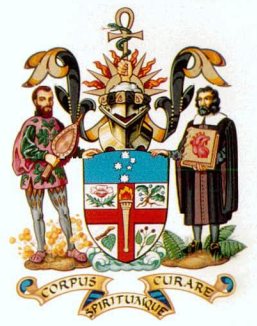


bulletin



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

VOL 13 NO 3

AUGUST
04

Intercollegiate Forum Report

Law Reports

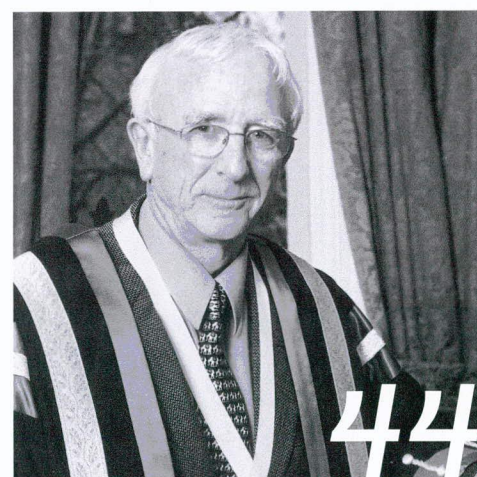
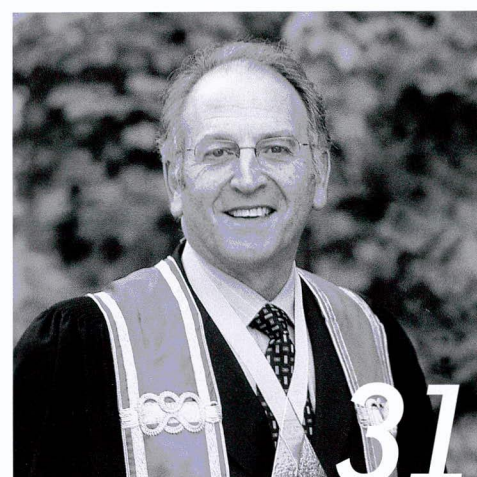
***JFICM Regional/National Committee
Annual Reports***

**Welcome to the
New-look Bulletin**



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

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 Professor Michael Cousins
 Associate Professor Kate Leslie
 Dr Mike Martyn
 Professor Garry Phillips
 Mr Eddie Dean

The Bulletin

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

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Michael Cousins AM

President's Message

A New Public Face for ANZCA House

I have been told by many people, including those advising me about the development of the ANZCA Foundation, that ANZCA needs to develop its image in the public and government forum in a much more effective way. As one part of the strategy to achieve this aim, an exciting contemporary display is being developed in the foyer of ANZCA House. The main part of the display will be in the form of a photographic mural which will represent a wide range of the work of Fellows, using very high quality photographs which have been obtained from various hospitals over the last few weeks. We have been advised "to let the pictures tell the story" and to use only a minimal number of subtly presented overlay headings. The display will cover anaesthesia, intensive care medicine and pain medicine. The contents of the mural were developed by first asking Fellows from the three key areas to write a concise description of the clinical, teaching and research work of the area. "Storyboards" were then developed to guide our design company as to the type of clinical scenarios that could be photographed

We anticipate that all of the work, including mounting the photographic and plasma screen display, will be completed by the end of September.

A follow on project that will draw upon materials from the above will be the preparation of a quality booklet that will be used for promotion of ANZCA's work with politicians, the media, the general public and potential donors such as those who will be approached by the ANZCA Foundation.

Fellows in Melbourne will be aware that many different specialty bodies are now using the excellent facilities of the ANZCA House Auditorium. We frequently have meetings of many sub-specialties within the RACP, with other specialty bodies also using this facility. Thus, it is important that we have an up-to-date presentation of the wide spectrum of work of the College.

OTS - AON Federal Government Program

In the last issue of this Bulletin I reported on the

information to enable a rigorous evaluation to be made. We are waiting to receive feedback from the Federal Government on the key issues that I indicated in my last message were of the utmost importance to this OTS - AON Program. We will ensure that these issues receive appropriate attention.

Nurse Practitioners

This continues to be a topic that occupies considerable time and attention. The ANZCA National Committee in New Zealand is working closely with the NZSA and I believe the steps which have been taken to date are entirely appropriate and the work has been carried out in a very effective way. However the 'Draft Scopes of Practice' for Nurse Practitioners has now been published by the Nursing Council of New Zealand and a meeting has been arranged for representatives of the ANZCA National Committee in New Zealand and the NZSA to meet with the Nursing Council to clarify the proposed details of the 'Scopes of Practice' which are intended by the Nursing Council.

The main concern for anaesthesia is that the 'Scopes of Practice' is so wide that it appears to be almost identical to the 'Scopes of Practice' for medical practitioners in New Zealand. This would appear to raise serious issues about delineation of responsibilities for patient care and the suitability for nurses to safely perform duties in areas that have previously required long periods of education and training within the context of a specialist medical training program. All of the work carried out by ANZCA and the NZSA in this area has been carefully evaluated and approved.

Intercollegiate Forum on Pain Medicine

This most successful Forum was held at ANZCA House on Friday, 9 July 2004. No less than 12 separate specialty bodies attended the Forum, including the current five specialities that make up the Board of the Faculty of Pain Medicine. A detailed report on this Forum is given elsewhere in this Bulletin. However on behalf

"...I would like to thank all the participants for their excellent contributions to this Forum which will undoubtedly lead to the further positive development of the field of Pain Medicine."

In order to get our message across. All of the photographic work has now been completed and the editing process has now commenced.

A second part of the display will be a plasma screen which will draw on video material that was obtained during the photographic shoot described above. High quality video material has also been obtained from television programs on various aspects of the College's work as well as videos contributed by Fellows. The plasma screen visual display will be capable of being used with overlaid words or with accompanying sound.

Federal Government OTS - AON Program. I can now report that the OTS Committee has completed its work, with major input from the College's Director of Professional Affairs, in developing a template for assessing overseas qualifications in the context of the OTS - AON Federal Government Program. The template is extremely detailed and covers every aspect of the ANZCA Training Program, to enable us to evaluate the comparability or otherwise of other programs. Council has now approved this template and work is proceeding in evaluating U.K. qualifications for which we have sufficient



of all College Fellows, and particularly the Fellows of the Faculty of Pain Medicine, I would like to thank all the participants for their excellent contributions to this Forum which will undoubtedly lead to the further positive development of the field of Pain Medicine. I would particularly like to thank Professor Richard Larkins AO, Vice Chancellor of Monash University, for opening the Forum and setting the scene for the rest of the day with some very pertinent comments. The Fellows of ANZCA who are not directly involved in Pain Medicine may find it interesting to read the report of the Forum and to be aware of the increasing interest of many specialty bodies in this rapidly developing area of medical practice. I am very proud of the role that ANZCA has played in fostering the Faculty of Pain Medicine.

Taskforces

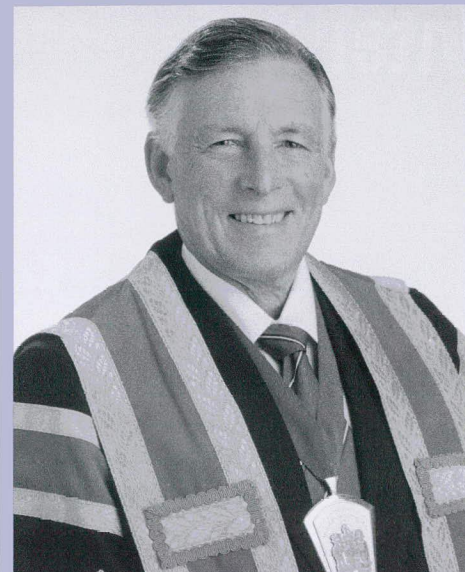
I have had an excellent response from ANZCA Councillors and some previous Councillors suggesting individuals who could either chair or participate in ANZCA Taskforces. However I would like to hear more from individual ANZCA Fellows about their views on these Taskforces and who they think could make important contributions. It is my strong view that the next five years will play a very crucial role in the development of the three areas under the administration of ANZCA. The current Taskforces are focussed predominantly on anaesthesia, although there is some significant overlap in some areas. These are all very important topics and we need your involvement, so please feel free to email me, call me or write me a letter.

ANZCA Foundation

Now that the work on the ANZCA foyer is proceeding rapidly, I am starting to plan for a major event to launch the ANZCA Foundation. A crucial aspect of the Foundation is to have a Board of prominent individuals from the general community who will be able to assist me in fund raising. I already have a handful of individuals with a strong profile and good connections.

However I do need a couple of additional Board members and again I need your help! Undoubtedly at least some of you will know a business leader, prominent identity, sporting identity or other individual who could contribute in some way to the Board. All I ask is that you let me know about this Individual and indicate your willingness to Introduce me. From that point on it will be entirely up to me to arrange to meet them and to discuss the work of the ANZCA Foundation. Please do this as a matter of urgency because I intend to launch the Foundation no later than November this year. Since we intend to have the Governor General, the Patron of the Foundation, present we do need to make a firm date soon for the Foundation launch.

Michael J Cousins
President



I hope that you enjoy the new look of the Bulletin. Our aim is to inform, educate and occasionally to entertain! I encourage all Fellows and Trainees of ANZCA, JFICM and FPM to contribute.

Kate Leslie
Communications Officer



Report

Intercollegiate Forum

On Friday 9 July last an Intercollegiate Forum on Pain Medicine was held at ANZCA House. The Forum was hosted by ANZCA President and Founding Dean of the Faculty of Pain Medicine, Professor Michael Cousins, and the current Dean of the Faculty, Associate Professor Milton Cohen. The thirty-seven invited attendees included,

"The complexity of modern medical practice has led to the growth of interdisciplinary Faculties..."

from the "parent" bodies of the Faculty, the President of the Royal Australasian College of Physicians, Dr Jill Sewell, the President of the Australasian Faculty of Rehabilitation Medicine, Associate Professor John Olver, RACS Councillor on ANZCA Council, Professor Bruce Waxman, Professor George Mendelson from the Royal Australian and New Zealand College of Psychiatrists and the Chair of the Working Party on Pain in Childhood, Paediatric and Child Health Division of the RACP, Dr Angela MacKenzie. Other senior representatives of bodies with relevance to Pain Medicine included the Chairs of the Chapters of Palliative Medicine and of Addiction Medicine of the RACP, Dr Will Cairns and Professor Greg Whelan respectively, the President of the Faculty of Occupational Medicine of the RACP, Dr David Fish, the Faculty of Radiation Oncology of the Royal Australian and New Zealand College of Radiologists, Dr Daniel Roos, the Director of Education of the Royal Australian College of General Practitioners, Dr Morton Rawlin, the President of the Australian and New Zealand Academy of Orofacial Pain, Professor Jack Gerschman, and the President-elect of the Australasian Faculty of Musculoskeletal Medicine, Dr David Vivian. A consumer representative Mrs Barbara Walker was also present.

The Forum had been convened to celebrate the fifth anniversary of the formation of the Faculty of Pain Medicine and specifically to enhance involvement of the currently participating bodies

and to explore the potential involvement of others in the development of this discipline.

The Forum was opened by Professor Richard Larkins AO, Vice-Chancellor of Monash University and formerly Chair of NHMRC, President RACP and Chair of the Accreditation Committee of the AMC.

Professor Larkins focussed on the impact of pain on society and on the practice of medicine. He identified that the complexity of modern medical practice has led to the growth of interdisciplinary Faculties and Chapters out of the traditional disciplines. Professor Larkins saw Pain Medicine as the litmus test of this movement: to get such a complex interdisciplinary project right would set the standard for others. Professor Larkins commended the Faculty for providing professional leadership and underlined the great need for Pain Medicine to address the multifaceted problems of patients with severe pain.



Above: Professor Richard Larkins, AO with the Dean, Assoc Professor Milton Cohen at the Forum

There followed presentations on the history of pain medicine and its development in Australia and New Zealand from Michael Cousins and from

FPM Board Members outlining the functions of the Faculty: Milton Cohen on education and training, Penelope Briscoe on examinations and Roger Goucke on hospital accreditation and continuing professional development. The Forum then heard presentations from each of the five parent bodies of the Faculty and a further eight presentations from other interested parties. It concluded with discussion guided by Associate Professor Leigh Atkinson, Immediate Past Dean of the Faculty.

Several themes emerged from this Forum which define the opportunities and challenges for intercollegiate development.

- **Governance of interdisciplinary endeavours**, including sharing of information, councillors and officers, coordination of websites and of continuing professional education programs
- **Career paths** crossing traditional disciplines, where many synergies, short- and long-term were discerned, including providing different levels of training and facilitation of training in private settings
- **Curriculum sharing and development**, potentially applicable also to undergraduate programs, including transferable modules, collaboration on scenarios and guidelines and, importantly, research
- **Barriers to training**, especially funding of training positions but including accreditation of sites for linked programs
- **Accessibility of expertise in pain medicine** by other medical groups as well as the community, with a particular emphasis on general practice.

It was apparent to all participating groups that there was much to be learned, borrowed and given to and from each other. To that end the Forum revealed great potential for broader intercollegiality: it was very satisfying that Pain Medicine should be the catalyst for that.



Aims

1. Report on the evolution of Pain Medicine as a specialty
2. To foster enhanced involvement of current participating Colleges/Faculties and other organisations
3. Examine the challenges of Pain Medicine:
 - a. Qualifications
 - b. Training programs
 - c. Training positions
 - d. Specialty man-power
 - e. Location and modes of practice of Pain Medicine
4. Examine the potential involvement of other bodies in the further development of Pain Medicine

Programme

1. Welcome

Professor Michael Cousins

AM FANZCA FFPMANZCA FACHPM
(President ANZCA, Founding Dean FPM)

Associate Professor Milton Cohen

FRACP FFPMANZCA FAFRM (RACP)
(Dean, FPM)

2. Opening of Forum

Professor Richard Larkins, AO FRACP

Vice-Chancellor and President, Monash University

Former Chair, NHMRC

Past President, RACP

Former Dean, Faculty of Medicine, Dentistry & Health Sciences, Melbourne University

3. Where From and Where To?

M Cousins

4. Brief Overview of Education/Training Program

M Cohen

5. Brief Overview of Examination Process

Dr Penelope Briscoe

FANZCA FFPMANZCA
(Chair, Examination Committee FPM)

6. Accreditation of Pain Units

Dr Roger Goucke

FANZCA FFPMANZCA FACHPM
(Vice Dean and Chair, Hospital Accreditation Committee FPM)

7. Continuing Professional Development

R Goucke

8. Relationship between FPM and:

■ RACS: **Professor Bruce Waxman** FRACS

■ RACP: **Dr Jill Sewell** PRACP

■ AFRM: **Associate Professor John Olver** PAFRM

■ RANZCP: **Professor George Mendelson** FRANZCP FFPMANZCA

■ ANZCA: **Professor Michael Cousins** AM

9. Input from bodies with potential interest in Pain Medicine:

■ Chapter of Palliative Care Medicine, RACP

Dr Will Cairns FRACGP FACHPM

Chair

■ Royal Australian and New Zealand College of Radiologists, Faculty of Radiation Oncology

Dr Daniel Roos

FRANZCR

■ The Royal Australian College of General Practitioners

Dr Morton Rawlin

FRACGP, Director of Education RACGP

■ Australasian Faculty of Musculoskeletal Medicine

Dr David Vivian

FAFMM GDMM MM (Pain Mgt)

■ Australian and New Zealand Academy of Orofacial Pain

Professor Jack Gerschman

BDS Sc PhD FFPMANZCA

■ Australasian Faculty of Occupational Medicine, RACP

Dr David Fish

PAFOM (RACP) FAFPHM

■ Australasian Chapter of Addiction Medicine, RACP

Professor Greg Whelan

FRACP FACHPM FAFPIIM

Chair

10. Forum: Development of Intercollegiality

- Better Links with Colleges and Faculties

Associate Professor Leigh Atkinson, AO

FRACS FFPMANZCA FAFRM

(Immediate Past Dean, FPM)

11. SUMMARY

M Cohen

A proceedings of the Forum will be published in the near future and the Faculty Board intends to vigorously pursue the many avenues raised during the Forum.

ML Cohen

MJ Cousins



Law Reports

Asset Protection

Plans of Professionals Under Threat

The Australian Government has recently announced proposals to change the bankruptcy laws, which would have a significant effect on the asset protection plans of many professionals and business owners. (Bankruptcy Legislation Amendment (Anti-avoidance and Other Measures) Bill 2004 - Exposure Draft).

Whilst the Government is acting to address community concerns about some professionals who seek to avoid payments to creditors through artificial means, the current proposals are wide ranging and retrospectively cover arrangements which many doctors and other professionals may already have in place.

"...high income earners who become bankrupt will not be able to rely on financial 'arrangements'..."

Professionals have and continue to have a legitimate interest in structuring their affairs in a way that provides comfort and protection to other family members. With litigation rates increasing, the cost of indemnity insurance increasing and the greater preponderance of litigation, these proposals, in their current form, could not come at a worse time.

The Federal Attorney General has stated:-

"Under these changes, the trustee in bankruptcy will be able to recover assets held in the name of the bankrupt's spouse, or that of another party, where the bankrupt has paid for and uses the asset. These changes will mean that high income earners who become bankrupt will not be able to rely on financial arrangements designed to shield assets from creditors".

However, the legislation goes far wider than might otherwise have been expected. If the principal "breadwinner" in the family becomes insolvent, any assets purchased out of the

earnings of the breadwinner, (regardless in whose name they are owned) may be attacked. Importantly, there is no time limit as to how far back such assets can be traced.

Properties which may have been in the name of a spouse or other entity for some years could now be subject to claims under these proposed insolvency laws.

A prudent and cautious professional, having placed assets in the name of a spouse many years ago, and without any knowledge of any present or future claim, could be caught under this new legislation.

Whilst there are some who would "creatively" seek to transfer assets or place them out of attack from creditors, with full knowledge of claims arising against them, others have legitimately sought asset protection based on legal and accounting advice, and have had these arrangements in place for many years.

Professionals are at legal risk from a number of sources:

- Directors liability;
- Medical indemnity claims;
- Occupation, health and safety laws;
- Trade practices actions;
- Environmental laws.

This is not to say that anyone should escape liability arising from their own actions. However, it is difficult to understand why legitimate business transactions and asset protection arrangements, in place for some years, should now be undone.

The Explanatory Memorandum accompanying the proposed legislation acknowledges that its provisions are wide spread:

"The amendments proposed by this Bill are intended to address the issue of high income professionals using bankruptcy as a means of avoiding their taxation and other obligations. In particular, the amendments will provide

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



creditors with improved access to assets which are substantially those of the bankrupt, but which are held in the names of other entities (such as the bankrupt's spouse or another family member).

Arrangements of the type which are potentially within the scope of the new provisions are not uncommon. Many professional people consider such arrangements to be a legitimate way of arranging their affairs to protect some of their personal wealth from claims which arise as a result of their professional activities. For professionals who are required to practice in their own name (that is, who are not allowed to incorporate) these arrangements may be seen as providing protection comparable to that given to a corporation".

Others have reviewed the legislation. Pitcher Partners, Chartered Accountants in Melbourne, have commented:

"For generations the Bankruptcy Act has had clear rules on the transfer of assets. The Government wants to change those rules retrospectively and remove the legitimacy of arrangements that presently provide some financial security. It will create uncertainty and lack of financial security for tens of thousands of Australian families who breadwinner takes risks to create wealth in Australia... in our view, the property rights of a spouse (and children) who are not bankrupt should be protected. The family home and other assets will be at risk if these proposals become law".

The Australian Government has called for submissions on the draft legislation. Parliamentary hearings on the Bill are likely in July 2004.

Deaths

Council noted with regret the death of the following Fellows:

Dr David W Cullingford (WA)
FFARACS 1969, FANZCA 1992

Dr Peter Richard Degotardi (NSW)
FFARACS 1968, FANZCA 1992



Informed Financial Consent

Most medical practitioners are now aware of the legal requirement for "informed consent". That is, the legal requirement to inform patients of all material risks involved in a medical procedure. "Informed consent" is therefore a clinical and legal requirement.

However, there are suggestions that informed consent also now requires full disclosure of the financial implications of medical treatment to patients. It is suggested that all patients should now be fully aware of the financial implications of medical treatment, including the decision not to proceed, to defer or cancel proposed treatment or to seek alternative treatment. There is clearly a differential between seeking treatment as a private and public patient, depending on whether the consumer can afford private health cover.

At this stage, there would appear to be no legal basis for requiring "informed financial consent". However, there are a number of professional and ethical reasons why full financial information should be disclosed to patients.

For example, the AMA Code of Ethics states:

"Ensure that your patient is aware of your fees where possible. Encourage an open discussion of health care costs".

The Australian and New Zealand College of Anaesthetists has issued guidelines, including recommendations that anaesthetists include in pre-anaesthetic consultations:

"Obtaining informed consent for anaesthesia and related procedures. This should include... and, where appropriate, informed financial consent".

The Dental Practice Board of Victoria has given guidance suggesting that dental care providers keep the patient informed of the probable costs of treatment.

Accordingly, it may well be the case that a Medical Practice Board would regard most health professionals as having a professional duty

"...medical professionals have an interest in ensuring that their costs are clear and transparent..."

(if not a legal obligation) to inform patients of financial implications of treatment (including no treatment or alternative treatment).

It is also clear that a misunderstanding or misrepresentation of costs can lead to complaints to relevant health complaints bodies, whether the Health Services Commissioner, Health Complaints Commissioner, Medical Boards etc. For example, complaints to the Health Commissioners/Health Ombudsman in the various states and territories in relation to costs or information regarding costs have averaged 5-8% of all complaints. Complaints about costs and information regarding costs have constituted 31% of complaints to the Private Health Insurance Ombudsman.

Accordingly, medical professionals have an interest in ensuring that their costs are clear and transparent. There is obviously some reticence on the part of some professionals to discuss costs. However, in this "modern world", consumers are aware of rights, want to understand all cost implications, and certainly wish to know how much they will be out of pocket.

The Tasmanian Health Complaints Commissioner's report (2002/2003) has noted:-

"The Commissioner also receives inquiries and complaints that deal with the issue of informed financial consent. With ever widening gaps between health fund rebates and medical fees, out of pocket expenses for patients can be substantial and in this environment the issue of financial consent is an important one."

General experience has also shown that a large reason for consumers and patients seeking to make complaints against health professionals has been a lack of knowledge or information or lack of communication. Information and communication regarding costs is part of this message. Good communication in relation to the costs and expenses likely to be incurred by the patient may avoid expensive and time consuming complaints



Spam, Spam, Spam

In 1970, when Monty Python aired its famous skit parodying processed ham, it could not have been imagined that 33 years later, Federal Parliament would pass the Spam Act 2003 ("Act"). This Act, which came into force on 10 April 2004, is intended to reduce the incidence of spam (the electronic variety). To this end, the Act establishes a compliance and penalty regime which is relevant to all organisations which use electronic messages to communicate with customers and the public. It is therefore important that businesses acquaint themselves with the main provisions of the Act and implement compliance strategies before 10 April 2004.

Commercial Electronic Messages

The Act deals only with commercial electronic messages. An "electronic message" includes, in summary, a message sent to an electronic address (eg an e-mail address or telephone number) via the internet or a mobile phone network in connection with an e-mail account, an instant messaging account or telephone account. Therefore, the Act covers email and mobile text messaging. It does not cover voice telemarketing.

The Act also only deals with electronic messages which are commercial in nature. A "commercial electronic message" has the purpose of:

- to offer to supply, to advertise or to promote goods or services;
- to advertise or promote goods or services, or a supplier of goods or services; or
- to offer to provide, or to advertise, a business or investment opportunity.

A message may also be an "electronic commercial message" if it contains a link to a commercial message.

For example, an e-mail from an internet service provider informing a customer of a new mobile phone offer would be a commercial electronic message. However, an e-mail informing a customer of his or her account balance would

"In 1970, when Monty Python aired its famous skit parodying processed ham, it could not have been imagined that 33 years later, Federal Parliament would pass the Spam Act..."

not be a commercial electronic message. If that e-mail also contains a link to a promotional webpage, it appears that it would not constitute a commercial electronic message provided that the link is only incidental to the non-promotional component.

Significantly, the Act will not affect email messages of a factual, rather than promotional, nature provided that they contain accurate information about the relevant organisation and the author of the message. This will include email messages sent in the ordinary course of business to customers.

Australian Link

The Act is only concerned with commercial electronic messages which have an Australian link. Not only may an organisation be liable for sending spam overseas from Australia, but it may also be liable for authorising the sending of spam from one overseas location to another where the central management and control of the organisation is based in Australia. Therefore, Australian-based companies with overseas operations need to ensure that those operations comply with the Act.

Unsolicited Commercial Electronic Messages

The Act generally prohibits the sending of unsolicited commercial electronic messages without the consent of the recipient. Consent may be either express, or reasonably inferred from the conduct and business. For instance, where a company has regularly sent a customer e-mails promoting special deals and the customer has in the past responded positively to such e-mails, it may be inferred that the customer has consented to future messages of this sort.

Consent to the sending of an unsolicited commercial electronic message to an electronic address may also be implied if -

- the address enables the public to send messages to a particular person within an organisation;
- the address has been conspicuously published;
- it can reasonably be assumed that the person or organisation concerned has agreed to the publication of the address; and
- the message is relevant to the work-related business of the person or organisation.

This exception does not apply if the person or organisation's expresses its wish not to receive spam.

Unfortunately, the Act provides no guidance as to what constitutes "conspicuous publication". It has been suggested that while an e-mail address or telephone number on a business card or company website will constitute conspicuous publication, the appearance of an e-mail address on an old chat-site or on company stationery will not.

Accurate Sender Information

An organisation's commercial electronic messages must contain the name and contact details of the organisation.

Functional Unsubscribe Facility

All commercial electronic messages must include a clear and conspicuous functional unsubscribe facility ("FUF"). A FUF is an opt-out facility which allows the recipient of a message to opt out of receiving further messages from the organisation.



Exclusions

Government bodies, charities, religious organisations and educational institutions are exempt from the requirements of the Act, except that they must still include accurate sender information.

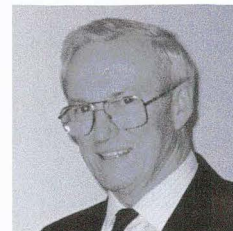
Penalties

Although the Act does not establish criminal penalties, it does authorise both private individuals and the Australian Communications Authority (**ACA**) to seek civil penalties for breaches of the Act. For instance, the maximum penalty that a court may impose for sending messages without a FUF, with inaccurate sender information or for contravention of the harvesting provisions are:

- \$1,100 per contravention for an individual, with a maximum of \$22,000 for all contraventions that occur on a single day; and
- \$5,500 per contravention for a body corporate, with a maximum of \$110,000 for all contraventions that occur on a single day.



Strategic Blood Forum Report



Garry Phillips
Director of Professional Affairs

The Australian Red Cross Blood Service (ARCBS) held a Strategic Blood Forum on May 18, which was attended by representatives from ANZCA, JFICM, RACS, RANZCOG, RACMA, State and Territory Health Departments, the Therapeutic Goods Authority, and the National Blood Authority. The purpose of the forum was for the ARCBS to provide information on supply/demand of blood and blood products, and to plan supply for 2005/2006. The main points in the presentations were:

- The blood supply in Australia and in other developed countries is very safe from the perspective of infectious risk, because of implementation of additional and increasingly sensitive laboratory screening methods, and progressively more restrictive donor eligibility criteria.
- Current threats and steps to reduce infectious risks of blood components include:
 - West Nile virus – not yet in Australia, and ARCBS has implemented donor

exclusion criteria. Laboratory screening can be introduced if required.

- Dengue fever – risk of transmission by transfusion is unknown.
- vCJD – ARCBS has implemented relevant donor exclusion criteria. No reported cases in Australia from transfusion.
- Bacterial contamination of platelets – rate of bacterial contamination is high. ARCBS proposes to phase out platelets manufactured by the platelet rich plasma method, and increase the proportion of apheresis platelets and buffy-coat derived platelets. The proportion of leuco-depleted platelets will also be increased.
- Malaria – ARCBS has donor deferral/restriction guidelines in place. No reported cases in Australia from blood transfusion.
- CMV – 60% of donors are CMV seropositive. ARCBS will increase donor screening, and increase the availability of apheresis leuco-depleted platelets.

- Platelet supply – Platelet usage increased 10% in 03/04 compared to the previous year. Platelet demand is increasing each year due to more complex surgery, and to increased massive transfusion associated with use of anticoagulant therapy and antiplatelet agents in patients requiring surgery or sustaining major trauma.
- Clinical Fresh Frozen Plasma – mostly derived from whole blood collections. Guidelines on warfarin reversal are shortly to be made available.
- Transfusion Related Acute Lung Injury (TRALI) – may be linked to multiparous blood donors. A leading cause of transfusion-related death. Australian data are being gathered.
- Value added products – include supply of CMV seronegative components, phenotyped red cells and irradiated components.
- Leucodepletion – leucodepleted products should be provided to immunodeficient patients.
- Other issues – blood product usage increase is considered to be mainly due to aggressive resuscitation of trauma patients; massive transfusion for major surgery; more complex cardiac surgery; increased use of antiplatelet drugs (especially clopidogrel); increased organ transplantation; more complex obstetrics; elderly patients with marrow failure; increased use of warfarin; haemophilia; oncology patients. Clinician education needs to be improved, particularly that of junior medical staff.

The best way for clinicians to obtain further information about issues raised at the Forum is to discuss them with their clinical haematologist or blood bank staff



A week in the life of a Primary Examiner



Kate Leslie
Communications Officer

The Primary Examination panel is comprised of enthusiastic Fellows with an interest in the basic sciences that underpin anaesthesia, and a desire to help with the development of our future anaesthetists. Each panel member contributes to roughly one examination per year, examining in either the written exam or the written and the vivas. Between examinations, the panel works on new written and multi-choice questions that

subsequently undergo scrutiny and refinement by the SAQ/MCQ subcommittee. In addition, the College now runs workshops annually for examiners to refine their skills. The goal is get the best out of the examiners – and the candidates! The most intense activity comes at viva time. The examiners meet at the College on the day before the exams to discuss the examination process in general and the viva questions in

particular. Then comes 3-4 days of examining in the chosen discipline – a tiring but rewarding experience! Examiners are elected to the Panel for a maximum of 12 years, with regular appraisal during that time. The College is very grateful to this diverse and energetic group of Fellows for their hard-work and dedication.



Above: Dr Neil Warwick, Dr Jo Sutherland and Dr Helen Kolawole

“The goal is get the best out of the examiners – and the candidates!”



Above: Dr Julia Fleming and Dr Noel Roberts

Honours and Awards

Council congratulates;
Dr Peter D (Toby) Thomas (SA) - Medal of the Order of Australia (OAM) for services in the aftermath of the Bali bombing



ANZCA Trainee Committee



Annabel Orr
Chair, Trainee Committee

The Trainee Committee is slowly finding its feet amongst College business, and trying to carve out a role for itself that will best serve the trainees. As such, it is probably worth highlighting the distinction between GASACT and other trainee committees representing commercial and industrial interests, and the Trainee Committee which functions under the auspices of the College and attends purely to matters of training and education and their guidelines rather than

members of the Committee and highlight any problems or difficulties they may be encountering in their training, or even to praise any positive aspects of their training!! Once these are up and running, communication between trainees should become a lot easier – particularly in regions where trainees are spread over large areas. We will also use the site to post relevant information as it becomes available and advise of any new developments that may occur.

We will be taking some of these points to the Education and Training Committee for their consideration. It is in this way that we hope to be able to best help trainees resolving any problems they are encountering, and feedback any solutions. Currently our focus is on the new FANZCA modular training system, as well as the current ITA assessment process, and the direction it will take in the future.

“...we are in the process of developing e-communities for each State and country...”

dealing with industrial and commercial concerns. We are here to help trainees with their training.

We really hope that trainees will take advantage of this site when it becomes available.

To that end, we are in the process of developing e-communities for each State and country represented by the Committee. We hope that this will provide trainees with an easy way to contact

The Committee met via teleconference in June, and we discussed a large number of matters and issues concerning the training program, including those that had been raised on a regional basis.

To be able to best serve the interests of the trainees, we need as much feedback as possible. New members are always welcome on the Regional Committees, and even if you think you are too remote, you aren't - teleconferencing facilities can always be arranged. If you don't want to be on the Committee but just have a point to make, feel free to contact the Committee members – hopefully soon on the e-community facility.



Inductions

Surf Life Saving Hall of Fame

Professor Tess Cramond

Professor Tess Cramond AO, OBE, FANZCA, FFPM, Past Dean of The Faculty of Anaesthetists was inducted recently into Surf Life Saving Australia Hall of Fame, in recognition of her contribution to the development of resuscitation techniques and training. With Karla Gilbert, World and Australia Champion Iron Woman she joined 45 men inducted since the establishment of Surf Life Saving Australia in 1907.

At the time when anaesthetists in operating theatres were using intermittent positive pressure to ventilate the lungs of unconscious apnoeic patients, community based groups were still teaching manual chest compression-arm lift techniques such as Holger-Neilsen Sylvester Brosch and Schafer.

Despite the published papers of James Elam, Peter Safar and Archer Gordon from 1958 onwards confirming the efficacy of expired air resuscitation using mouth to mouth, mouth to nose and mouth to mask techniques there was considerable

opposition to direct oral contact from some medical practitioners and from many community groups.

In 1961, on two successive weekends at St Andrews Hospital Brisbane, in cooperation with the late Dr Roger Bennet, a Fellow of the Faculty and later Federal President of the ASA she anaesthetised and rendered apnoeic four volunteer Surf Life Savers using thiopentone and gallamine.

Doctors, nurses, ambulance officers, surf life savers and members of other community groups were taught expired air resuscitation and the use of the Ambu Bag. The project showed the feasibility of teaching these techniques in the community as well as their efficiency and safety.

The results formed the basis of the Queensland submission to Surf Life Saving Australia and became the National submission to the International Convention on Life Saving – and expired air resuscitation was accepted.

The four volunteers – Bruce Campbell, Jack Deerlove, Alan Doig and Earle Smith have had an ongoing commitment to the development of the highest standards of resuscitation teaching. Bruce Campbell later held office in the Royal Life Saving Society while Jack Dearlove, Alan Doig and Earle Smith have been senior office bearers in Surf Life Saving Australia and on the Australian Resuscitation Council. They all joke about the swollen lips they had on those weekends – and about not being able to eat steak for a week after their fellow life savers practised "jaw thrust" at the angle of the mandible.

Professor Cramond commented that today the project would not receive approval from an Ethics Research Committee – and she would not undertake it, but also adds "It is the most valuable research I have ever undertaken because it has contributed to saving so many lives".

Below: Professor Tess Cramond pictured with Bruce Campbell, Alan Doig and Jack Deerlove.

PHOTOGRAPH BY DARREN ENGLAND, THE COURIER-MAIL





Education Report

Anaesthetists' Non-Technical Skills (ANTS)



Russell W. Jones
Director of Education, ANZCA

The speciality of anaesthesia has long recognised the importance of non-technical skills in the success of clinical procedures. However the absence of a suitable framework representing these skills and the lack of a validated measurement tool for evaluating their performance has hindered the formalised teaching of these skills. A potential solution has been developed by a team of researchers from the University of Aberdeen and the Scottish Clinical Simulation Centre¹. These researchers have published several papers describing the development and validation of a system which may be applicable to some aspects of training within our College. Most recently an article evaluating this system has been published in the *British Journal of Anaesthesia*².

Using the acronym ANTS (Anaesthetists' Non-Technical Skills) the system comprises a framework and associated measurement process that has the potential to support training in essential, non-technical areas. ANTS comprises 4 skill categories each subdivided into a total of 15 elements:

A. Task management

1. Planning and preparing
2. Prioritising
3. Providing and maintaining standards
4. Identifying and utilising resources

B. Team working

5. Coordinating activities with team
6. Exchanging information
7. Using authority and assertiveness
8. Assessing capabilities
9. Supporting others

C. Situation awareness

10. Gathering information
11. Recognising and understanding
12. Anticipating

D. Decision making

13. Identifying options
14. Balancing risks and selecting options
15. Re-evaluating

The system defines each skill element and also includes examples of good and bad behavioural

markers. For example, the *ANTS Handbook*³ defines "planning and preparing" as developing in advance primary and contingency strategies for managing tasks, reviewing these and updating them if required to ensure goals will be met; making necessary arrangements to ensure plans can be achieved. The *Handbook* specifies the following behavioural markers for good and bad planning and preparing.

Good practice:

- Communicates plan for case to relevant staff
- Reviews case plan in light of changes
- Makes post-operative arrangements for patient
- Lays out drugs and equipment before starting case

Bad practice:

- Does not adapt plan in light of new information
- Does not ask for drugs or equipment until the last minute
- Does not have emergency/alternative drugs available suitable for patient
- Fails to prepare post-op management plan

Similar definitions and examples of good and bad practice are provided for each of the 15 elements. Observers are able to score a person's performance on each of the elements using a five point rating system.

Those interested in learning more about ANTS are encouraged to view the articles, reports and conference papers available at www.abdn.ac.uk/iprc/ants_papers.shtml. ANTS will also be discussed at the Combined Meeting of the Medical Education, Simulation and Skills Training, Welfare of Anaesthetists and Anaesthetists in Management SIGs to be held on the Gold Coast during 1st – 3rd October 2004.

¹ Fletcher G, Flin R, McGeorge P, Glavin R, Maran N, Patey R. Evaluation of the prototype anaesthetists' non-technical skills (ANTS) behavioural marker system: WP7 Experimental Report. University of Aberdeen Technical Report for NHS Education for Scotland. Aberdeen: University of Aberdeen

² Fletcher G, Flin R, McGeorge P, Glavin R, Maran N, Patey R. Anaesthetists' non-technical skills (ANTS): evaluation of a behavioural marker system. *Br J Anaesth* 2003; 90(5): 580-588.

³ Anaesthetists' non-technical skills (ANTS) system handbook. www.abdn.ac.uk/iprc/papers%20reports/ANTS/ANTS_handbook_v1.0_electronic_access_version.pdf

Letter to the Editor

Further to the excellent article written by Terry Loughnan on Robert Hamilton Orton, I would like to add some additional comments both from personal experience and from the article written by Bob Gray in the Alfred Hospital's *Faces and Places* (Vol. 3).

I was privileged in that I was a registrar at the Alfred Hospital during Bob Orton's last year as Director of Anaesthesia. Many times during that year he was unwell, particularly with his unstable diabetes. Registrars were given the morning off after working the previous night and if Bob Orton was at work we would join him for morning tea in the Department and then proceed to his office for a one-to-one tutorial on many topics. These tutorials were of high quality and certainly assisted in the preparation for the Part II FFARACS.

From the article in *Faces and Places*, many points could be made. Quoting directly "Dr Orton's contributions to the technique of controlled and assisted respiration were original and important, as were his studies of the effect of these techniques upon the acid-base equilibrium of the body, and the series of articles written and lectures given on this then complex subject, revealing as they did his clarity of thought, oratorical skills and physiological mastery, became the basis of cardio-thoracic anaesthesia throughout Australasia."

Finally, I would like to mention the textbook *Anaesthetic Methods* written by Orton, Renton and Kaye, published in 1946 which received international and local acclaim.

Yours sincerely, **Ian Rechtman**

I endorse Ian Rechtman's remarks and would seek to encourage replies from fellows who knew these people of whom I write. **Terry Loughnan**



ADRAC Recommendation on the safe use of Parecoxib Sodium

The Adverse Drug Reactions Advisory Committee (ADRAC) recently published an article in the Australian Adverse Drug Reactions Bulletin (Vol 23, No 3, June 2004) on renal failure with peri-operative parecoxib. The article, reprinted below with the permission of the ADRAC, highlights the need to use a single dose only, since the risk of renal failure is increased in multiple doses. The article can also be accessed and downloaded from the Therapeutic Goods Administration website at <http://www.tga.gov.au/adr/aadrb/aadr0406.htm>

PARECOXIB – ONE SHOT ONLY

Parecoxib sodium (Dynastat) is a recently marketed parenteral COX-2 inhibitor which is approved for

a **single** peri-operative dose for the management of post-operative pain. The Australian Drug Evaluation Committee recommended approval for parecoxib at a single dose only, because of concerns about the safety of multiple doses.

ADRAC has, to date, received 20 reports of adverse reactions associated with parecoxib, and 13 of these involved renal impairment with elevated creatinine and/or oliguria, including four cases of acute renal failure. Multiple doses of parecoxib were given in six cases, with patients receiving up to five doses. The other seven patients received only one dose, but two had risk factors: one was also taking a diuretic and an angiotensin

II receptor antagonist; and the other had pre-existing mild diabetic nephropathy. The patients were aged 41-78 (median 66) years.

It is clear that parecoxib can cause renal impairment and the risk is increased with multiple doses. Those patients most at risk are those mentioned in the Precautions section of the product information, including those with impaired renal function, heart failure, liver dysfunction, those taking diuretics and ACE inhibitors, and the elderly.



Series on Past Deans and Presidents

Lennard Gilmore Travers MBE

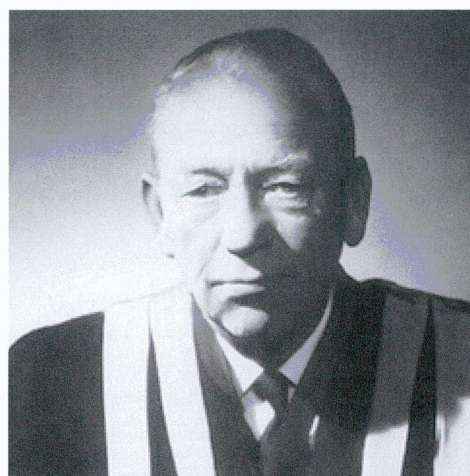
Lennard G Travers was the third Dean of the Faculty of Anaesthetists, Royal Australasian College of Surgeons, filling this position from the retirement of Dr Robert Orton in 1959 until 1961, when Dr James F McCulloch succeeded him in the role.

Lennard Travers was born in 1905 and died in 1968 at the age of 63. He matriculated in 1923, having played in the First Eighteen football team, rowed in the final eight that won the "head of the river" that year and was made a prefect. He entered Ormond College and graduated MB BS from the University of Melbourne in 1930. Becoming a fellow of the Royal College of Surgeons of Edinburgh, he returned to Australia and practised surgery in the Littlejohn Clinic at Heidelberg, Melbourne.

He joined the A.I.F. in 1939 at the outbreak of hostilities, entering as a Captain and being promoted to Lieutenant Colonel. He commenced as a surgeon, and was posted to Al Qantara in Egypt, but due to cheiropompholyx or eczematous affliction of the hands he had to retire from surgery. This was a tremendous blow, depriving him of his preferred career choice and markedly altering the course of his life in many ways. He was subsequently posted to an administrative unit and in later years become ADMS (Assistant Director of Medical Services) of the Morotai area. In this role he was instrumental in the medical planning for the A.I.F. operations in Borneo, and it was largely for this work that he was awarded the MBE in 1946. Coincidentally, Dr James McCulloch, who was to follow him as Dean, was attached to the 2/5 Australian General Hospital in Morotai.

Prior to the end of the Second World War Len was persuaded by Mr Benjamin Rank to take up a career in anaesthesia, and the two formed a team that achieved a great deal in plastic surgery and in anaesthesia. He went on to become Senior Honorary Anaesthetist at the Royal Melbourne Hospital and proceeded to become Chairman of Staff of the hospital.

Len joined the Australian Society of Anaesthetists and served as Victorian State Representative in



1950. At that time he was selected to form a triumvirate of himself, Douglas Renton and J. Ellis Gillespie to negotiate the formation of a Faculty within the Royal Australasian College of Surgeons. This group was later joined by Dr Harry Daly from New South Wales and Gilbert Troup from Western Australia. As such he can truly be considered as one of the founding fathers of the Faculty of Anaesthetists. The role that he played at this time must have been extremely difficult, as he would have been seen by some anaesthetists to have sympathy for his surgical colleagues because of his surgical background. However, he carried off his role and went on to represent the specialty in its highest capacity.

Len Travers became a Fellow of the Faculty of Anaesthetists, RACS and a Fellow of the English Faculty. He served on the interim and inaugural Board of Faculty, going on to become Dean. He was an examiner for the Diploma in Anaesthesia (Melbourne) and Consultant Anaesthetist for the Royal Australian Air Force with rank of Group Captain.

Len Travers shared a very special bond with the history of anaesthesia in Australia. As is described in Gwen Wilson's book "One Grand Chain", his father's cousin Geoffrey Frederick Travers, was appointed as the first anaesthetist (Chloroformist) to a Melbourne Hospital (Alfred Hospital) in 1888. It was the same year that Dr Charles de Lambert was appointed to be the first anaesthetist to a hospital in Sydney (St Vincent's).

It is uncertain, due to lack of documentary evidence, as to which appointment was the first, however the year 1888 was a monumental one for the development of anaesthesia as a speciality in Australia.

I will leave the last word to the entry in the Board Minutes of 15 June 1968. "Since the last meeting of the Board, the Faculty has suffered the loss of a former Dean of Faculty, Dr Lennard Travers. Dr Travers' election to the office of Dean gave both confidence and pleasure to the whole Faculty, for he was a man of integrity and goodwill. His quiet presence made meetings of the Faculty of Anaesthetists and the Australian Society of Anaesthetists seem complete, not only because of his comradely manner, but because of firm and impartial opinion on all matters which came under discussion. Lennard Travers was regarded with affection by all who knew him well. To the younger anaesthetists he always extended a helping hand and was a colleague they respected; to the older anaesthetist he was a man who in his retiring way made a great contribution to the development of the speciality in Australia. We regret his passing, but his name will be ever present in the Annals of the Faculty of Anaesthetists". His memory is honoured by the Lennard Travers Professorship, an honour awarded to an Australasian anaesthetist every four years. The recipient delivers a lecture at the Annual Scientific Meeting in that year.

Much of the detail of this monograph is derived from Gwen Wilson's book *Fifty Years: The Australian Society of Anaesthetists*, from the Obituary written by Dr John Tucker and printed in the Dean's Newsletter December 1972, and from the Australasian Visitor's Lecture delivered in Canberra by Dr Rod Westhorpe and published in the Faculty of Anaesthetists Bulletin, Vol.2, May 1991. I am also indebted for the assistance and support provided by Caroline and Richard Travers (son of Lennard Travers).

Terry Loughnan



Obituary

John Campbell Barrett FANZCA, FJFICM

19 June 1933 - 16 May 2004

Cam Barrett died suddenly at his home in Wellington, New Zealand, on 16 May 2004.

Cam had a long and distinguished career in anaesthesia and intensive care in New Zealand, and his passing leaves us to reflect on an outstanding contribution to the profession.

The son of a distinguished general surgeon, Cam was educated at New Plymouth Boys' High School and the Otago University Medical School. Post graduate studies took him to Britain, where in 1962 he helped start a two bed ICU at University College Hospital. Returning to Wellington in 1963, Cam was given the task of looking after ventilated surgical patients scattered around a number of wards. This was less than satisfactory, and in 1964, Cam and a number of surgical and medical colleagues opened the Wellington Intensive Care Unit, one of the first in New Zealand. The Director of Anaesthesia at the time, Graeme Marshall, allocated Cam two sessions for ICU, and this increased to four in 1966. Cam worked continually in the ICU until his retirement from Wellington Hospital in 1998.

In those early days, Cam sacrificed considerable family time to run the ICU. He also worked to

establish intensive care as a recognised specialty in New Zealand. His work load eased slightly when Maliq Jaimon joined him in 1974, but Cam remained committed to his ICU patients, often slipping in early in the morning to sort out any problems before he began his anaesthetic list for the day.

Cam was a great supporter of training, fostering many careers in intensive care. Six current Intensive Care directors in New Zealand began their training in Wellington ICU, surely a testament to Cam's vision. He was also a champion for ICU nurses, being actively involved in their training and upskilling.

Cam was a Foundation Fellow of the Faculty of Intensive Care when it was started in 1992, and also a Foundation Fellow of the Joint College of Intensive Care Medicine in 2001. He was also a founding member of ANZICS. In 2003, ANZICS established an Honours Board to acknowledge outstanding contributions to Intensive Care in Australasia. Cam was one of the first nominations accepted for the ANZICS Honours Board.

If Cam had done nothing more than his ICU work, we would be honouring a giant in the anaesthetic community. But he did so much more for the

profession and for his colleagues. It is an old cliché, but one worth repeating. If you want something done, get a busy man to do it. That busy man was Cam Barrett. He served on the New Zealand Committee of the Faculty of Anaesthetists, becoming Chairman in 1973. He also served as President of the New Zealand Society of Anaesthetists. He was Chairman of the Division of Surgery at Wellington Hospital. Following a study visit to Britain, he was instrumental in starting day case anaesthesia and surgery in Wellington.

These duties were all on top of busy private and public practice. Cam was also actively involved in obstetric anaesthesia with its frequent busy call outs at night.

As if he had not done enough, Cam was responsible for starting the Wellington Anaesthesia Trust. This has been instrumental in funding anaesthetic research and equipment purchase in Wellington for more than ten years. Pulse oximeters, PCAs and Quality Audit are every day things now, but they were all developments initiated in Wellington by funding from the Trust.

Perhaps, however, the Trust's biggest contribution to anaesthesia in Wellington is its early support and funding of the Simulation Centre. This was the first such facility in New Zealand, and will continue as a lasting legacy for Cam Barrett.

Cam was a well liked colleague, ever ready with a quiet word of encouragement to a registrar having difficulties with examinations, and always willing to cover an ill or bereaved colleague. He was happily married to Liz for many years, and was justifiably proud of their four children. The arrival of grand children was a particular delight for him.

We have lost an outstanding friend and colleague, and offer our sympathy to his family.

Graham Sharpe
Bob Ure



Drs Lyndall Patterson (SOT and Rotational Supervisor), Justine McCarthy (PFY) and Di Khursandi (ANZCA Councillor) representing ANZCA at the Royal Brisbane and Womens' Hospitals Careers Expo on 18th June 2004. There were many enquiries from young Doctors about a career in anaesthesia. The stand and display (including an anaesthetic machine) won first prize!



Museum Report

Geoffrey Kaye Museum of Anaesthetic History on Display



Ms Elizabeth Triarico
Museum Curator

A unique replica of Australia's first ether inhaler, intricately designed chloroform bottles and a rare 1870s nitrous oxide gasometer are just some of the many fascinating objects that can be found in the Geoffrey Kaye Museum of Anaesthetic History, *Going to Sleep* display. Located on the 5th Floor of ANZCA House, *Going to Sleep* is part of an ongoing dynamic Museum display program.

Going to Sleep highlights the wide variety of processes involved in the induction of anaesthesia since it was first introduced in the 1840s. As well as an amazing array of objects, the display includes

"The displays will be innovative and explore a range of themes..."

many interesting stories such as that of Agnes Carstares, the first child to be born using chloroform anaesthesia. According to

contemporary sources the event was considered to be so significant to Agnes' parents that they formally christened her Agnes *Anaesthesia* Carstares!



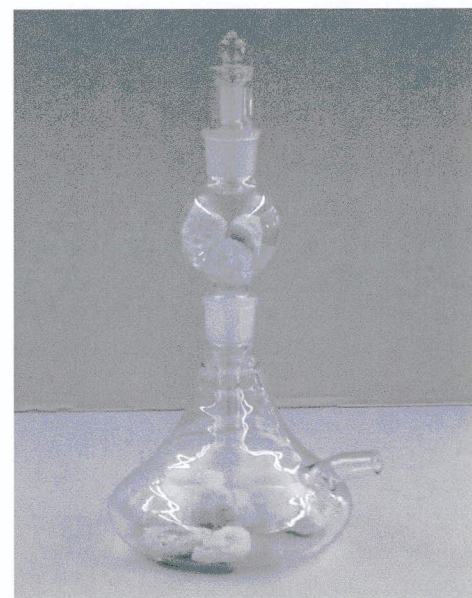
Above: Agnes Anaesthesia Carstares, 17 years of age. The first child to be born using chloroform anaesthesia.

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.

The Museum displays will be changed on a regular basis and will showcase a wide variety of objects from the Museum collection. The displays will be innovative and explore a range of themes which illustrate the important impact that the development of anaesthesia has had on society and its continuing contribution to the advancement of medicine in general.

Australia's First Ether Inhaler

Dr. William Russ Pugh, worked as a general practitioner and surgeon, in Launceston, Van Dieman's Land (Tasmania) and was the first to use ether for general surgery in Australia. This historic event took place at St John's Hospital, Launceston on Monday June 7, 1847.



Above: Pugh's Ether Inhaler (Replica), Geoffrey Kaye Museum of Anaesthetic History Collection.

Unfortunately, Dr. Pugh's original inhaler has not survived. The replica which is currently on display is the only one in existence and is

based on a contemporary description of Pugh's ether inhaler which appeared in *The Launceston Examiner*, June 9 1847.



Left: Dr William Russ Pugh Photograph c. 1865 W.L. Crowther Library State Library of Tasmania

Left: Geoffrey Kaye Museum of Anaesthetic History Display ANZCA House St. Kilda Road, Melbourne, Australia





MOPS

Report of Audit of 2003 MOPS Returns

The participation rate in MOPS among the Fellows over the past 12 months has remained constant at 45% (cf 47% in 2002). New Zealand stands out at 77% while South Australia and Western Australia remain at low compliance at 32% and 25% respectively. Of those returns submitted 94% met all criteria.

- The number of non-fellows continues to increase with 121 participants in 2003. Sixty percent of these are from New Zealand. 40 participants were randomly selected for auditing. 37 returned the documentation supporting their returns. Returns from the other 3 are still awaited. The participants audited came from ACT (1), HK (1), NSW (13), NZ (11), QLD (3), SA (1), TAS (1), VIC (7) and WA (2).
- The members of the CE & QA committee who are also Councillors performed the audit.
- The returns were audited according to the criteria set out in the programme manual, which are the accuracy of returns and the relevance of activities to the participants practice.
- Results: (thus far)
 - 28 were satisfactory
 - 6 were given Provisional Approval
 - a. 5 failed to provide a copy of their Medical Registration
 - b. 1 needed further documentary evidence,
 - 0 returns had significant errors in documentation.
- The auditors were pleased to see the range of activities that participants had taken part in. It was also noted that some participants had under claimed, in that when reviewing the documentation, it was apparent that they could have claimed for more activities to be credited in their return.

6. Errors noted:

- Evidence of attendance at hospital / practice CME (Code 1.2) and QA meetings (Code 2.2) was variable in quality, with only some practices providing annual attendance certificates.
 - Some participants claimed CME and QA activities that they could not provide supporting documentation for.
 - There were discrepancies between the participants' claims for HELP Modules submitted (Code 141), and those distributed in 2003.
 - Some participants claimed "participation points" when they were in fact presenters and should have claimed "presenter points".
 - A few participants used the incorrect QA Committee Work Code for claiming activities in this area.
 - Claiming QA Supervisor of Training points when they were not the designated SOT at the hospital.
 - Providing documentary evidence for activities not listed on the annual return.
 - A tendency to provide documentary evidence to satisfy the minimum number of CME and QA points rather than all the activities listed on the annual return.
- The auditors considered that the activities that the participants recorded were relevant to their practice.
 - Recommendations (many of these are repeated from previous audits):
 - The documentation of attendance at local CME and QA meetings should be improved; I would recommend that an attendance register is kept for such meetings, and if possible, annual statements of attendance issued,
 - Participants will be reminded of the definitions of local QA meetings, QA committee meetings and major QA meetings, and that there are separate points for participants and presenters / instructors for the activities,

ANZCA Maintenance of Professional Standards Program 2003 Participation Details

All Participants						
	Returns Submitted	Met All Criteria	Average CME Points	Average QA Points	Met Due Date	
NZ	367	98%	296	166	94%	
ACT	23	96%	162	56	86%	
NSW	524	93%	164	56	91%	
NT	6	83%	275	86	60%	
QLD	201	92%	150	54	94%	
SA	76	86%	201	56	91%	
VIC	279	97%	192	65	97%	
WA	65	94%	236	58	93%	
TAS	35	91%	155	51	88%	
HK	26	96%	217	54	96%	
SIN		%			%	
MAL	4	50%	364	78	100%	
Other	22	95%	201	53	86%	
Total	1628	94%	204	83	93%	

All Fellows						
	Active Fellows	Returns Submitted	Met All Criteria	Average CME Points	Average QA Points	Met Due Date
NZ	381	294	98%	217	84	93%
ACT	42	22	95%	164	56	86%
NSW	843	507	93%	164	56	90%
NT	12	6	83%	275	86	60%
QLD	470	192	92%	152	54	93%
SA	231	75	85%	202	56	91%
VIC	638	269	97%	194	65	97%
WA	231	59	95%	244	57	93%
TAS	69	33	91%	157	48	87%
HK	148	26	96%	217	54	96%
SIN	48		%			%
MAL	47	4	50%	364	78	100%
Other	195	20	95%	208	53	89%
Total	3355	1507	94%	186	63	93%

All Non Fellows						
	Returns Submitted	Met All Criteria	Average CME Points	Average QA Points	Met Due Date	
NZ	73	97%	617	499	97%	
ACT	1	100%	122	64	100%	
NSW	17	100%	169	61	100%	
NT		%			%	
QLD	9	89%	112	49	100%	
SA	1	100%	152	30	100%	
VIC	10	90%	128	49	100%	
WA	6	83%	139	64	100%	
TAS	2	100%	124	84	100%	
HK		%			%	
SIN		%			%	
MAL		%			%	
Other	2	100%	127	53	50%	
Total	121	96%	433	327	97%	

- The same format and timetable should be used for next year. Selected Councillor members of CE & QA will be asked to perform the audit of 40 randomly selected returns,
- The auditors made a note of any outstanding issues with each participant's returns, and these were notified to the participant when the material was returned to them.

Neil Maycock

Quality Activities / Maintenance of Professional Standards
Officer Australian and New Zealand College of Anaesthetists
8 July 2004



Australian Medical Workforce Advisory Committee (AMWAC) National Medical Careers Surveys

In 2004, AMWAC proposes to undertake two surveys:

AMWAC Longitudinal Medical Careers Study - Follow-up Survey

A follow-up survey of all doctors participating in the AMWAC longitudinal medical careers study. The purpose of this follow-up survey is to track career movements and changes and factors influencing these movements and changes during the past two years. This study includes doctors who participated in 2002 and:

- are still in vocational training in Australia or overseas;
- have completed vocational training and are now fully qualified specialists;
- are presently taking a break from training or medical practice;
- have left medicine as a career since September 2002.

2004 Survey of Doctors in Vocational Training

A survey of all doctors who have commenced vocational training since 1 October 2002.

The purpose of this survey is to gain information about factors influencing the career choice and workforce participation decisions of doctors who have entered vocational training in the past two years. All medical college training programs are assisting with the administration of this survey.

The findings of the 2002 AMWAC national survey of doctors in vocational training provided governments and the profession with valuable information about the plans, views and needs of doctors in vocational training. These findings have been used to inform policy initiatives in the vocational medical training area. For information about the Medical Careers report and the Medical Careers policy workshop report visit the AMWAC website at: www.healthworkforce.health.nsw.gov.au

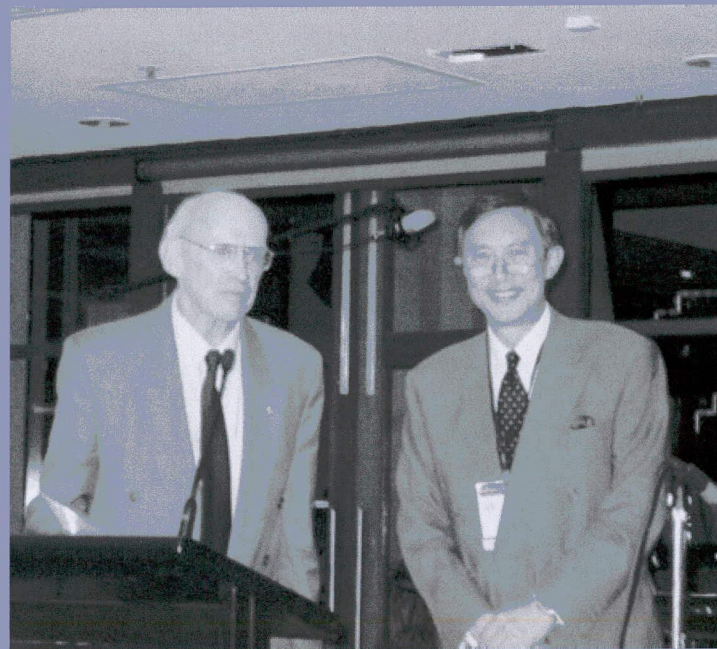
We need your help so we can have confidence in the findings

The individual career decisions of postgraduate doctors have a significant impact on the structure and the future of the medical workforce and are of importance to governments, the medical profession, including doctors in training, and the Australian community. It is therefore important that doctors who receive one of these surveys take the time and effort to complete it so that these influential groups can have confidence in the findings.

The surveys will be going out in September. Please let AMWAC know if you do not receive one of these questionnaires or if you would like further information about this project.

AMWAC contact details: Phone: (02) 9391 9933; Email healthworkforce@doh.health.nsw.gov.au

ANZCA Citations



Dr Carl Edmonds, WA (left) and Dr Peter McCartney, Tas (right) were recently awarded ANZCA Council Citations for their contribution to diving and hyperbaric medicine. The awards were presented by Dr Robert Wong, Chairman of the Diving and Hyperbaric Medicine Special Interest Group, at the Conference Dinner of the Undersea and Hyperbaric Medical Society Meeting in Sydney.



Milton Cohen

Dean's Message

On 9 July last, the College and the Faculty hosted an Intercollegiate Forum on Pain Medicine at ANZCA House. This signal event is reported on page 6 of in this Bulletin.

Arising out of the Forum, it is clear there are as many challenges as there are opportunities for Pain Medicine as a discipline and for pain clinicians as an identifiable group of practitioners. Whilst it was surprising to note the lack of attention paid to the problem of clinical pain by some of the disciplines represented at the Forum, it was very encouraging to identify several areas for present and future synergy with other bodies. These include in particular the Chapter of Palliative Medicine (RACP), with which several Fellows of FPM are already involved, the Chapter of Addiction Medicine (RACP) and the Royal Colleges of General Practitioners. The Intercollegiate Committee of your Board has already moved to strengthen existing ties and to establish new connections, especially with respect to learning tools and training opportunities.

Of course this again raises the issue of the profile of Pain Medicine which I mentioned in the June Bulletin. In a way analogous to the environmental movement, we could "think globally and act locally". An opportunity for the former will occur on Monday 11 October next, which has been proclaimed World Pain Awareness Day by the IASP. Details will be circulated in Synapse. Meanwhile many Fellows are involved in formal and informal talks, to community groups, undergraduate students, general practitioners and other specialists: from a small but vital Faculty, each of us could promote our discipline and the opportunities for training in it. The Faculty's promotional material has been revised and will be available soon.

As we approach the examination to be held in Adelaide in October, I would remind Fellows that the Alternate Pathway to Fellowship will close after the 2005 examination. If you know

of a colleague active in pain medicine for whom a formal training program is not possible or appropriate, such a person may be interested in applying for election to Fellowship via the Alternate Pathway. Their decision will need to be made soon.

As we Pain Fellows are such a diverse group, our travels may well bring us into contact with significant individuals who could enhance our Annual Scientific Meetings. The Board is always on the lookout for keynote speakers and is keen to receive suggestions.

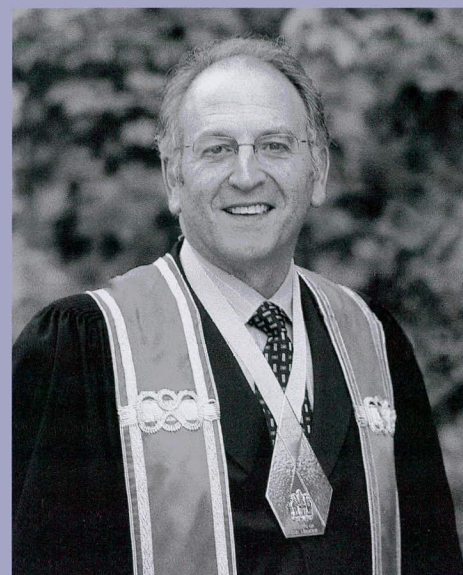
The Faculty is proud to offer congratulations to two Fellows who have been recognised in the Queens Birthday Honours List, Immediate Past Dean Professor Leigh Atkinson AO and Dr Richard Vaughan AM, both neurosurgeons.

"...it is clear there are as many challenges as there are opportunities..."

As he is now College President, the Founding Dean of the Faculty, Professor Michael Cousins, has stepped down from the Board and Associate Professor Ben Marosszeky FAFRM(RACP) has been coopted in his place until elections next year. The Faculty welcomes Ms Mary Silvestro who has been appointed as assistant to the Executive Officer, Margaret Benjamin. The Faculty Office has now moved into dignified premises in "Ulmaroa", near the College Library: when in town, Fellows could take the opportunity to enjoy our new "home".

Milton Cohen

Dean





Held on April 29, 2004 at CTEC Building UWA Perth

Highlights from the Board Meeting

Professor Hugh Dickson, President Australasian Faculty of Rehabilitation Medicine (RACP) and Dr Meredith Craigie, Chair FPM Paediatric Pain Medicine Working Party were visitors to the Board Meeting.

Education

Objectives of Training and Reading List. The revised document will now be circulated to Trainees and will be available on the web within the next two weeks.

'History of the Patient with Pain'. The revision of this document is progressing.

The 'Relationship between Childhood Maltreatment and Chronic Pain in Adult Life' document is progressing and will be finalised within the next month.

The 'Psychosocial Assessment of Patients with Chronic Pain' document is progressing and will be finalised shortly.

The 'Pain Orientated Physical Examination' video will be presented for the first time at the Refresher Course Day on April 30.

Supervisor of Training Manual. Work on this manual is progressing.

Research

The FPM Research Committee is holding its first face to face meeting on May 2 in Perth.

J Fleming commented that a list of pain medicine research projects is now on the web site.

NHMRC Acute Pain Management: Scientific Evidence

The revision of this book is progressing under the Chair, Pam Macintyre. Meetings of the working party were held in January and March.

Paediatric Pain Medicine

M Craigie reported that work on a national audit

for acute pain management is progressing. She has approached the ANZCA Clinical Trials Group for possible funding. Other research projects include a study of ketamine in scoliosis surgery at the Royal Children's Hospital and virtual reality for procedural pain management at the Women's and Children's Hospital in Adelaide.

Paediatric Pain Medicine Fellows have continued to participate in local and national meetings.

Several members of the Working Party have participated in the first draft of the NHMRC Acute Pain Guidelines revision and M Craigie has also contributed to the ANZCA Clinical Indicators for Acute Pain.

Palliative Medicine

The Faculty will write a letter of support to the AMC in relation to the Chapter of Palliative Medicine's application for specialty recognition.

Intercollegiate Forum on Pain Medicine

Invitations to medical Colleges and affiliated groups will be forwarded within the next week for this forum to be held on 9th July.

The Use of Drugs Beyond Licence in Palliative Care and Pain Management

R Goucke, J Fleming and D Jones agreed to prepare a document for discussion by the Board.

Annual Scientific Meetings

The Faculty is running conjoint sessions at each of the participating Colleges' ASMs. Professor Ralf Baron will be speaking at the RACS Scientific Meeting in Melbourne and also at the RANZCP Scientific Meeting in Christchurch.

Admission to Fellowship of the Faculty of Pain Medicine

By training and examination:

Kieran James Davis	NZ
Robert Lattik	NSW
Bernard Mun Kam Lee	NSW
Susan Martha Lord	NSW
Wai Nung Tong	Qld

The Multidisciplinary Pain Centre at Royal Brisbane Hospital won the prize for best poster at the Royal Brisbane and Womens' Hospitals Careers Expo on 18th June 2004.

Australian and New Zealand College of Anaesthetists
Fellowship of Faculty of Pain Medicine

Pain Relief - A Basic Human Right

Why Train in Pain Medicine?

Pain relief is important in all branches of clinical medicine.

Training in Pain Medicine includes the care of patients with acute pain, cancer pain, musculo skeletal pain, headache and pain due to injury disease or disorder of the central nervous system - and the specific needs of children and the elderly.

Award of the Fellowship is dependent on completion of the training and examination requirements as determined by the Board of Faculty.

What Does Training Involve?

Training is a minimum of five years and will normally commence during the training programme of the primary specialty - Anaesthesia, Medicine, Psychiatry, Rehabilitation Medicine or Surgery.

Trainees must undertake a prospectively approved one year structured training period in a Faculty Accredited Pain Management Centre and a further one year of further experience with direct relevance to Pain Medicine. Retrospective approval may be granted.

Who Qualifies to Train in Pain Medicine?

Medical graduates who have one of the following degrees:

- FANZCA
- FRACP
- FRANZCP
- FRACS
- FFRM (RACP)

The four Colleges, with the Faculty of Rehabilitation Medicine, determine the training requirements, accredit training posts and conduct examinations. All Colleges and the Faculty of Rehabilitation Medicine are represented on the Board of the Faculty and on the Panel of Examiners.

What Are the Career Prospects?

Pain Medicine is a rapidly developing specialised area of Medicine.

- It provides the opportunity for working as a member of a multidisciplinary team
- It facilitates collaborative research
- It utilises special expertise in pharmacotherapeutics, interventional techniques and psychosocial support to improve the quality of life of patients with pain.

Multidisciplinary Pain Centre, Royal Brisbane Hospital, Staff

Medical	Nursing	Administration Officer
■ Consultants	■ Clinical Nurse Consultant	Secretary
■ Anaesthetists	■ Clinical Nurse	Available as needed
■ Psychiatrists	■ Community Liaison Nurse	■ Consultants in all medical specialities
■ Rehabilitation Medicine	■ Research Nurse	■ Social Worker
■ Registrars	Allied Health	■ Dietician
■ Anaesthetists (Approved for training in Pain Medicine)	■ Physiotherapist	■ Pharmacist
■ Psychiatrists	■ Occupational Therapist	
■ Resident Officers (Approved for training in General Practice)	■ Psychologist	
	■ Pharmacist	



Board Members/ANZCA Committees

Board Members

Dean	Milton Cohen
Vice Dean / Chairman HAC	Roger Goucke
Censor	David Jones
Assistant Censor / Treasurer	Graham Rice
Education Officer	Robert Helme
Chairman Examination Committee	Penelope Briscoe
Chairman Research Committee	Julia Fleming
ASM Officer	Stephan Schug (non Board Member)
MOPS Officer	Leigh Atkinson Bruce Kinloch Ben Marosszeky
Co-opted Member representing ANZCA	Mike Martyn

Examination Committee

Chair	Penelope A Briscoe
Dean (ex officio)	Milton L Cohen
Education Officer	Robert Helme

Members

ANZCA	Lindy Roberts
AFRM (RACP)	Carolyn Arnold
RACP	Ray Garrick
RANZCP	George Mendelson
RACS	Leigh Atkinson

Education Committee

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

Members

ANZCA	Jane Trinca
New Fellow Representative	Susan Lord
AFRM (RACP)	Geoff Booth
RACP	Michael Butler
RANZCP	Faizur Noore
	Frank New
RACS	Leigh Atkinson

Hospital Accreditation Committee

Chair	Roger Goucke
	Milton Cohen
	Penelope Briscoe
	Robert Helme
	Julia Fleming
	Ben Marosszeky

Research Committee

Chair	Julia Fleming
	Milton Cohen
	Anthony Schwarzer
	Robert Helme
	Stephan Schug
	Colin Goodchild
	Di Pacey
	Phil Siddall
Univ of Adelaide (non Fellow)	Andrew Somogyi
Univ of Qld (non Fellow)	Maree Smith

Representation on ANZCA Committees

Education	Rob Helme
General Examinations	Penelope Briscoe
Primary Examination	Penelope Briscoe
CE&QA	Leigh Atkinson
Constitution Review	Milton Cohen
Workforce	Rob Helme
Board of Anaesthesia, Intensive	
Care & Pain Medicine Foundation	Milton Cohen
Communications	Leigh Atkinson
Information Technology	Malcolm Hogg
ASM Scientific Program	
Officer 2005	Michael Butler /Bob Large
ASM	Stephan Schug
Research	Julia Fleming
ACECC	Jane Trinca
Library	Roger Goucke
Salaries Review Committee:	Milton Cohen
Asia Pacific	Vacant
Clinical Indicators Working Party	Paul Wrigley
OTS	David Jones

Regional Committees

Queensland	Leigh Atkinson / Graham Rice
New South Wales	Milton Cohen
Victoria	Julia Fleming
Tasmania	Gajinder Oberoi
South Australia	Penelope Briscoe
Western Australia	Roger Goucke
New Zealand National Committee	David Jones

External Committees & Organisations:

Australasian Anaesthesia	Lindy Roberts
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Queen's Birthday Honours 2004

AO Officer in the Order of Australia – for distinguished service of a high degree to Australia or to humanity

Professor Rupert Leigh Atkinson FRACS

AM Member in the Order of Australia – for service in a particular locality or field of activity or to a particular group

Professor Richard John Vaughan FRACS



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*
- 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 (1999) The Handover of Responsibility During an Anaesthetic (*Adopted February 2001*)
- PS15 (2000) Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery with amendment to the title to read Recommendations for the Perioperative Care of Patients Selected for Day Care Procedures (*Adopted February 2001*)
- PS18 (2000) Recommendations on Monitoring During Anaesthesia (*Adopted February 2001*)
- PS20 (2001) Recommendations for Responsibilities of the Anaesthetist in the Post-Operative Period (*Adopted February 2001*)
- PS31 (2003) Recommendations on Checking Anaesthetic Delivery Systems (*Adopted July 2003*)



Queensland Regional Committee

Retirement and Ten Year Presentation



Joyce Holland
Regional Administrative
Officer Queensland

When I started in the position of Administrative Officer Queensland in 1994 there were 259 Queensland Fellows and today there are 491. Those ten years have seen many changes in the College in Queensland. Courses have been developed and are now provided for all pre exam requirements. The Combined CME Meetings are increasingly successful and this year the 8th Annual Registrars' Meeting will be held. QATS, the Queensland Anaesthetic Training Scheme is now a secretariat responsibility and the Revised FANZCA Program is a fait accompli. The secretariat staff has increased to include

a second full time member to deal with the many varied events that occur in the name of anaesthesia in Queensland.

College House in Brisbane was renovated and now provides a self contained office for anaesthesia and intensive care and the constantly used conference rooms, have helped to make it all happen.

I am very proud of what I have been able to assist Queensland Fellows to achieve during my tenure.

Since I announced my retirement I have been truly touched by the many messages I have received from Fellows and Trainees. I will certainly miss the constant challenges and contacts of the position.

Now it is time for me - to cook and sew and make flowers grow. To revive hobbies and interests and do those things I have always wanted to do. And to read and sleep and travel and spend much more time with my four grandsons, and hopefully a granddaughter in the New Year. I thank you all for the gift of a digital camera which I will use with the utmost joy.

My personal sincerest thanks to many of you for your friendship and caring over the years.

To College Staff around Australia and New Zealand I thank you all for your camaraderie and support over these years.



Queensland Annual ANZCA/ASA Continuing Education Meeting



The 28th ANZCA/ASA Annual Continuing Education Meeting of Queensland was held on Saturday 10th July at the Caloundra Cultural Centre, Sunshine Coast. The theme of the meeting was "Challenges In Anaesthesia In 2004". 150 delegates and 17 Health Care Industry companies participated.

The keynote speaker was Professor Barry Baker, Nuffield Professor of Anaesthetics, University of Sydney, who spoke on the "Ageing Practitioner in Australia". Other aspects covered included "ECG and the Anaesthetists" presented by Dr Rob Moss, "Pacemakers", presented by Dr Cathy Kingsford (Scientist), "The Role of Maternal Oxygen in Foetal Distress", presented by Dr Steve Mitchell, "Epidurals in 2004" presented by Dr Martin McNamara, and "Regional Techniques with Catheters", presented by Dr David Scott. Delegates were highly satisfied with the educational program.



The conference was opened by Dr Martin Culwick, Queensland ASA Chairman. Dr Michael Beem, Queensland Chairman of the ANZCA presented a Council Citation to Dr David McConnell and also presented a gift on behalf of the College recognising Mrs Joyce Holland's retirement.



Victorian Regional Committee Annual Combined ANZCA/ASA CME Meeting

The 25th Annual Combined CME of the Victorian Section of the Australian Society of Anaesthetists and the Victorian Regional Committee-ANZCA was held on Saturday 17th July 2004 at the Sofitel Melbourne. The meeting "Risky – Bloody – Obstetrics: Clinical dilemmas in everyday practice" attracted a larger than anticipated number of registrants including seventeen (17) Health Care Industry exhibitors.

The program focused on obstetrics, haematology for anaesthetists, risk management and issues relating to consent including case presentations and discussion. Contributors included prominent local and interstate anaesthetists, physicians and medical risk management experts. The recently created Supervisor of Training Certificate of Recognition was presented to Supervisors present.

The CME Organising Committee and Ms Corinne Millane, VRC Administrative Officer is to be applauded for a job well done! A limited supply of surplus copies of the Meeting abstract book remains and can be obtained by contacting the Victorian Regional Committee at the College.

Andrew Schneider
Convenor

New Fellows Conference



Vic ANZCA/ASA





Victorian Regional Committee

Annual Anaesthetic Registrars' Scientific Meeting

The 2004 Annual Registrars' Scientific Meeting was held on Friday 16th July in the "ANZCA House" Auditorium.

There were a record number of presentations (20), and once again, the standard of work presented was high. The meeting attracted the unprecedented number of 136 registrants, including 14 Health Care Industry exhibitors.

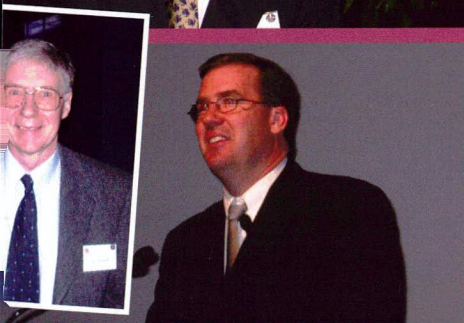
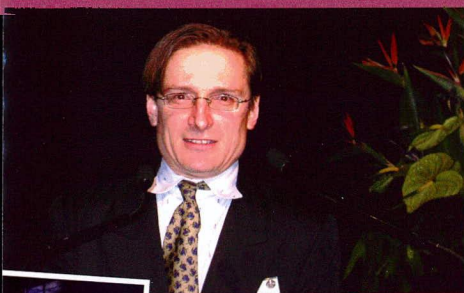
Dr Tony Keeble, from the Department of Anaesthesia, Ballarat Base Hospital was awarded the \$500 prize donated by AstraZeneca Pty Ltd for his presentation "Temperature management during interhospital transfer of intubated patients: A comparison of passive versus active warming."

Many thanks to our Administrative Officer, Ms Corinne Millane, Formal Projects Officer

Dr Beth Ashwood, Deputy Chair Dr Winifred Burnett, and College Staff for their assistance, and organisation of the Meeting. My thanks go to those Fellows [Drs Mark Anderson, Peter Howe, Maggie Wong, Andrew Schneider and David Story] for their willingness to act as session chairs or judges.

David Bain
Regional Educational Officer

CME Meeting



Vic ARSM



Formation of a Conjoint Rural Committee of JFICM and ANZICS

There has been much ongoing discussion regarding rural issues in the intensive care community over the last few years. Out of this, a Rural Email List has been established successfully and has been an active and positive forum for exploring the many problems encountered in rural areas. From this forum, there has also been discussion of setting up a rural committee to help formally address these issues.

At a recent Board meeting of the Joint Faculty, a proposal for a conjoint Committee regarding rural intensive care was considered. After discussion, it was agreed that;

1. This conjoint committee should be established with members representing both JFICM and ANZICS and that the Committee should report to both Boards.

2. The Committee should probably be composed of:

- A JFICM Board member
- An ANZICS Board member
- An ACEM nominee
- 2 rural representatives nominated by JFICM (Australian)
- 2 rural representatives nominated by ANZICS (Australian)
- A New Zealand rural representative (nominated by either JFICM or ANZICS)

3. The chairman will be elected by the Committee members and should be a rural representative.

4. Initial Terms of Reference for the Committee would include:

- To investigate ways of attracting JFICM intensivists to rural practice.
- To investigate ways to better support JFICM and non-JFICM intensive care practitioners in rural practice.
- To investigate ways of allowing ICU training in rural ICUs (accreditation of sites, rotations from metropolitan ICUs)
- To investigate whether it is practical to set up a rural group such as a rural SIG between JFICM and ANZICS and ACEM along the lines of the Rural SIG of ANZCA and ASA.
- To facilitate CME in rural areas for both JFICM and non-JFICM practitioners (Tertiary hospital visits, visits by tertiary centre intensivists, learning packages etc)

Could anyone interested in becoming involved in this new committee please contact either myself at stephen.edlin@health.wa.gov.au or Carol Cunningham-Browne at jficm@anzca.edu.au.

Dr Stephen A. Edlin
Rural Focus Officer

Jack Havill

Deans Message

kia ora (Hello),

As I begin my term as Dean, I wish to pay tribute to the hard work carried out by members of the previous Board and the supporting administrative staff. I have been constantly impressed by the display of dedication and professionalism.

Felicity Hawker, a previous Dean, has now resigned from the Board after eleven years of excellent contributions across many portfolios, which commenced with the Interim Board of the Faculty of Intensive Care, ANZCA, and involved most notably, the realization of the Joint Faculty. Felicity was working hard right up to the time of departing and one of her later legacies will be a major contribution to creating a working committee to address rural intensive care issues. An opportunity was taken to farewell Felicity at the June Board Meeting where she was thanked on behalf of the Fellowship.

“...I wish to pay tribute to the hard work carried out by members of the previous Board and the supporting administrative staff. I have been constantly impressed by the display of dedication and professionalism.”

Neil Matthews was also acknowledged as he now steps down from a productive time as Dean. It is worthwhile reflecting about a few of the changes that have occurred under Neil's Deanship. A new Trainee Program has been developed. Neil, in particular, has been instrumental in establishing links with the Australasian Academy of Critical Care Medicine and an agreement now exists whereby the Journal of Critical Care and Resuscitation is now the Journal of the JFICM. An excellent liaison has been established with ANZICS and we look forward to developing this partnership over the coming years. Two examples of this include cooperation at the Inaugural JFICM Annual Scientific Meeting to be held in 2005

and moving towards the establishment of a combined committee which will address Intensive care and training issues affecting our rural colleagues. All of the above are likely to have long term effects on the directions of the JFICM. Neil has been excellent in a number of political areas and his insight and wise counsel will continue on the Board for at least another year. Thankyou Neil.

Board Elections 2004

The Fellowship has spoken and we have three new elected Board members who bring significant strength to the Board. Stephen Edlin, Deputy Chairman of the Fellowship Examination Committee, has been involved as an Examiner for nine years. David Ernest has been a co-opted member on the Training Committee and was an ANZICS representative on the Intensive Care Medical Liaison Committee and Joint Specialist

Advisory Committee – Intensive Care since 1996. Megan Robertson has been a past Chair of the Victorian Regional Committee and is active in ANZICS affairs. In view of this significant body of experience, we look forward to their contributions.

Valò Dr Cam Barrett

Many of you will know Cam Barrett from Wellington. He died unexpectedly in May. I would like to pay tribute to him and acknowledge his life of work in intensive care medicine. He was one of the pioneers in New Zealand and established the first Wellington ICU in 1963, continuing to help staff the unit until his

death. An obituary is printed elsewhere in the Bulletin but we recognise him as an innovator and a fine man who encouraged many others in the intensive care discipline.

Future Directions

As we look ahead, some of our immediate goals are:

1. Development of a formal detailed curriculum.

At this point we have an excellent set of Objectives of Training (developed with considerable input from Felicity Hawker) and a well respected Fellowship Examination which measures what we expect the candidates to know. Further work is required on defining the curriculum in detail and one of our aims is to "blueprint" the process so that the Objectives, Curriculum detail, and the Examinations are all clearly aligned. This is a major exercise and the new Education Officer, David Ernest, will lead the process with assistance from the Director of Education Russell Jones.

2. Supporting the needs of ICM specialists working in a rural environment.

A formal committee is to be established with representation from the JFICM and ANZICS Boards and other members representing rural intensive care. This is an exploratory endeavour which should allow a structured and representative way for those involved to address the issues which have emerged at various times over many years.

We are hoping that the New JFICM Program, which allows Basic Trainees to do training in ICUs who do not meet the strict Core Training guidelines, but can nevertheless offer some good experience, may overcome part of the problems.

3. Intensive Care Primary Examination.

The JFICM Board has discussed the establishment of a separate dedicated primary examination for those trainees undertaking



intensive care training only. There is a significant group who will use this method of entrance into advanced training. Assuming that the proposal is accepted, it is not the intention that this Examination would replace existing options for the first Part, but rather act as an

In conclusion, I am proposing to visit all the Joint Faculty Regional Committees in my first year as Dean, and ensure a good liaison between the Fellowship and the Board. Please do not hesitate to contact me directly with any concerns you may have.

"...one of our aims is to "blueprint" the process so that the Objectives, Curriculum detail, and the Examinations are all clearly aligned..."

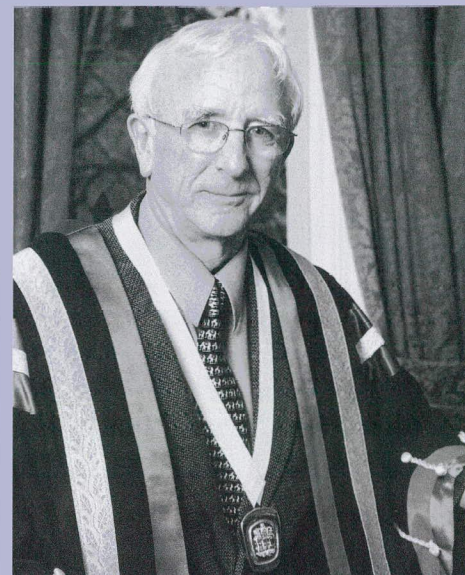
alternative. Dr Peter Morley (Chairman of the Examination Committee) and his Committee are reviewing issues such as when the exam will be offered and its content. Obviously there will also be resource considerations and administrative support needed.

4. **Area of Need and Overseas Trained Specialists.**

Considerable pressure is coming from Federal and State Government agencies on all Colleges to 'fast-track' the assessment of OTSs for Areas of Need. Colleges are being requested to identify a list of acceptable specialist qualifications for ICM from other countries, which will allow OTS in Areas of Need to be 'fit for task' in an AON position without further consultation with the JFICM. This raises quality and safety issues, and also the concern that a two tier system of medicine will develop. Intensive Care Medicine is a young and changing specialty in many other countries and it is difficult to ensure consistent standards comparable with Australia and New Zealand. We will be working with our Fellow Colleges and the Government to achieve the best possible outcomes for the Australian public.

Jack Havill

Jack Havill
Dean





Retirement from Board

Dr Felicity Hawker



The June Meeting of the Board of Faculty this year marked the retirement of Dr Felicity Hawker from the Board after 15 years representation on the national executive. Her period of appointment has spanned an era of great professional growth and development within the Intensive Care community and Felicity has been extensively involved in all aspects of this transition.

After receiving her specialty qualification (FFARACS) in 1984, Felicity was elected to the

national Section of Intensive Care Executive of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons in 1989. She moved on to the Board of the Faculty of Intensive Care in the newly formed Australian and New Zealand College of Anaesthetists in 1993 and held numerous offices with both the Faculty and the College over the next 10 years.

Felicity expanded her involvement in Faculty affairs, initially in her role as Regional Education

Officer (Intensive Care) for NSW from 1988-1991, then as a Member of the Education Committee (Intensive Care) 1989-1993, Faculty Education Officer 1994-1997, a Member of the Education Committee (ANZCA) 1994-1997, and Member of the Joint Specialist Advisory Committee (FICANZCA/RACP) from 1995- 2001. From 1997 – 2000 she was elected Censor and Vice-Dean. She was also responsible for Hospital Accreditation, Maintenance of Standards and Rural Affairs, and has been an Examiner from 1993. In these roles, she helped determine the direction of Intensive Care training and certification and thus shape the future of our profession.

Felicity became Dean of the Faculty in June 2000 and held this position during the momentous and very challenging period during the formation of the Joint Faculty with ANZCA and RACP. This transition, which united the two main streams of Intensive Care Medicine, required political sensitivity, diplomacy and an enormous amount of time and hard work, which Felicity generously provided. The success of the new Joint Faculty and the excellent standing of our professional body owes a great deal to the endeavours of Felicity and other Board members during this time.

It is testament to Felicity's untiring energy and commitment to Intensive Care that she was also a member of the ANZICS Executive/Board from 1991-1997. Throughout this time, she has continued her full-time clinical position as Director of Intensive Care at Cabrini Hospital and maintained her international expertise in the intensive care aspects of liver disease. In addition, she somewhere found time to be a mother and wife, and we must acknowledge the support provided by Bruce, Paul and their family.

The Board, on behalf of the Fellows and Trainees of the Joint Faculty, wish to express their sincere thanks and appreciation for the enormous contribution Felicity has made to Intensive Care Medicine in Australia, New Zealand and internationally during her tenure from 1989-2004.





New Fellows Conference 2004: The Intensive Care Perspective

The New Fellows Conference was held at Rottnest Island in April this year as a satellite meeting to the Perth ANZCA ASM. The two day meeting was attended by 18 new Fellows with 3 from the Joint Faculty.

"Risk Management in clinical practice" was the meeting theme and high quality talks were presented, with topics ranging from Risk Assessment to Maintenance of Professional Standards. Specific Intensive Care issues discussed included Rural Intensive Care, and the value of our Maintenance of Professional Standards programme.

Rural Intensive Care

Issues that were addressed included geographical remoteness of units from tertiary institutions, limited accessibility of tertiary unit support, lack of continuing education, medical and nursing staff shortages and the use of outdated equipment. Lively discussion of these challenges facing rural ICU resulted in the suggestion of several possible solutions.

1. Increased utilisation of telemedicine for regular "paper ward rounds" and teaching sessions. In particular, the Queensland scenario was commended, where units located throughout the state and even interstate can participate in the presentation and discussion of unusual and difficult cases. A recent article in *Critical Care Medicine* (Breslow et al, *Crit Care Med* 2004;32:31-38), discussed the use of this modality in the USA and reported a favourable impact on patient morbidity and mortality and ICU length of stay.
2. The formal linking of rural intensive care units to tertiary units, facilitating the exchange of knowledge, experience and staff, and combining research data. This would be akin to the concept of "sister cities" or professional mentoring at a unit level.
3. The development of dedicated rural ICU meetings (MOPS accredited) for updates in Intensive Care issues, for example as a satellite meeting to ANZICS ASM.

4. The Joint Faculty should canvas government for funding to improve staffing and equipment in isolated ICUs.

5. Further discussion is required to consider the rotation of advanced trainees through rural units as part of their core intensive care training to gain additional experience under different circumstances and to reduce rural staffing shortages.

6. There have been suggestions that the Intensive Care nurse practitioner model may be a possible measure to ease staffing pressures in remote areas.

Maintenance of Professional Standards

In a pro/con debate, shortcomings of the current MOPS programme were highlighted, particularly that MOPS does not adequately reflect skill maintenance. A case scenario was presented requesting a choice as to whom should insert your central line – the academic who fulfilled his MOPS requirement many times over but had limited clinical exposure, or the hands-on clinician who did not meet MOPS requirements but had inserted 200 central lines safely in the last six months.

However, current evidence does not support simulators as being adequate to maintain clinical skills and good clinical practice requires the application of evidence-based medicine, ie. appropriately timed and executed skills.

MOPS does not reflect clinical skills and hence the current edition of MOPS will only have limited success in assessing clinical performance. MOPS needs to be refined to reflect maintenance of knowledge and skills.

Conclusion

Risk management is akin to retirement planning: you always get told about it but there is no definitive independent source of information. With our increasingly litigious society, risk management should become second nature for

all clinicians. Should the Joint Faculty approach indemnity insurers to fund risk management courses? There is the incentive of reduced litigation and in turn, attendees could be offered reduced premiums for indemnity insurance.

The New Fellows Conference was a very useful meeting. However, there was poor Intensive Care representation. A recommendation was made to the Board of the Joint Faculty to link an Intensive Care NFC to the inaugural JFICM conference in Sydney 2005 and maintain an inter-specialty flavour to increase new fellows' exposure to other specialties.

Dr Marc Ziegenfuss

Admission to Fellowship of the Joint Faculty of Intensive Care Medicine

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

Graeme Maclaren	Vic
Peter Dzendrowskyj	NZ
Enda David O'Connor	Qld
Asif Raza	Vic
Elizabeth Louise Trent	NZ

Admission to Fellowship by Election, under Regulation 5.3:

Lara Shekerdeman	Vic
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Annual Report to Fellows 2003-2004

Joint Faculty of Intensive Care Medicine



Dr Neil T. Matthews
Immediate Past President

I have pleasure in presenting the Annual Report of the Joint Faculty of Intensive Care Medicine for 2004.

In summary, much has been achieved not the least being the acceptance of the Regulations incorporating the new Training Program, which required enormous effort, especially from the Administrative Staff. Importantly, the Australian Medical Council has ratified the Joint Faculty Fellowship as the only specialist training Diploma in Intensive Care.

Education and Training

This portfolio has been very active in the past year. There has been a continued increase in trainees registering for the program and the introduction of the new program has been a major initiative. Of note:

- The new training program for trainees commencing training from December 2003 has been implemented, and incorporated in the new Regulations. It allows for more flexibility of training between specialist programs and improved capacity for part time training. A notable change is that Basic Training will be permitted in non-accredited units (subject to approval by the Censor) and it is hoped this will go some of the way to ultimately encouraging doctors to smaller and rural units.
- Supervisors of Training are a very important group in the Fellowship. Following a survey, a number of initiatives are under consideration by the Education Committee to facilitate training of Supervisors.
- A new Education Committee was formed in October 2003, along with a Training Committee acting as a subcommittee. This was implemented following recommendations from the Australian Medical Council Accreditation Review. This will allow some streamlining of Board processes to permit more time for strategic discussions.
- A Trainee Committee has also been established with representation from each Australian State and New Zealand. The Chairperson of that group is elected and sits on the Education Committee. Trainees make an excellent contribution and offer a particularly useful perspective to many issues.
- A comprehensive Trainee Kit has now been produced and circulated.
- In training assessment will now be mandated prospectively.
- A "Senior" Registrar position has been endorsed as a requirement prior to completion of training.

Workforce issues remain a major concern and the Board will collaboratively work with ANZICS to explore problems of access and choice for medical graduates in their career choice. A reduction in working hours because of mandated changes in Awards will have an effect on training, and this has to be assessed.

Trainees

The following statistics are reported concerning Joint Faculty trainees as at June 2004:

Total Registered Intensive Care Trainees 561 (incl. 64 not active)

Male 381 Female 117

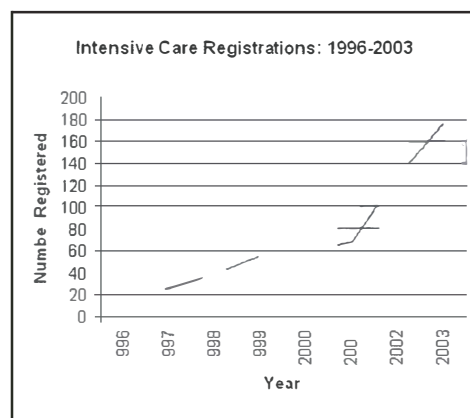
NSW	172	TAS	4
VIC	90	NT	6
ACT	16	NZ	42
Id	68	HK	15
SA	47	UK	11
WA	27		

Breakdown by training*

Trainin via JFICM onl **	199
Via JFICM and ANZCA	172
Via JFICM and RACP	51
Via JFICM and ACEM	60
Via JFICM, ANZCA & ACEM	3
Undertaking PIC	13

* Active trainees only

** includes those who may have completed other specialist training programs



Examination

August/September 2003 Paediatric Intensive Care Fellowship Examination

The written section of the Examination was held in Sydney. The Oral Sections of the Examination were held at The Children's Hospital at Westmead. The sole candidate Dr Jonathan Egan, was successful.



August/September 2003 General Intensive Care Fellowship Examination

The written section was held in Adelaide, Brisbane, Hobart, Hong Kong, Melbourne, Perth, Sydney and Townsville. The Oral Sections of the Examination were held at the Flinders Medical Centre and at the Royal Adelaide Hospital. This is the first time the Joint Faculty has used two Intensive Care Units in conducting the clinical section of its Fellowship Examination. Fifteen of the twenty-three candidates were approved.

Successful candidates

Dr C T Allen	Dr M J McNamara
Dr S Baker	Dr D J R Morgan
Dr C M Bradford	Dr S J Morphet
Dr D W Collins	Dr M K Saxena
Dr J A Fletcher	Dr P I Seet
Dr P B Goldrick	Dr C R Soh
Dr H G Koelzow	Dr T J Wigmore
Dr M F H Lindley-Jones	

April/May 2004 General Intensive Care Fellowship Examination

The written section of the Examination was held in Auckland, Brisbane, Hong Kong, Melbourne, Perth and Sydney. The Oral Sections of the Examination were held at the Royal North Shore Hospital. Seventeen of the twenty-two candidates were approved.

Successful candidates

Dr R J Ayer	Dr B P O'Brien
Dr J J Bates	Dr E D O'Connor
Dr N A M Blackwell	Dr A Raza
Dr K W Chan	Dr J E Ritchie
Dr D R Charlesworth	Dr S Sturland
Dr C M Cody	Dr H L Tan
Dr C L Foot	Dr S J Warrillow
Dr C Graves	Dr H T W White
Dr R A Lewin	

The G.A. (Don) Harrison Medal

The G.A. (Don) Harrison Medal was jointly awarded to two candidates for the first time following the 2003 Fellowship Examinations. I had the pleasure to present the Medal to Dr Jeremy Cohen of the Royal Brisbane Hospital in



Neil Matthews joined past Deans Alan Duncan and Geoff Clarke in Perth at the AGM, May 2004

Queensland and to Dr David Morgan of the Royal Perth Hospital in Western Australia, at the RACP ASM in Canberra in May this year.

New Examiner's Workshop

New members to the Joint Faculty's Panel of Examiners attended an Examination Workshop in February this year conducted by ANZCA. The two-day workshop covered a range of educational topics and examination techniques as a general introduction for recently appointed examiners. It is envisaged that this workshop will be an annual event where new examiners are introduced to the examination process.

OTS Performance Assessment (Examination)

The Joint Faculty conducted its first Performance Assessment Examinations for Overseas Trained Specialists in 2003. Three OTS candidates presented for assessment in the September 2003 sitting. Two candidates sat the Paediatric Performance Assessment of which both passed. One candidate presented for the General Performance Assessment and was unsuccessful.

Successful candidates (Paediatric):

Dr Peter Rhodes
Dr Andreas Schibler

Two OTS candidates presented in May 2004, of which one was successful.

Successful candidate:

Dr Jorge Brieva

Hospital Accreditation

Accreditation of Hospitals for training continues and is a considerable workload. Guidelines for accreditation of core training overseas have been developed, with the Paediatric Intensive Care Unit at Children's Hospital of British Columbia being the first to obtain such accreditation. Accredited Units are now required to submit data annually and the review of Policy Document IC-3 "Guidelines for Hospitals Seeking Accreditation for Training in Intensive Care Medicine" has withdrawn the S3 classification.

Representatives of the Board and Regional Committees reviewed 15 Intensive Care Units in the 2003 year. Currently accredited units in Australia, New Zealand and Hong Kong comprise the following:

- 33 units accredited for the full 24 months of core intensive care training
- 20 units for 12 months of training
- 12 units for 6 months of training



Annual Report to Fellows 2003-2003 (continued)

A survey of Units accredited for training was conducted to gather data on supervision and rostering within co-located Intensive Care Units. The results are currently being considered.

Professional Affairs

The Joint Faculty has formed a relationship with the Australasian Academy of Critical Care Medicine. This achieves an educational arm for the Joint Faculty, especially with the co-badging of the Journal "Critical Care and Resuscitation" as our official Journal, and is an important and significant milestone in our development.

The Board endorsed exploration of the following initiatives to assist rural doctors:

- A need for Representation on Board
- Development of the Focus Group to meet 3-4 times a year
- Establishment of an email list for improved communication
- SSRS funding is available for infrastructure for CPD for rural doctors.
- Co-operation with ANZICS by developing a bipartisan approach.

The Board reviewed and approved IC-11 "Guidelines for the In-Training Assessment of Trainees in Intensive Care Medicine". The document has been amended to include reference to the new program structure and incorporates the requirement that in-training assessment be compulsory for all advanced training, and desirable for basic training. The ITA form will also be updated to include reference to Advanced Training.

The Board approved IC-3 "Guidelines for Intensive Care Units Seeking Accreditation for Training in Intensive Care Medicine". The major amendments include the withdrawal of the S3 classification, and the requirement for C24 classified units to normally have a caseload of 750 patients per annum, a high level of illness severity and a range of speciality exposure. Policy Documents IC-1 and IC-3 have now been

cross-referenced to clarify issues relating to the classification of units and issues relating to training requirements.

The Joint Faculty has produced a Career Guide on Intensive Care Medicine for medical students and junior doctors. The Guide has been well received.

In addition to attending meetings of parent Colleges, other important liaison kept members of the Board busy.

- Meetings with the Australian Medical Council and other medical colleges, to discuss Overseas Trained Specialists and Area of Need with the aim of fast tracking recruitment of specialists
- Investigation into the possibility of dual certification was discussed with senior representatives of the Australasian College for Emergency Medicine.
- A meeting with rural representatives in Cairns was fruitful in sharpening the focus on rural intensive care.

Continuing Education

The 2004 ASM in Perth was well attended, and the visiting speakers Professors Ian Roberts, David Linton, Michael Meisner and Dr David Burgner were all well received.

Hopefully all Fellows will be aware that the Joint Faculty is organising its first stand alone meeting on 10 – 12 June 2005 on Neurosciences, to be held in Sydney, with an impressive list of invited speakers. Future meetings will concentrate on single topic themes. Support will continue for ANZCA and RACP ASM's but in different formats that support education of anaesthetists and physicians who are involved in management of intensive care patients.

The introduction of an electronic mode of annual return for those participating in the MOPS Program has been introduced this year.

Finance

The Joint Faculty's audited accounts have been circulated to all Fellows. They are now separately identified, with strategies being developed for management of funds. An agreement on rental/use of facilities at ANZCA House has been reached.

The following concessions for Subscriptions were agreed :

1. Fellows over the age of 65 years practising any form of medicine 50%
2. Fellows under the age of 65 years practising medicine but not practising anaesthesia, intensive care medicine, pain medicine or related discipline 50%
3. Fellows not practising any form of medicine 100%
4. Fellows working in a missionary or similar field where the income is small 100%
5. Fellows engaged in full-time College-funded or College-approved research and undertaking no more than two clinical sessions per week 50%
6. Fellows undertaking two or less sessions per week over one full year in intensive care medicine, anaesthesia, or pain medicine, not practising any other form of medicine or related activity 50%
7. Fellows resident outside Australia and New Zealand 50%
8. Fellows resident outside Australia, New Zealand, Hong Kong, Singapore or Malaysia after five years of residency outside these countries 75%

Research

At the present time, the Joint Faculty continues its support of the ANZCA Foundation and the ANZCA Clinical Trials Group. Such support is contingent on a collaborative and non-competitive relationship with ANZICS.



Fellowship Affairs

Honours and Appointments

The Board congratulated the following Fellows on their honours:

T.E. Oh, WA – Fellowship of the College of Anaesthetists, Colleges of Medicine of South Africa

Professor G.A. Barker, Canada – Life Time Achievement Award, The World Federation of Paediatric Intensive and Critical Care Societies

Dr Alan Duncan (WA) – Chief Editor, *Anaesthesia and Intensive Care*

Dr Peter Sharley (SA) – Order of Australia Medal, Bali Bravery Awards

Dr Di Stephens (NT) – Order of Australia Medal, Bali Bravery Awards

Admission to Fellowship

The following Fellows were admitted to Fellowship of the Joint Faculty of Intensive Care Medicine by examination in the previous 12 months:

Stuart Bradley Baker	SA
Elizabeth Jane Bennett	Qld
Satyadeepak Bhonagiri	NSW
Celia Maree Bradford	NSW
Jeremy Cohen	QLD
David William Collins	NSW
Kush Gurunath Deshpande	Vic
Peter Dzendrowskyj	NZ
Robert Wilson Frengley	NZ
Dhawal Ramniklal Ghelani	NSW
Paul Brian Goldrick	Qld
Heike Gunhild Koelzow	NSW
Iain George Johnston	Qld
Paul James Lane	QLD
Mark Joseph Lennon	WA
Mark Anthony Philip Lucey	Ireland
Graeme Maclaren	VIC
Martin John McNamara	Qld
Manoj Krishan Saxena	NSW
Judith Shen	IIK

Endorsed in Paediatric Intensive Care

Jonathan Rogers Egan NSW

Fellows' Statistics

Total Fellows: 482 421 male 61 female

Geographical disposition:

VIC:	86	New Zealand:	51
NSW:	127	Hong Kong:	16
ACT:	6	Malaysia:	2
QLD:	69	United Kingdom:	28
SA:	39	Ireland:	0
WA:	33	Canada:	5
TAS:	10	United States:	7
NT:	1	Other:	6

Total Australia: 370

Internal Affairs

Jack Havill has been appointed Dean-elect.

Drs Gill Bishop and Toby Thomas and Professor Tony Bell have stepped down from the Board and their considerable contributions are acknowledged. Dr Felicity Hawker, past Dean, has also resigned from the Board, following 20 years of significant contribution to College, Faculty and Joint Faculty Affairs.

In March a call for nominations was forwarded to all Fellows. Eight nominations were received for three positions, and a ballot conducted in May. The results are attached at Appendix 2 and I congratulate Drs Megan Robertson, David Ernest and Steve Edlin and wish them a very rewarding time on the Board. I would also like to thank Dr Ranald Pascoe for his contribution as the co-opted representative of Queensland on the Board during the past year.

The following is the result of the ballot:

Envelopes Received	209
Less Invalid Envelopes	15
Total Ballots Received	194
Less invalid Ballots	3
191 x 3 = 573	

<i>Position of Ballot</i>	<i>Votes Counted</i>
ROBERTSON, Megan Sue	102
EDLIN, Stephen Arthur	96
ERNEST, David	83
CORKERON, Michael Anthony	78
FREEBAIRN, Ross Callum	70
PASCOE, Ranald Lochiel Stewart	59
LAMBERT, John Francis	49
GOWARDMAN, John Robert	36
Total Votes	573

In conclusion I would like to thank our Executive Officer, Ms Carol Cunningham-Browne and our administrative staff Andrew Coghill and Megan Freeth. I would like to also thank other Board Members for their support, counsel, hard work and vigorous debate to ensure the Board maintains standards of excellence in the Specialty of Intensive Care Medicine on behalf of its Fellows and Regional Committees.

I have greatly appreciated the collegiality and co-operation of ANZICS Presidents, John Santamaria and David Fraenkel. The relationship between the two organisations is essential to ensure the strength and growth of intensive care medicine as a specialty.

Importantly, I would like to thank our Fellows and Trainees for their encouragement, support, passion and energy which have ensured a vibrant and energetic Board. It has been an honour and a pleasure to represent you as Dean. I congratulate Jack Havill on his appointment as the new Dean, and I wish him well.



Regional/National Committees Annual Reports

New Zealand

New Zealand National Committee

Office Bearers and Members

<i>Chair</i>	Dr Ross Freebairn
<i>Vice Chair</i>	Dr Seton Henderson
<i>Honorary Secretary</i>	Dr Tony Williams
<i>Elected member</i>	Dr Les Galler
<i>Co-opted 5th member</i>	Dr Emma Merry from 30 June 2003.

Ex-Officio Members

Associate Professor Jack Havill;
Vice Dean of JFICM

Dr Peter Roberts;
Royal Australasian College of Physicians

Dr Peter Cooke;
Australian and New Zealand College of
Anaesthetists

Dr Bruce King;
Australian and New Zealand Intensive Care Society

New Fellows Representative Dr Claudia Schneider
from 10 Nov 2003.

Administrative Assistant Jan Brown

*Total Number of National Committee
Meetings for year:* 3

Attendances of Elected and Co-opted Members

Seton Henderson	(3-3)
Les Galler	(0-3)
Ross Freebairn	(3-3)
Tony Williams	(3-3)
Emma Merry	(3-3)

Education and Training

Currently New Zealand has 41 Trainees.

Annual General Meeting

Held at Te Papa, Wellington on the 25th March 2004.

Chairman's Report

The last year has been busy with changes in legislation in New Zealand. The Health

Practitioners Competence Assurance Act 2003 (HPCA) has now been passed and it is being implemented in stages this year. This Act is the legislation regulating medical practitioners and all other health professionals. Areas like 'recertification' and 'Scopes of Practice' are being tested through this legislation as there is the potential for change in the future. The Accident Compensation Corporation Act is currently being reviewed and it is likely to change with regard to how medical misadventure is assessed.

Our Fellowship numbers have increased to over 50 during the year which enabled us to increase our Committee to 5 by co-opting Dr Emma Merry as the 5th member and inviting Dr Claudia Schneider to come on to the Committee as the New Fellows representative. Dr Schneider was also our representative to the New Fellows Conference in Perth in May 2004.

The following are areas where the New Zealand National Committee has been involved:

Medical Council of New Zealand

Two separate submissions were prepared for the MCNZ by the Committee on Scopes of Practice and Qualifications under the HPCA.

- (i) The first was in anticipation of the implementation of the new legislation.
- (ii) The second submission was on recertification and re-credentialling for Scopes of Practice. There is a suggestion that the Ministry of Health, through the credentialling process would be able to define Scopes of Practice of non-vocationally registered health professionals. We are concerned that this is open to manipulation that may not be in the best interest of the public.

The Committee sought clarification from the MCNZ on the definition of the wording 'practice of medicine' and if that applied to visiting speakers. They have now defined their policy further by adding to their statement 'that providing there is no patient contact,

it is considered to be a non-clinical practice and therefore does not require MCNZ approval.'

Health and Disability Commission:

Review of the HDC Act and Code.

The Committee has prepared a submission to the H&DC review. Our concerns were the need to clarify consent for trials on unconscious patients and to ensure that there was a right to appeal the H&DC findings in a higher court.

Ministry of Health

- (i) Intensive Care Services Document.

The Ministry of Health has been preparing this document over a long period. It has been developed with the input from ANZICS, JFICM and the CCNS (Critical Care Nurses). The final document which has been circulated included the JFICM Minimum Standards which is very pleasing. The Ministry now requires this service from the District Health Boards.

- (ii) Clinical Action Plan for Emerging Infectious Diseases. Our Committee has representation on the Ministry of Health Working Party setting up the MOH plan. The current consensus has taken some time to reach and the MOH has moved away from establishing a 'SARS' hospital. The lack of ICU funding, beds and other resources has been made apparent to the MOH planners.
- (iii) Clinical Training Agency (CTA). Intensive Care funding has not been separated out from the other specialist branches in the Strategic Intentions 2004-2013. This has concerned the NZNC and we have registered these concerns with the CTA as future funding could become a problem. The Committee hopes to address this within the next year. Training and training time has become an issue with the reduction in the working hours of the residents impacting upon rostering. A/Prof Havill is currently preparing a discussion document for the Committee dealing with the trainees' hours



of work and relationship of safety and learning. This paper deals with rostering and training while considering the level of back-up for each ICU. The RMO contracts may need to change as a result of this research.

(iv) Labelling of medication (injectable medications). The Committee is still awaiting a reply after enquiring which division of the MOH or other agency was responsible for this area. Medsafe claims to be responsible for the legal requirements of prescribing, but not for the safety of the labelling. Pharmac will purchase to the standard required but labelling is not currently part of the standard.

Education

A Faculty workshop on education and teaching was run at the New Zealand ANZICS meeting in March in Wellington facilitated by A/Prof Jack Havill.

Ross Freebairn

Chairman

Joint Faculty Fellowship Examinations 2005

General Examinations

April/May	Location	Date
WRITTEN SECTION	All Major Centres	4th April
ORAL SECTION	Sydney	18th – 20th May
CLOSING DATE		7th February
August/September	Location	Date
WRITTEN SECTION	All Major Centres	1st August
ORAL SECTION	Melbourne	14th – 16th September
CLOSING DATE		6th June

Paediatric Intensive Care Examination

August/September	Location	Date
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: \$TBA

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.



Regional/National Committees Annual Reports 2003-2004

New South Wales

Office Bearers and Members

<i>Chair</i>	Dr Edward Stachowski
<i>Vice Chair</i>	Dr Yahya Shehabi
<i>Secretary</i>	Dr Ian Seppelt
<i>Elected members</i>	Dr Elizabeth Fugaccia Dr Dorothy Breen (resigned 2003) Prof John Myburgh (also ex-officio)
<i>ACT Representative</i>	Dr John Gowardman Dr Helen Bidstrup
<i>New Fellows' Representative</i>	Dr Michael Davis
<i>Ex-officio Board Members</i>	Dr Richard Lee Dr Ray Raper Dr Gill Bishop (resigned 2003) Dr Jonathan Gillis

Changes in the Regional Committee membership

During the past year a number of changes in the membership of the regional committee have taken place. These include Dorothy Breen resigning due to her move to Ireland. Dorothy had been a member of the Regional Committee since 1998 and had participated in many of the committee's meetings and activities. John Gowardman's move to Tasmania earlier this year saw ACT Fellows now being represented by Helen Bidstrup. We wish John all the best with his move to Launceston and thank him for his enthusiastic representation of the ACT Fellows on the Regional Committee. Gill Bishop resigned from the Board of the Joint Faculty as well as the NSW Regional Committee in June 2003. Gill had been an active member and stalwart on the committee for many years. Her wisdom and insight will be missed.

Total number of Regional Committee meetings held

<i>Dates of meeting</i>	3
	30 July 2003
	19 November 2003
	31 March 2004

Attendances of elected members

Edward Stachowski	3
Dorothy Breen	0
Elizabeth Fugaccia	3

Yahya Shehabi	1
Ian Seppelt	3
John Myburgh	2

Hospital accreditation

At present 18 hospitals in NSW / ACT are accredited for training purposes. The following hold C24 classification:

John Hunter	Prince of Wales
Westmead	Royal North Shore
Sydney Children's	St Vincent's
Liverpool	Royal Prince Alfred
The Children's Hospital at Westmead	Canberra
St George	Nepean

C12 classification is held by

Concord	Gosford
Blacktown	Wollongong

C6 classification is held by

North Shore Private	Hornsby
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Statistics

Out of a total of 472 Fellows of the Joint Faculty of Intensive Care Medicine, 129 are from NSW and 7 from the ACT. This represents 27% of the Fellows of the Joint Faculty. NSW representation on the Board of the Joint Faculty remains strong with Ray Raper, Richard Lee, John Myburgh and Jonathan Gillis all contributing to managing the affairs of the specialty.

The year 2003 saw five out of six NSW candidates who presented for the Fellowship Examination pass. They included Celia Bradford (Royal North Shore Hospital), Tim Wigmore (Westmead Hospital), Heike Koelzow (Royal Prince Alfred Hospital), Manoj Saxena (St George Hospital) and David Collins (Prince of Wales Hospital).

NSW Intensive Care Long and Short Courses

A long course program for trainees studying toward the Fellowship Examination is now in its fifth year. The course has the active support

of 11 Intensive Care Units around the Greater Sydney Metropolitan region. The units involved include Concord, Royal North Shore, Prince of Wales, Blacktown, Nepean, St George, Liverpool, Wollongong, Royal Prince Alfred, St Vincent's and Westmead.

Local Fellows give of their time and effort freely to teach and help prepare candidates for the exam. With the rotation of the Wednesday evening teaching sessions between the 11 units no one facility is ever overburdened. The candidates have also expressed the benefits derived from visiting other units and being exposed to consultants other than those they work with on a daily basis.

The year 2004 has seen the number of Sydney based trainees intending to sit the exams rise to 13. Whilst some are planning to sit in 2005, most are preparing for exams this year. This number is the highest ever in the Sydney region at any one time.

With the rise in the number of registered trainees, together with keen desire on the part of many intensivists to help them in their exam preparation, a Sydney Short Course in Intensive Care Medicine was successfully convened from 27-29 April 2004. A dedicated cohort of intensivists have formed a non-profit, charitable organisation known as 'Australian Critical Care Education Incorporated.' This incorporated association will be the vehicle to organise the future Short Courses, as well as other teaching activities dedicated to trainees in intensive care.

Role of the Senior Registrar

Members of the regional committee endorse the training changes that have included a period of advanced training time being spent in the capacity as a senior registrar in recognised units. It was agreed that spending time in the post of a senior registrar will give valuable experience and insight for trainees as they plan to make a transition to consultant practice. The NSW Regional Committee has been actively pursuing these changes for many years in the belief that it will be of benefit to trainees.



Victoria

Medical Workforce – Intensive Care

Difficulties continue to exist in filling numerous consultant intensivist positions throughout NSW. This tends to be most difficult in metropolitan district and rural base hospitals, whereas the teaching hospitals remain relatively well serviced. In some cases these problems are exacerbated by poorly equipped, under-resourced facilities that are mis-managed by bureaucratic area health service officials who have very little idea of what actually goes on in an intensive care unit. This has resulted in positions and conditions being deemed inefficient and unattractive to appropriately qualified intensivists.

The idea of the solo intensivist running an intensive care unit should have been relegated to the bin long ago. Adequate support in the form of fellow senior and junior medical staff, be they employed locally or as locums, together with nursing and paramedical staff and competent management is fundamental for the survival of these smaller non-tertiary intensive care units, especially those in rural areas.

Members of the regional committee have been involved in processing of Area of Need applications from NSW Health. It is likely that this problem will grow with the 'easy solution' of trying to attract overseas trained doctors being favoured by employers rather than attacking one of the root causes of the problem – workplace / work-practice reform. Attracting trainees to the specialty remains difficult, and will not get better till our workplace treatment of trainees is improved to be in line with that of other specialist trainees.

The hospital inspection teams have highlighted the problems they have seen and suggested strategies to improve the facility's ability to attract appropriately qualified intensivists. It is anticipated that Area of Need applications will grow in number in the ensuing years as various government agencies continue to dither about what to do as an interim measure, rather than trying to find real solutions. The changes needed to make a difference in 5-10 years time are needed now, not tomorrow.

Trainees

Attracting locally qualified trainees remains a perennial problem for most small as well as large intensive care units. Who are our trainees? Why do they choose to work in intensive care? What do they think about their training and workplace conditions? These are some of the questions to which E Stachowski and E Fugaccia sought an answer in an anonymous survey of registered trainees recently compiled. The preliminary analysis of the data is almost complete and will be submitted to the Board of the Joint Faculty for the June meeting. A full presentation of the results will be given in the 2004 ANZICS ASM in Melbourne.

Trainees' Representation

The NSW Regional Committee has supported the need for trainee representation on the Board of the Joint Faculty as well as the Regional Committees. This has seen Celia Bradford from Royal North Shore Hospital nominated as the NSW Trainees' Representative. NSW and ACT based trainees should feel free to approach Celia should they have concerns with regard to training and Faculty issues.

Future activities

With greater than 75 fellows in the NSW / ACT region six positions on the regional committee are due to be filled for the period July 2004 - June 2006. Election to membership of the new regional committee has been recently finalised. Successful nominees were Edward Stachowski, Yahya Shehabi, John Myburgh, Ray Raper, Elizabeth Fugaccia and Ian Seppelt.

It is anticipated that in the coming year there will be three NSW Regional Committee meetings, which will be scheduled to follow within 6 weeks of a Faculty Board meeting. A new Chairman will be elected at the next regional committee meeting due to be held in July 2004.

Edward Stachowski

Chairman (Retiring)

Office Bearers and Members

<i>Chair</i>	Dr Craig French
<i>Deputy Chair</i>	Dr David Ernest
<i>Honorary Secretary/Treasurer</i>	Dr David Green
<i>Ex-Officio Board Members</i>	Dr Felicity Hawker
	Dr Peter Morley
<i>Co-opted New Fellow</i>	Dr Julian Hunt Smith
<i>Co-opted Committee members</i>	Dr Jon Buckmaster
	Dr Chris Maclsaac
	Dr Megan Robertson
<i>Regional Administrative Officer</i>	Ms Corinne Millane

The Committee's major challenge remains increasing the awareness of Regional Committee and Joint Faculty affairs amongst Victorian Fellows. Unfortunately we have had only limited success: four out of over seventy eligible fellows nominated for the 2004-2006 Regional Committee. They are David Ernest, John Buckmaster, Julian Hunt-Smith and I. I sincerely thank this small and enthusiastic group who have given their time to represent Victorian fellows. Officer Bearers will be selected at the Thursday 10th June 2004 VRC Meeting. I would also like to take this opportunity to sincerely thank retiring Members and Members who did not renominate for election for their expertise and welcome contribution over the last two years.

Over the past twelve months the Committee has continued to review College and Joint Faculty Professional Documents and participate in hospital credentialling. Other items addressed included the Medical Practitioners Board of Victoria's performance management document and its implication for Victorian Fellows, the development of a Victorian Registrars' inter-hospital lecture course and the credentialling of overseas trained specialists occupying locum appointments in Victoria. The Regional Committee also represented the Joint Faculty at the Victorian Medical Postgraduate Foundations Career Expo promoting a career in Intensive Care Medicine to final year medical students and hospital medical officers.

On behalf of the VRC JFICM I would like to thank Ms Corinne Millane for her expert assistance and the JFICM Executive Officer Ms Carol Cunningham Browne for her ongoing support.

Craig French

Chairman



Regional/National Committees Annual Reports 2003-2004

Western Australia

Committee Members

<i>Chair</i>	Dr David Simes
<i>Vice Chairman</i>	Dr Cyrus Edibam
<i>Honorary Secretary</i>	Dr Bernice Ng
<i>Member</i>	Dr Brad Power
<i>Board Representative</i>	Dr Vernon van Heerden

The year in the West culminated in hosting the National Annual Scientific Meeting with the College of Anaesthetists and Faculty of Pain Medicine. Labelled "State of the Art", the Perth Concert Hall provided an ideal venue for the plenary components of the meeting, with the adjacent Duxton Hotel being used for smaller presentations. Congratulations to Mark Josephson, Lindy Roberts, Congress West and the organizing committee for creating such an excellent ASM.

The Intensive Care speakers were of an outstanding quality. Professors Ian Roberts (Foundation Speaker), Bala Venkatesh, David Burgner, David Linton and John Myburgh put in multiple appearances, with a supporting cast

headed by Vernon Van Heerden, Michael Meisner, Mary Pinder and David Blythe. It was a great mix of international and local talent.

On the examination front, Western Australia basked in some reflected glory with David Morgan sharing the Don Harrison Medal for 2003. Congratulations to David and to all the other successful examination candidates.

Central Faculty initiatives saw the beginning of a successful Trainee Committee, providing closer in-put from Trainees and recent graduates into the Faculty's education programme. Stuart Baker is the first Western Australian representative.

I was the fortunate recipient of the initiative to invite Regional Chairmen to attend the Faculty meeting in Melbourne. This was an eye-opener to a self-confessed authority-hating anarchist who was anticipating a grey, indoor world of structured meetings. Instead, it proved to be a group of altruistic people spending the better

part of two days jointly carving out Joint Faculty decisions for the common good of Intensive Care in Australia and New Zealand. Thank you for this opportunity.

There are two farewells to note: one is the imminent departure of Dr Neil Matthews, from his position as Dean. We thank him for his work on behalf of the Faculty during his period of office; the lesser is the disappearance of the conjoint ASM with the College of Anaesthetists, to be replaced by a "presence" of Intensive Care at the ASM's of both parent Colleges.

Finally, I thank the Committee for their support over the last two years and welcome Dr Cyrus Edibam as the incoming Chairman. His appointment earmarks a rejuvenation in attitude and vigour in Western Australia, for which the constituency is ripe!

David Simes
Chairman

Changes to the Regulations

The Board approved the following amendments to the Regulations, with regard to training:

Regulation 7 – Senior Registrar Requirements

'Senior Registrar' position is a position that involves increased seniority close to the time of completion of specialist training, i.e. when there is a reasonable expectation of completion within a year. The Trainee will have a lesser level of supervision than Junior trainees, with greater clinical autonomy and responsibility. Rostering must be independent of Junior medical officers and must include longitudinal responsibility for patient care beyond the series of single shifts (this implies an on-call component). The position will also involve specific responsibility for supervision and training of more Junior medical officers and involvement in research, education and administration. (Refer Regulation 7.4.5.2 and 7.4.7.7)

Regulation 7.3.5 – Other Training

"Other training may be approved by the Training Committee having regard to the trainee's individual training and experience. A specialist in another related area of acute medicine who is more than 5 years post award of postgraduate diploma and who has been working full-time in that specialty will be eligible for award of Fellowship after completion of supplementary training (as determined by the Training Committee to provide equivalence of training), success at the Fellowship Examination and satisfactory completion of the Formal Project".

Regulation 7.4 – Program for Training and Certification in Intensive Care Medicine

Eligibility for Fellowship of the Joint Faculty requires

- 12 months of clinical internal medicine

(which may be undertaken as basic training). For trainees undertaking combined IFICM and ACEM training, 6 months of this period may be spent in an Emergency Department

Regulation 7.4.5.4

12 months clinical internal medicine in either the BTYs or the non-core (elective) ATY year, at least 6 months of which should normally be undertaken in a registrar position. A registrar position is a position considered by the Censor to be equivalent to a position accredited by the RACP and which involves supervision of junior medical officers and supervision by registered specialist physicians. For trainees undertaking combined JFICM and ACEM training, 6 months of this period may be spent in an Emergency Department. For the paediatric endorsement 12 months must be spent in paediatric medicine.



South Australia

Office Bearers and Members

<i>Chair</i>	Dr Sandra Peake
<i>Vice Chair</i>	Dr Robert Young
<i>Hon. Secretary</i>	Dr Gerard O'Callaghan
<i>Hon. Treasurer</i>	Dr Evan Everest
<i>Committee Members</i>	Dr Stephen Keeley Dr Andrew Holt
<i>Ex-Officio Members</i>	Dr Neil Matthews (co-opted)
<i>Younger Fellow Representative</i>	Dr Stuart Baker (co-opted)
<i>ANZICS Representative</i>	Dr Mary White (co-opted)
<i>NT Representative</i>	Dr Dianne Stephens (co-opted)
<i>Regional Administrative Officer</i>	Ms Christie Richards

Total No. of Regional Committee

Meetings for Year: 2

Attendances of Elected Members: (No. of Meetings)

Sandra Peake	2 of 2
Robert Young	2 of 2
Gerard O'Callaghan	1 of 2
Evan Everest	0 of 2
Stephen Keeley	0 of 2
Andrew Holt	0 of 2

Education

Trainees: Following the separation of retrieval and intensive care services at the Royal Adelaide Hospital (RAH), trainees at the RAH will now rotate into the Retrieval Service in one week blocks. A city-wide based program of tutorials for exam candidates has been established with tutorials being held at all teaching hospitals. "Tub's course" was again oversubscribed and very successful. Thanks to all those who participated in the various sessions.

Supervisors of Training: Following the removal of the Regional Education Officer position, and in order to maintain communication between the committee and trainees, the South Australia committee invited the Supervisors of Training at Flinders Medical Centre (A. Holt), and the

Women's and Children's Hospital (WCH) (S. Keeley) to become co-opted members on the committee. Both invitations were accepted. The supervisors of training at The Queen Elizabeth Hospital (TQEH) (S. Peake) and RAH (R. Young) at that time were already elected members.

Unit Reviews and Accreditation: TQEH and the WCH intensive care units underwent inspection in October 2003. R. Lee was the out-of-state representative on the Accreditation Team. Following inspection, accreditation at the WCH remains unchanged at 12-months core training. However, TQEH has been changed from 24-months to 12-months core training due to case-mix (i.e. no cardiac surgery or trauma). Concern was expressed at the February Regional Committee meeting about the future recruitment of trainees at TQEH; particularly as many trainees are from overseas and wish to be assured that the Faculty requirement of 2 core years can be met.

Continuing Education

Local Meetings: A combined JFICM and ANZICS meeting on Consent has been planned for May. Justice Tom Gray and Anita King (SA Law Society) have been invited to attend.

JFICM meeting Perth 2004: David Evans accepted the invitation to attend the New Fellows Conference at the JFICM Meeting in Perth in May.

JFICM meeting Adelaide 2005: M Chapman has agreed to be the Convenor. However, because of limited man-power resources in South Australia, the committee have expressed serious reservations about convening a Scientific Meeting only 6 months after the Annual Scientific Meeting of ANZICS and ACCCN which is to be held in Adelaide.

Other Matters

An on-going reciprocal arrangement has been set up whereby the Chair of ANZICS (SA) and the Chair of the JFICM (SA) will be invited to the meetings of the other's Regional committee. M. White (Chair, ANZICS) attended the February

JFICM Regional Committee meeting. S. Peake attended the ANZICS Regional Committee meeting.

Acknowledgements

Dr Toby Thomas resigned from the Board and the Regional Committee (Board representative). Many thanks for his work over the years.

The Committee thank Christie Richards for her support and help this past year.

Sandy Peake

Chair

Honours and Appointments

The following awards in the Queens Birthday Honours List were noted:

Dr Barry John Duffy (AM)
Member in the General Division

Dr Simon John Hockley (OAM)
Member in the General Division

Dr Peter Dean Thomas (OAM)
Member in the General Division

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

Highlights from the June Board Meeting

Constitution of the Board

New Board members Drs Steve Edlin (WA), David Ernest and Megan Robertson (Victoria) were welcomed to the Board. Dr Felicity Hawker resigned at this meeting, following eleven years of service to the Faculty of Intensive Care, ANZCA and the Joint Faculty. Presentations were made to Dr Hawker and also to Dr Neil Matthews, who has stepped down as Dean but continues as a member of the Board. The following office-bearers were appointed:

Dean	J. H. Havill
Vice Dean and Censor	R. P. Lee
Education Officer	D. Ernest
Treasurer and Assistant Censor	P.V. van Heerden
Co-ordinator, Advanced Training and Chairman, Hospital Accreditation Committee	R.F. Raper
Member	J. Gillis
Rural Focus Officer	S.A. Edlin
Member and Immediate Past Dean	N.T. Matthews
Chairman, Fellowship Examinations Committee	P.T. Morley
ASM Officer, Assistant Education Officer	J. A. Myburgh
MOPS Officer and Communications Officer	M.S. Robertson
Member of ANZCA Council	G.D. Phillips
Member of RACP Council	N. Thomson

Representatives from Queensland and Tasmania will be co-opted.

Format of the Fellowship Examination

The Board is considering a proposal to change the format of the Fellowship Examination. This is necessary in view of the increasing number of candidates. At present the Fellowship Examination Committee is considering incorporating some of the Investigations currently examined in the OSCE system into the Written Section of the Examination, and moving the cold (medical) cases to the OSCE Section.

A Separate Primary Examination in Intensive Care

Following a recommendation from the Education Committee, the Board has supported the in-

principle decision to develop a Separate Primary Examination in Intensive Care. It is proposed this will be available in addition to other Primary Examinations which are currently accepted as appropriate first part exams for conjoint trainees. The Examination will enable those trainees who wish to complete intensive care training only, to sit a dedicated intensive care Primary exam.

Applications for Basic Training

The Board resolved that applications for accreditation of basic training and advanced training for the elective year may be undertaken in unaccredited intensive care units, subject to formal application to the Censor, submission of a detailed Job Description and the proposed training program.

Hours of work for Trainees

The Board discussed the issue of the possible reduction in working hours for trainees and its relationship to safety and learning. A discussion paper is being circulated for consideration.

Senior Registrar Requirements

Regulation 7 and the definition of a Senior Registrar was amended to require that 'Rostering must be independent of junior medical officers and must include longitudinal responsibility for patient care beyond the series of single shifts (this implies an on-call component).'

Other Training

The Regulations regarding training were amended as follows:

7.3.5 "Other training may be approved by the Training Committee having regard to the trainee's individual training and experience. A specialist in another related area of acute medicine who is more than 5 years post award of postgraduate diploma and who has been working full-time in that specialty will be eligible for award of Fellowship after completion of supplementary training (as determined by the Training Committee to provide equivalence of training), success at the Fellowship Examination and satisfactory completion of the Formal Project".

Conjoint Emergency Medicine/Intensive Care Training

Following discussions with the Australasian College for Emergency Medicine regarding conjoint training, the Regulations have been amended to permit trainees who are undertaking combined ACEM and JFICM training to have six months of emergency medicine training accredited for the basic training medicine requirement for the JFICM program. Such trainees will still be required to complete six months of clinical medicine training.

Formal Project

The Formal Project Guidelines have been amended to clarify that, rather than be reported in the style of a thesis, projects must be reported in the style of a paper for a peer reviewed journal.

Overseas Trained Specialists for Area of Need

The Board noted discussions on the issue of the streamlining of assessment of OTS for Area of Need appointments, a program proposed by the Federal Department of Health and Ageing. A list of overseas qualifications is being developed, defined as 'Category 1', being qualifications considered acceptable by medical colleges as appropriate for doctors taking up areas of need positions in Australia.

Conjoint Committee for Rural Intensive Care

The Board has agreed that a conjoint committee should be established comprising rural representatives from JFICM, ANZICS and ACEM. The Committee will investigate opportunities for:

- Attracting FJFICM intensivists to rural practice,
- Supporting FJFICM and non-FJFICM intensive care practitioners in rural practice,
- allowing ICU training in rural ICUs, and
- facilitating CME in rural areas for both FJFICM and non-FJFICM intensive care.

Accreditation of Core Training overseas

The Board endorsed the accreditation of the British Columbia Children's Hospital for a maximum of twelve months of core training, under its new policy of permitting one year of the three years of advanced training to be undertaken overseas.



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 Accreditation 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*
- PS38(1999) Statement Relating to the Relief of Pain and Suffering and End of Life Decisions *Bulletin June 1999, pg 93*
- PS39(2003) Minimum Standards for Intrahospital Transport of Critically Ill Patients *Bulletin June 2003, pg 90*
- PS40(2000) Guidelines for the Relationship Between Fellows and the Healthcare Industry *Bulletin March 2000, pg 55*
- PS45(2001) Statement of Patient's Rights to Pain Management *Bulletin March 2002, pg 72*
- PS48(2003) Statement on Clinical Principles for Procedural Sedation *Bulletin March 2003, pg 73*
- PS49(2003) Guidelines on the Health of Specialists and Trainees *Bulletin August 2003, pg 88*



Review PS24 (2004)

Australian and New Zealand College of Anaesthetists ABN 82 055 042 852 and
Gastroenterological Society of Australia ABN 44 001 171 115 and
Royal Australasian College Of Surgeons ABN 29 004 167 766

Guidelines on Sedation for Gastrointestinal Endoscopic Procedures

1. Introduction

Sedation for gastrointestinal endoscopic procedures includes the administration by any route or technique of all forms of drugs which result in depression of the central nervous system. The objective of these techniques is to produce a degree of sedation of the patient so that the procedure may be facilitated.

These techniques are not without risk because of the:

- 1.1 depression of protective reflexes.
- 1.2 depression of respiration.
- 1.3 depression of the cardiovascular system.
- 1.4 wide variety and combinations of drugs which may be used, with the potential for drug interactions or for adverse reactions, including anaphylaxis.
- 1.5 individual variations in response to the drugs used, particularly in children, the elderly, and those with pre-existing medical disease.
- 1.6 wide variety of procedures performed.
- 1.7 differing standards of equipment and staffing at the locations where these procedures are performed.

It is important to understand the variability of effects which may occur with sedative drugs, however administered, and that over-sedation, airway obstruction or cardiovascular complications may occur at any time. To ensure standards of patient care, the following guidelines are recommended.

2. Patient Preparation

- 2.1 The patient should be provided with

written information which includes the nature and risks of the procedure, preparation instructions (including the importance of fasting), and what to expect during the immediate and longer term recovery period, including following discharge.

- 2.2 Informed consent for sedation and the procedure should be obtained.

3. Patient Assessment

- 3.1 All patients should be assessed before sedation for gastrointestinal endoscopic procedures. Assessment should include:
 - 3.1.1 Details of the current problem, co-existing and past medical and surgical history, history of previous sedation and anaesthesia, current medications (including non-prescribed medications), allergies, fasting status, and particularly in the case of patients having upper gastrointestinal endoscopic procedures, the presence of false, damaged or loose teeth.
 - 3.1.2 Examination, including that relevant to the current problem, airway, respiratory and cardiovascular status, and other systems identified from the history.
 - 3.1.3 Results of relevant investigations.
- 3.2 This assessment should identify those patients with special risks, such as patients in ASA Grades P-3 to P-5 (see Appendix I), including the elderly and those with severely limiting heart disease, cerebrovascular disease,

significant lung disease, liver failure, acute gastrointestinal bleeding and cardiovascular compromise, severe anaemia, morbid obesity and shock. In emergency situations, the potential for aspiration of gastric contents must be considered and prevented, if necessary by endotracheal intubation. The above patients require special consideration (see 4.6).

4. Staffing

- 4.1 When sedation is used for gastrointestinal endoscopic procedures, there must be a minimum of three appropriate staff present for endoscopy – the proceduralist, the assistant to the proceduralist, and the person providing sedation and monitoring of the patient.
- 4.2 For all sedation for gastrointestinal endoscopic procedures, a medical practitioner with specific training and experience in airway management and resuscitation must be involved in the sedation or the procedure.
- 4.3 From the time of initiation of sedation, a person with appropriate training must be present whose sole responsibility will be to monitor the patient's level of consciousness and cardiorespiratory status during the procedure, and to assist in resuscitation if required.
- 4.4 The person responsible for administering sedative drugs requires sufficient training to be able to:
 - 4.4.1 Understand the action of the drug or drugs being administered.



4.4.2 Detect and manage appropriately any complications arising from these actions.

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

4.5 If anaesthetic agents such as propofol are used, a medical practitioner trained in the use of these agents must be present to care exclusively for the patient.

4.6 If major risk factors are identified, or difficulties can be anticipated, involvement of an anaesthetist in administering sedation and monitoring the patient is recommended.

5. Facilities, Including Equipment

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

- 5.1 Adequate uncluttered floor space to perform resuscitation should this prove necessary.
- 5.2 Appropriate lighting.
- 5.3 An operating table or trolley which can be readily tilted.
- 5.4 A supply of oxygen and suitable devices for the administration of oxygen to a spontaneously breathing patient.
- 5.5 A means of inflating the lungs with oxygen (e.g. a range of face masks, pharyngeal airways and self-inflating bag suitable for artificial ventilation).
- 5.6 Laryngoscope, blades, endotracheal tubes and laryngeal mask airways.
- 5.7 Adequate suction source, catheters and Yankauer-type handpiece.
- 5.8 Appropriate drugs for cardiopulmonary resuscitation (see Appendix II).

5.9 Drugs for reversal of benzodiazepines and opioids.

5.10 Intravenous fluids and equipment.

5.11 A pulse oximeter which must be used whenever sedation is employed.

5.12 Equipment suitable for measurement of blood pressure.

5.13 Ready access to an ECG monitor and defibrillator.

5.14 A means of summoning assistance in the event of an emergency.

6. Technique and Monitoring

6.1 Reliable venous access should be in place for all gastrointestinal endoscopic procedures when sedation is used.

6.2 As most complications of sedation and endoscopy are cardiopulmonary, doses of sedative drugs should be kept to the minimum required for patient comfort, particularly for those patients at increased risk.

6.3 All patients receiving sedation for gastrointestinal endoscopic procedures should have supplemental oxygen.

6.4 Monitoring of patient response to verbal commands should be routine. Loss of such response indicates that loss of protective airway reflexes may have occurred, and that respiratory and/or cardiovascular depression must be considered likely.

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

7. Recovery and Discharge

7.1 Recovery should take place under appropriate supervision in the procedure room or an adjacent area designated for this purpose and adequately equipped and staffed. Oxygen, suction, resuscitation drugs and equipment should be immediately available until the patient returns to their pre-sedation state.

7.2 The patient should be discharged only after an appropriate period of recovery and observation. Discharge of patients should be authorised by the practitioner who administered the drugs, or another qualified person. The patient should be discharged into the care of a responsible adult to whom written instructions should be given. Written instructions should include advice regarding eating and drinking, as well as the prohibition of driving, operating machinery and making legally binding decisions.

7.3 For those endoscopy centres that do not have a full range of support services, prior arrangements should be in place to allow the efficient transfer of any patient to an appropriate facility when necessary.

8. Documentation

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

9. Training in Sedation for Gastrointestinal Endoscopic Procedures

It is recommended that medical practitioners and nurses involved in caring for patients undergoing gastrointestinal endoscopic procedures should have received training in the sedation and



Review PS24 (2004) (Continued)

monitoring of patients undergoing such procedures, as well as training in cardiopulmonary resuscitation. This training should be reviewed and updated on a regular basis.

References

1. Australian and New Zealand College of Anaesthetists' Professional Document T2 *Recommendations on Minimum Facilities for Safe Anaesthesia Practice outside Operating Suites 2000* (as updated on ANZCA website).
2. American Society of Anesthesiologists *Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists*. *Anesthesiology* 2002; 96: 1004-1017
3. Intercollegiate Working Party, UK Academy of Medical Royal Colleges and their Faculties. *Implementing and Ensuring Safe Sedation Practice for Healthcare Procedures in Adults 2001*
4. American Society for Gastrointestinal Endoscopy. *Guidelines for the use of deep sedation and anaesthesia for GI endoscopy*. *Gastrointestinal Endoscopy* 2002; 56: 613-617
5. Clarke A C, Chiragakis L, Hillman L C, Kaye G L *Sedation for endoscopy: the safe use of propofol by general practitioner sedationists*. *Medical Journal of Australia* 2002; 176: 158-161

Appendix I

The American Society of Anesthesiologists' classification of physical status:

- P-1 A normal healthy patient.**
- P-2 A patient with mild systemic disease.**
- P-3 A patient with severe systemic disease.**
- P-4 A patient with severe systemic disease that is a constant threat to life.**
- P-5 A moribund patient who is not expected to survive without the operation.**

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

Appendix II

Emergency drugs should include at least the following:

adrenaline
atropine
dextrose 50%
lignocaine
flumazenil
naloxone

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.

This document has been prepared having regard to general circumstances, and it is the responsibility of the practitioner to have express

regard to the particular circumstances of each case, and the application of this document in each case.

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

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

Promulgated: 1992

Reviewed: 1997

Date of current document: June 2004

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ANZCA Website: <http://www.anzca.edu.au/>

RACS Website: <http://www.racs.edu.au/>

GESA Website: <http://www.gesa.org.au/>



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

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 (1999) The Handover of Responsibility During an Anaesthetic *Bulletin November 1999, pg 62*