewed the Terms of Reference of the Conjoint Rural Committee which will shortly meet for the first time.

Critical Care and Resuscitation

The Board supported the decision that the Journal should be circulated at no cost to all trainees who have paid their yearly training fee.

ACCC

The Board have prepared a response to the ACCC on issues relating to accreditation of hospitals and training programs, trainee selection processes and assessment of overseas specialists, following its request for an update on these issues.

Finance

Unpaid Subscriptions

The Board resolved that as from the 2006 subscription, Fellowship of JFICM may be withdrawn by a resolution of the Board at their first meeting following 24 months of non-payment of a subscription (usually February, 26 months after the subscription was due and payable).

Fees

The Board approved the following fees for 2005:

1. That the Faculty Registration Fee for trainees for 2005 be increased from \$300 to A\$350, payable to the Melbourne Office.
2. That the Annual Basic Training Fee for 2005 remain as follows:
Australia and Hong Kong - A\$350
New Zealand - NZ\$379.47 (Inc. NZ GST)
(payable to NZ office)
3. That the Annual Advanced Training Fee for 2005 remain as follows:
Australia and Hong Kong - A\$925
New Zealand - NZ\$1002.89 (Inc. NZ GST)
(payable to NZ office)
4. That the Conditional Advanced Training Fee for 2005 remain as follows:
Australia and Hong Kong - A\$350
New Zealand - NZ\$379.47 (Inc. NZ GST)
(payable to NZ office)
5. That the Annual Administration Fee for 2005 remain at A\$150.
6. That the Faculty Examination Entry Fee for 2005 remain at A\$1900 and must be remitted to the Melbourne Office.
7. That the fee for non-Fellows' participation in the Maintenance of Professional Standards Program be A\$500 +GST.
8. That the Faculty Annual Subscription for 2005, due and payable on 1st January 2006, remain at A\$990 +GST where applicable, payable to the Melbourne Office.
9. That the Overseas Trained Specialist Assessment Fee for 2005 remain at A\$1300 plus GST.
10. That the Occupational Training Visa processing fee remain at A\$150.
11. That the Area of Need Assessment fee be increased to \$1300 plus GST.
12. That the fee for AON Site Visit be \$1500 + GST plus reasonable travel and accommodation costs when there is a requirement for a reviewer to attend an on-site review.

Continuing Education

New Fellows Conference

The Board appointed the following representatives to the New Fellows Conference, to be held in New Zealand in May 2005:

| | |
|----------------------|-------|
| Dr Jeremy Cohen | (Qld) |
| Dr Neil Orford | (Vic) |
| Dr David Collins | (NSW) |
| Dr Peter Dzendrowskj | (NZ) |
| Dr Louise Trent | (NZ) |

Dr Neil Matthews was nominated as the Board member in residence.

Future of JFICM involvement in Annual Scientific Meetings

The Board resolved that:

1. The Board endorses a graduation ceremony to be held at the stand alone JFICM ASM 2005 in Sydney.
2. Graduands will have the alternative option to present at the ceremonies of other parent college graduation ceremonies for the award of their JFICM Diploma.
3. Graduands will only be able to present once for their JFICM Diploma.
4. Graduands presenting for award of the Fellowship by Examination within two years of admission will be eligible for basic complimentary registration to the meeting.

The JFICM will continue to provide an intensive care program to the ASM's of ANZCA and RACP.

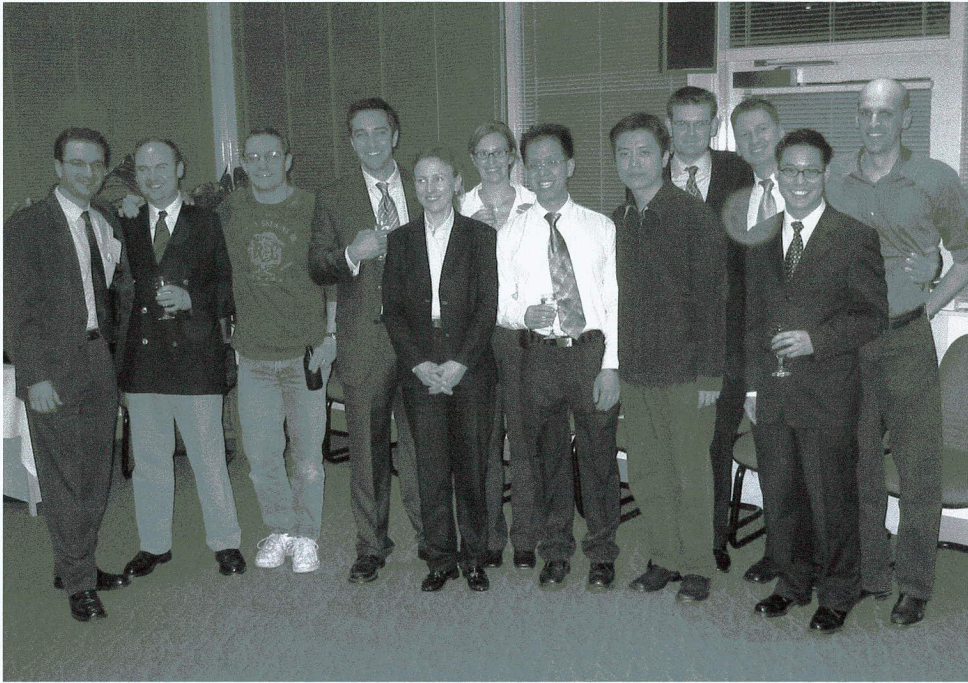
INTERNAL

Strategic Meeting

The Board agreed to hold a strategic planning meeting in October 2005.



Joint Faculty of Intensive Care Medicine July/September 2004 Fellowship Examination



Successful candidates of the JFICM Fellowship Examination, September 2004

From left: Drs Roberto Citroni, Michael Scully, David Pilcher, George Alvarez (OTS), Ivana Kliman, Sarah Wesley, Winston Cheung, Dominic So, Stewart Moodie, Simon Hockley, Stephen Lam & Matthew Maiden.

Absent: Drs Stuart Wilson & Alex Wurm.



Successful candidates of the Paediatric Intensive Care Fellowship Examination, September 2004

From left: Dr Stephen Williams & Dr Peter Praeger



Chairman of Examinations Dr Peter Morley congratulates Dr Neil Matthews on his retirement from the Panel of Examiners following 12 years of service as an Intensive Care examiner



Back Row: Drs Megan Robertson, Peter Morley, Rob Boots, John Myburgh, Steve Edlin, Ray Raper, Ross Freebairn, Jonathan Gillis, Exec Officer Carol Cunningham-Browne

Front Row: Drs Neil Matthews, Vernon van Heerden, Richard Lee, Jack Havill, Garry Phillips, and David Ernest.



Presentations



A/Prof. Jack Havill (Dean) presenting the immediate past Deans Portrait (Dr Neil Matthews)



Dr Felicity Hawker was acknowledged for 12 years service as an examiner.

“The Board recognises the contribution of Drs Felicity Hawker and Graeme Hart upon retirement from the Panel of Examiners...”



Dr Graeme Hart was also acknowledged for 12 years service as an examiner.



ANZICS Gift (painting)

“At the recent ANZICS Board meeting in Melbourne, the Dean presented President Dr David Fraenkel with a gift to commemorate the move of ANZICS House to their new home in Ievers Terrace in Carlton. The painting is by Melbourne artist Anthony Day entitled “Goulburn Sunlight”.



Examiner's Dinner September 2004

From left: Prof Andrew Bersten, Kylie and Andrew Coghill, Dr Geoff Clarke



JFICM Staffers Megan Freeth and Andrew Coghill put together a display for delegates at the recent ANZICS ASM in Melbourne.



Honour

Professor Thomas Anthony Buckley

Professor Thomas Anthony Buckley has been awarded the Bronze Bauhinia Star by the Hong Kong SAR Government. The prestigious award was "in recognition of his distinguished and valuable contribution in the clinical management of the Severe Acute Respiratory Syndrome patients in the Intensive Care Unit and infection control."

Professor Buckley studied medicine at the University of Otago in New Zealand before specialising in anaesthesia and intensive care medicine, training in New Zealand, England and Hong Kong. He is currently Chief of Service and Associate Professor in the Department of Intensive Care, Chinese University of Hong Kong and Princess Margaret Hospital.

In March 2003 at the outbreak of the SARS epidemic in Hong Kong, Professor Buckley was working at the Prince of Wales Hospital where several staff members had developed features of atypical pneumonia. Professor Buckley began what he thought was a routine week of consultant call on Wednesday 12th March but by the end of the week, it was obvious the Prince of Wales Hospital was facing a major crisis.

His role involved patient management and staff welfare (both physical protection and psychological well being) while liaising with hospital administration as to an appropriate level of personal protection for what at that stage was an unknown infectious entity. Over the next 7-10 days, hospital closure and suspension of all clinical services except those involving SARS patients occurred as the crisis was brought under control.

As the disease spread back into the community other hospitals started to admit patients and towards the end of March 2003, Princess Margaret Hospital was designated to receive all SARS patients. Very quickly Princess Margaret Hospital's ICU was overwhelmed and almost 40% of the ICU's medical and nursing staff contracted SARS including the Chief of Service.

At the beginning of April, Professor Buckley was asked to go to the Intensive Care Unit of Princess Margaret Hospital to take charge of clinical management and infection control within the ICU. Following the introduction of enhanced infection control measures, no further staff within the ICU contracted SARS.



Through the contributions of many health care workers the epidemic was brought under control and many lessons have been learnt which will enable the world to better face similar challenges in the future.

The Bronze Bauhinia Star awarded to Professor Buckley publicly acknowledges his pivotal role in the management of the SARS epidemic in Hong Kong. His dedication and professionalism under such extreme circumstances and at considerable personal risk should serve as an inspiration to all intensivists.

On behalf of all Fellows and trainees, the Board wishes to congratulate Professor Buckley on receiving this honour and his outstanding achievements during the SARS crisis. May we all maintain this high standard of professionalism that has now been set.

Mops Update

The JFICM Maintenance of Professional Standards Program continues to grow, with over 270 Fellows and 35 non-Fellows now registered with the program. The MOPS manual, recently updated this year, explains the objectives and key elements of the program, and also provides examples of activities which can be included in credit points allocation.

Participation in a MOPS program is mandatory for the following groups:

1. intensivists registered in New Zealand
2. intensivists registered in New South Wales
3. members of the JFICM Panel of Examiners

Participants need to submit their annual returns for MOPS for the 2004 year by the end of February 2005. Annual returns received after this time will be acknowledged but will be designated as late.

Annual audits of MOPS returns will be commencing early next year. This will require 5% of participants each year to verify the accuracy of their returns by providing relevant documentation. The randomly selected participants to be audited will be contacted in early 2005.

MOPS Online Diary

Fellows are encouraged to register for this convenient online service which allows each participant to view their diary, input points directly from their desktop, and finally submit their annual return to the Joint Faculty with the

touch of a button. Even Fellows who prefer to use the Paper Diary for accruing points will enjoy the benefits of the simple and time-efficient electronic submission of their annual return.

In order to register, participants first need to obtain a Medeserv Intouch User password via the JFICM website and then contact Megan Freeth at the JFICM office to register as an online service user.

Information regarding all of these services is available in the Members Section of the Website at www.jficm.anzca.edu/members/mops/index.htm

If you have any suggestions or questions regarding the Program, I would be happy to receive them.

Megan Robertson
MOPS Officer



Trainee Committee

A Trainee Committee has recently been established for the Joint Faculty of Intensive Care Medicine. The purpose of the committee is to provide feedback from trainees to the Education Committee on broad education and training matters and also to provide trainees with a mechanism for approaching the Joint Faculty with any matters of interest to trainees and provide a more relevant and immediate form of action. This committee was established following recommendations from the AMC, which suggested a systematic feedback was needed for trainees. Each state of Australia is represented on the committee and there is a representative from New Zealand. The committee has an elected chairperson.

The members of the committee are:

- Dr Leo Nunnink (QLD)
- Dr Amy C-M. Bertinelli (NZ)
- Dr Celia M. Bradford (NSW - chair)
- Dr Stephen W. Lam (SA)
- Dr Stuart Baker (WA)
- Dr Peter C. Rogers (TAS)
- Dr Matthew Piercy (VIC – deputy chair)

The committee meets four times a year. The issues arising concern registrar training,

for example rostering and hours of work, and education, for example teaching and exam preparation. The chair of the committee liaises directly with the Education committee. This allows concerns to be addressed. The chair has full voting rights on the Education Committee.

Celia Bradford
JFICM, NSW Chair



Trainees are encouraged to voice any concerns regarding education and training to their state representative. Feedback from training registrars is invited via email link to each committee member. Email addresses are available from the Joint Faculty.

Joint Faculty of Intensive Care Medicine

Changes to the Regulations

At its recent meeting, the Board of Faculty resolved:

That under the Regulations for Regional and National Committees, Regulation 4.16 be amended to read:

- 4.16 The Committee will have the power to co-opt a trainee representative. This representative will attend meetings but will have no voting rights.

That new Regulations be implemented for the award of the Felicity Hawker Prize, being the award for the trainee or new Fellow who is judged to make the best contribution at the Formal Project Session held as part of the Annual Scientific Meeting:

7.4.9 Formal Project

To satisfy the requirements of advanced training, a Formal Project must be completed as detailed in the document 'Formal Project Requirements'.

- 7.4.9.1 The Prize shall be awarded to the Trainee, or Fellow within 1 year of award of the Diploma of Fellowship, who is judged to make the best contribution at the Formal Project Session held as part of the Annual Scientific Meeting. This Session will only be open to Trainees or Fellows to present material related to their Formal Project as defined in the Faculty's Policy Document.

- 7.4.9.2 The Prize will take the form of a medal.

- 7.4.9.3 Eligibility for the Prize will be limited to current or past registered trainees in Intensive Care who fulfil the criteria set out in Regulation 7.4.9.

- 7.4.9.4 The Board shall, from time to time, appoint three adjudicators for the Prize in addition to the Chairman of the Education Committee who will Chair the Adjudication Panel. This task may be delegated to the Chairman of the ASM Committee. Adjudicators shall have the power to co-opt at the meeting should one or more of the adjudicators be unable to attend.

- 7.4.9.5 If, in the opinion of the adjudicators, no presentation attains a sufficiently high standard, the Prize will not be awarded.

- 7.4.9.6 If necessary, the Scientific Convenors will pre-select presentations for the Formal Project Session on the basis of the submitted abstracts. Presentations will take the form of a ten minute paper which must be based on the topic of the Trainee's Formal Project. Performance during five minutes of discussion will also be considered by the adjudicators.

- 7.4.9.7 That the title be "The Felicity Hawker Medal".

Admission to Fellowship of the Joint Faculty of Intensive Care Medicine

The following have completed all requirements for admission to Fellowship by examination:

| | |
|------------------------------------|-----------|
| Michael Francis Hugh Lindley-Jones | Qld |
| Charles Mashonganyika | Qld |
| David James Ritchie Morgan | WA |
| Stuart Baker | WA |
| Daniel Vincent Collins | Ireland |
| Roslyn Maree Purcell | Qld |
| Chai Rick Soh | Singapore |

Admission to Fellowship by OTS Assessment, under Regulation 5.2:

| | |
|----------------|-----|
| George Alvarez | NSW |
|----------------|-----|



Policy Document: IC-14 (2004)

Australian and New Zealand Intensive Care Society ABN 81 057 619 986
and Joint Faculty of Intensive Care Medicine

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

Royal Australasian College of Physicians

Statement on Withholding and Withdrawing Treatment

1. While intensive care treatment may be life-saving for patients with reversible critical illness, medical intervention can cause considerable suffering for patients and their families with little or no benefit. The withholding or withdrawing of specific treatments is appropriate in some circumstances.
2. The ethical principles that inform medical practice include respect for human life and dignity, patient autonomy, justice, beneficence and non-maleficence. These principles are sometimes in conflict. Resolution of such conflict depends on the particulars of the situation (including the likely patient outcome), and the philosophical viewpoints of those involved.
3. The benefits of intensive care treatment include the prolongation of life and the minimisation of disability. The potential benefits of treatment must be weighed against the burden, which might include pain, suffering, and compromise of dignity. In most situations, assessment of the potential benefits and burdens of treatment is based on probability rather than certainty.
4. Communities have the right to regulate access to public resources, even if this entails the non-provision of potentially beneficial healthcare.
5. There is no obligation to initiate therapy known to be ineffective, nor to continue therapy that has become ineffective.
6. Any consideration of the withholding or withdrawing of treatment should take into account the nature and probability of all potential outcomes together with any known views of the patient concerning an acceptable quality of life and an acceptable burden of treatment. The patient's views should be ascertained directly if the patient is competent. For an incompetent patient, their likely views may have been expressed in an 'advance directive' or may be obtainable from the next-of-kin, the primary medical practitioner or another patient confidante.
7. The competent adult patient is entitled to withhold or withdraw consent for any treatment at any time, even if this may shorten their life. When such decisions are under consideration, the doctor has a responsibility to assess the competence of the patient and to provide all the information required to fully inform such a decision.
8. Consideration of the withdrawal or limitation of specific treatments may be initiated by the patient, the patient's family and friends, or healthcare professionals. Any decision to withdraw or limit treatment first requires the consensus of the intensive care team and the primary medical or surgical team. Dissent should be resolved over time with further discussion.
9. Once medical consensus is achieved, the concurrence of those with legal authority and/or the next-of-kin should be sought. Adequate time should be allowed for this process. The factors taken into account in reaching the medical consensus should be fully explained and it should be made clear that the burden of end-of-life decision-making for an incompetent patient does not rest solely with the next-of-kin. Where there is persistent disagreement between the healthcare team and the next-of-kin, it may be appropriate to involve non-medical professionals, clinical ethics committees or legal processes.
10. All decisions regarding the withdrawing or withholding of treatment should be documented in the clinical record. The documentation should include the basis of the decision, and should identify those amongst whom the consensus has been reached. Significant treatments that are to be withheld or withdrawn and those to be continued should be specifically documented.
11. When any or all aspects of active treatment are to be withheld or withdrawn, appropriate consideration should be given to an alternative care plan ('comfort care'), focusing on dignity and comfort. This is especially applicable when death is expected. The use of medication for control of patient symptoms in this setting is appropriate, even if this may shorten life.
12. Withholding treatment and withdrawing treatment are legally and ethically equivalent. Decisions to withhold treatment should involve the same principles and processes as decisions to withdraw treatment.
13. When death follows the withdrawal or withholding of treatment in accordance with the principles outlined in this statement, the cause of death is the medical condition that necessitates the treatment that is withheld or withdrawn.
14. To facilitate appropriate processes in the withholding and withdrawing of treatment in critically ill patients, guidelines should be developed locally in accordance with the principles outlined in this document. The development of such guidelines should also involve consideration of all relevant local factors including organisational and legal issues, as well as religious, ethnic, and cultural diversity.

*Adapted from the ANZICS
Statement Promulgated September 2003
Promulgated: October 2004
Date of current document: October 2004*

This is a position statement of ANZICS and JFICM, and is not intended to be legal or professional advice, or to be relied on in any particular case. A decision to withhold or withdraw treatment may have serious legal implications, which should be addressed having regard to the particular case and individual circumstances.

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

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Policy Document: IC-15 (2004)

Joint Faculty of Intensive Care Medicine

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

Recommendations on Practice Re-Entry for an Intensive Care Specialist

1. Introduction

The Joint Faculty of Intensive Care Medicine (JFICM) considers it essential that Intensive Care specialists should upgrade their knowledge and clinical skills before returning to clinical practice after a prolonged period of absence. This is regardless of the reasons for such prolonged absence (such as family commitments, practice in another area of medicine, practice overseas in a volunteer capacity, or a long period of illness).

JFICM considers that in such circumstances, the specialist should be advised and encouraged to develop an agreed "retraining" or "refreshment of knowledge and skills" program before re-entering independent specialist clinical practice.

2. JFICM Practice Re-Entry Program

2.1 The program requires supervised experience in an Intensive Care Unit for a duration that is appropriate for the participant's circumstances, as agreed between the specialist and the Censor. The duration of supervised practice would usually be at least four weeks for every year of absence from Intensive Care clinical practice, up to a maximum period to be determined by the Censor.

2.2 This program is an educational service by JFICM for Intensive Care Specialists wishing to re-enter intensive care practice after a significant absence (eg. 24 months) from practising intensive care medicine. It involves participation in a program that offers a renewal of experience in current intensive care practice.

2.3 The program requires that the specialist submit an individual program for prospective approval by the Censor. Essential features of the program should include:

2.3.1 Nomination of the department in which the specialist wishes to undertake the Practice Re-entry Program; and

2.3.2 provision of details of the clinical experience to be undertaken, and

2.3.3 an endorsement of the program and its duration by the Director of the nominated department.

2.4 At the completion of the program, providing that the Director of the Department confirms in writing that the participant has satisfactorily completed the program, the Censor will endorse the participant as having satisfactorily completed a retraining program.

3. JFICM recognises that the circumstances of each specialist required to follow this process will vary, and that the program should be tailored to the individual.

4. The process described above is distinct from the Professional Practice Review component of the Maintenance of Professional Standards Program, and distinct from any process involving assessment of a specialist's practice at the request of a Medical Board, Council or Health Authority.

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.

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JFICM website: www.jfcm.anzca.edu.au

Supervisors of Training in Intensive Care

The following appointments were ratified by the Board of Faculty:

Dr Sathyajith Velandy Koottayi
Western Hospital, Vic

Dr John Gowardman
Launceston General Hospital, Tas

Dr Stephen Nolan
Blacktown Hospital, NSW

Dr Seton Henderson
Christchurch Hospital, NZ



Joint Faculty of Intensive Care Medicine

Policy Documents

- IC-1 (2003) Minimum Standards for Intensive Care Units Bulletin August 2003, pg 69
- IC-2 (2000) The Duties of an Intensive Care Specialist in Hospitals Accredited for Training in Intensive Care Bulletin November 2000, pg 53
- IC-3 (2003) Guidelines for Intensive Care Units seeking Accredited for Training in Intensive Care Medicine Bulletin November 2003, pg 61
- IC-4 (2000) The Supervision of Vocational Trainees in Intensive Care Bulletin March 2000, pg 57
- 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 (2002) Statement on the Ethical Practice of Intensive Care Medicine Bulletin November 2002, pg 57
- IC-10(2003) Minimum Standards for Transport of Critically Ill Patients Bulletin March 2003, pg 29
- IC-11 (2003) Guidelines for the In-Training Assessment of Trainees in Intensive Care Medicine Bulletin November 2003, pg 64
- 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
- IC-14(2004) Statement on Withholding and Withdrawing Treatment Buletin November 2004, pg 66
- IC-15(2004) Recommendations on Practice Re-Entry for an Intensive Care Specialist Bulletin November 2004, pg 67
- PS38(2004) Statement Relating to the Relief of Pain and Suffering and End of Life Decisions Bulletin November 2004, pg 80
- PS39(2003) Minimum Standards for Intrahospital Transport of Critically Ill Patients Bulletin June 2003, pg 90
- PS40(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
- PS49(2003) Guidelines on the Health of Specialists and Trainees Bulletin August 2003, pg 88



Professional Document: Review PS10 (2004)

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

Guidelines on the Handover of Responsibility During an Anaesthetic

1. Introduction

During an anaesthetic, the major responsibility of the anaesthetist is to provide care for the patient. This requires the continuous presence of an anaesthetist. In certain circumstances, it is necessary for the anaesthetist to hand over that responsibility to an anaesthetic colleague. Such handovers will not compromise patient safety provided that appropriate procedures are followed. In prolonged anaesthetics, handover may be advantageous to the patient by preventing undue fatigue of the primary anaesthetist.

Temporary relief of the Anaesthetist

This is necessary when the primary anaesthetist must leave the patient but will return to resume management of the patient.

Permanent handover of responsibility for care

This is necessary when the primary anaesthetist must leave the patient under the care of another anaesthetist for the remainder of the anaesthetic.

2. Protocol for transfer of responsibility

The primary anaesthetist must be satisfied as to the competence of the relieving anaesthetist to assume management of the case AND must only hand over responsibility at a time when the clinical status of the patient is stable and no potential adverse events are likely to occur.

The relieving anaesthetist must be willing to accept responsibility for the case and must have had all facts relevant to the safe management of the patient adequately explained.

The following matters must be considered by both the primary and the relieving anaesthetists:

untoward events and any foreseeable problems plus the plans for further intraoperative and postoperative management.

- 2.3 The current state of the surgical procedure and its implications for the management of anaesthesia.
- 2.4 Observations of the patient according to College Professional Document PS18 Recommendations on Monitoring During Anaesthesia as shown by the anaesthetic record.
- 2.5 A check to ensure correct functioning of the anaesthesia delivery system, monitoring devices in use and any other equipment which is interfaced with the patient.
- 2.6 Notification of the handover to the operating surgeon and to the consultant anaesthetist (in the case of a trainee).
- 2.7 In the case of a temporary relief, the relieving anaesthetist should not change the anaesthetic management substantially without conferring with the primary anaesthetist, except in an emergency AND the primary anaesthetist must be available to return at short notice.

College Professional Documents

College Professional Documents are progressively being coded as follows:

- TE** Training and Educational
- EX** Examinations
- PS** Professional Standards
- T** Technical

Policy – defined as ‘a course of action adopted and pursued by the College’. These are matters coming within the authority and control of the College.

Recommendations – defined as ‘advisable courses of action’.

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

Statements – defined as ‘a communication setting out information’.

This document is intended to apply wherever anaesthesia is administered.

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Promulgated: 1985

Reviewed: 1991, 1994, 1999

Date of current document: Oct 2004

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Professional Document: Review PS38 (2004)

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

Statement Relating to the Relief of Pain and Suffering and End of Life Decisions

ANZCA's Mission Statement is "To serve the community by fostering safety and quality patient care in anaesthesia, intensive care and pain medicine".

ANZCA Council and the Boards of Faculties:

1. support the concept of death with dignity and comfort, and the right of terminally ill patients to receive expert palliative care. They further support the provision of adequate pain relief and treatment of other symptoms to relieve suffering in the terminally ill. Relief of pain and suffering and not the death of the patient is the primary intent.
2. recognise that there are many patients with severe pain associated with non-terminal cancer, or with conditions other than cancer, who have to suffer for prolonged periods because of ineffective treatment of the underlying disease. They are further committed to the relief of pain and suffering in such patients in order to restore quality of life, and to minimise the risk of such patients seeking to end their life.
3. respect the right of mentally competent patients to decline treatment or to request treatment to be withdrawn, even if such treatment may be life saving.
4. do not support the institution or continuation of medical interventions which offer no benefit to the patient.
5. do not support the application of medical interventions in which the primary intent is to end the life of the patient.
6. respect the individual beliefs and rights of Fellows and patients.

Associated Document: PS45 – Statement on Patients' Rights to Pain Management

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 Date of current document: Oct 2004

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 JFICM Website: <http://www.jficm@anzca.edu.au/>



Australian and New Zealand College of Anaesthetists

Professional Documents

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

- TE1 (2003) Recommendations for Hospitals Seeking College Approval for Vocational Training in Anaesthesia *Despatched with August 2003 Bulletin*
- TE2 (2003) Policy on Vocational Training Modules and Module Supervision *Despatched with August 2003 Bulletin*
- TE3 (2003) Policy on Supervision of Clinical Experience for Vocational Trainees in Anaesthesia *Despatched with August 2003 Bulletin*
- TE4 (2003) Policy on Duties of Regional Education Officers in Anaesthesia *Despatched with August 2003 Bulletin*
- TE5 (2003) Policy for Supervisors of Training in Anaesthesia *Despatched with August 2003 Bulletin*
- TE6 (2000) Guidelines on the Duties of an Anaesthetist *Bulletin July 2000, pg 86*
- TE7 (1999) Secretarial and Support Services to Departments of Anaesthesia *Bulletin November 1999, pg 69*
- TE8 (2003) Guidelines for the Learning Portfolio for Trainees in Anaesthesia *Despatched with August 2003 Bulletin*
- TE9 (1999) Quality Assurance *Bulletin June 1999, pg 94*
- TE10 (2003) Recommendations for Vocational Training Programs *Despatched with August 2003 Bulletin*
- TE11 (2003) Formal Project Guidelines *Bulletin November 2003, pg 92*
- TE13 (2003) Guidelines for the Provisional Fellowship Program *Despatched with August 2003 Bulletin*
- TE14 (2001) Policy for the In-Training Assessment of Trainees in Anaesthesia *Bulletin November 2001, pg 84*
- TE17 (2003) Policy on Advisors of Candidates for Anaesthesia Training *Despatched with August 2003 Bulletin*
- TE18 (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 (2003) Recommendations on the Pre-Anaesthesia Consultation *Bulletin November 2003, pg 87*
- PS8 (2003) Guidelines on the Assistant for the Anaesthetist *Bulletin November 2003, pg 89*
- PS9 (2001) Guidelines on Conscious Sedation for Diagnostic, Interventional Medical and Surgical Procedures *Bulletin June 2001, pg 88*
- PS10 (2004) Guidelines on the Handover of Responsibility During an Anaesthetic *Bulletin November 2004, pg 79*



- PS12 (2001) Statement on Smoking as Related to the Perioperative Period *Bulletin November 2001, pg 79*
- PS14 (1998) Guidelines for the Conduct of Major Regional Analgesia in Obstetrics *Bulletin November 1998, pg 81*
- PS15 (2000) Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery *Bulletin November 2000, pg 75*
- PS16 (2001) Statement on the Standards of Practice of a Specialist Anaesthetist *Bulletin November 2001, pg 81*
- PS18 (2000) Recommendations on Monitoring During Anaesthesia *Bulletin November 2000, pg 78*
- PS19 (2001) Recommendations on Monitored Care by an Anaesthetist *Bulletin November 2001, pg 82*
- PS20 (2001) Recommendations for Responsibilities of the Anaesthetist in the Post-Operative Period *Bulletin November 2001, pg 83*
- PS21 (2003) Guidelines on Conscious Sedation for Dental Procedures *Bulletin June 2003, pg 93*
- PS24 (2004) Guidelines on Sedation for Gastrointestinal Endoscope Procedures *Bulletin August 2004, pg 66*
- PS26 (1999) Guidelines on Providing Information about the Services of an Anaesthetist *Bulletin November 1999, pg 63*
- PS27 (2004) Guidelines for Fellows who Practice Major Extracorporeal Perfusion *Bulletin February 2004, pg 66*
- 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 (2003) Recommendations on Checking Anaesthesia Delivery Systems *Bulletin August 2003, pg 85*
- PS37 (2004) Statement on Local Anaesthesia and Allied Health Practitioners *Bulletin February 2004, pg 69*
- PS38 (2004) Statement Relating to the Relief of Pain and Suffering and End of Life Decisions *Bulletin November 2004, pg 80*
- PS39 (2003) Minimum Standards for Intrahospital Transport of Critically Ill Patients *Bulletin June 2003, pg 90*
- PS40 (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 (2004) Recommendations for Training and Practice of Diagnostic Perioperative Transoesophageal Echocardiography in Adults *Bulletin February 2004, pg 70*
- PS47 (2002) Guidelines for Hospitals Seeking College Approval of Posts for Vocational Training in Diving and Hyperbaric Medicine *Bulletin November 2002, pg 82*
- PS48 (2003) Statement on Clinical Principles for Procedural Sedation *Bulletin June 2003, pg 97*
- PS49 (2003) Guidelines on the Health of Specialists and Trainees *Bulletin August 2003, pg 89*
- PS50 (2004) Recommendations on Practice Re-entry for a Specialist Anaesthetist *Bulletin February 2004, pg 73*