

Australian and New Zealand College of Anaesthetists

ACN 055 042 852

Faculty of Intensive Care
Faculty of Pain Medicine



Bulletin

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

Inside...

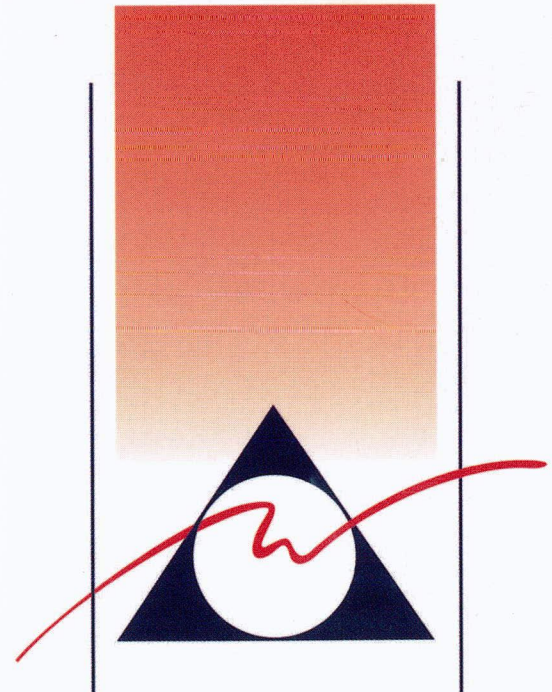
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**National Anaesthesia Day
2000**

Wednesday 5 July

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Mrs Joan Sheales, Editor
Dr R.G. Walsh
Dr M. Martyn
Dr I. Rechtman
Dr R.S. Henderson
Dr R.N. Westhorpe
Dr R.V Trubuhovich
Mr E. Dean

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Telephone: +61-3 9510 6299
Facsimile: +61-3 9510 6786
E-mail: ceoanzca@anzca.edu.au
Internet: <http://www.anzca.edu.au/>

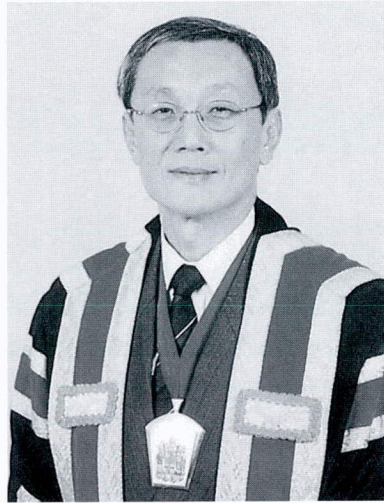
Regional Committee offices can be contacted via email as follows:

VIC: victoria@anzca.edu.au
NSW: nsw@anzca.edu.au
SA: sa@anzca.edu.au
QLD: qld@anzca.edu.au
WA: anaesthesia.wa@hcn.net.au
TAS: surgeons.tas@racs.edu.au
NZ: anzca@actrix.gen.nz

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PRESIDENT'S MESSAGE



My first written words in office pay tribute to the selfless dedication my predecessor, Dr Richard Walsh, committed to his Presidency. Richard served the College with aplomb, humour, sensitivity, and hard work. We are truly grateful to him and his wife Vivienne. My second pleasant duty is to thank our Victorian Fellows for organising a superb ASM. The quality of the scientific program was matched by the stylish organisation. Joe Novella's Virtual Congress, a world 'first' in anaesthesia, was hugely popular. Its role in continuing education is now guaranteed. Thank you Phil Ragg, Rowan Molnar, Kate Leslie, and the Organising Committee.

Corporations focus on goals determined by their mission statements, and develop strategies to achieve their goals. Our College is no different; our goal is to serve our community with safe and quality care in our disciplines. Council in the near future will revisit strategies to better focus on that goal. One strategy is to project the College as an educational body, ie a tertiary institution that embodies teaching, training, continuing self-development, and research, and advances professional standards. The College does not merely 'train'. It develops programs and promotes policies to enhance best practice. Indeed, the *agenda* for the last Council meeting covered 22 pages. It is through education that we 'go for gold', an appropriate aphorism in this Olympic Year.

July 5, 2000 is National Anaesthesia Day. This year the theme is simply 'Anaesthesia', a promotion on the basics of a good, safe anaesthesia service to our community. Some Fellows may

view NAD with a jaded eye, but it is the one opportunity we have each year as a unified body to project ourselves – and we're worth it. I urge all anaesthetists to pitch in and show the public what you do and how well you do it. NAD kits may be obtained from the College, and please forward ideas to Dr Mike Martyn, the College Communications Officer.

The College works through elected office bearers. Fellows are reminded that College officers practise anaesthesia, intensive care and pain medicine for a living, just like any of you. If there are hiccups in College affairs, it is because they are not full-time professional administrators or policy makers. To make our College better, and hence our disciplines better, help our officers and committees – become involved.

Finally, Fellows should be aware of the wonderful work put in by the College staff. From Mrs Joan Sheales, our CEO, to the junior staff, everyone is committed to our College. Their work covers seven regions in Australia and New Zealand, three overseas regions, 3,000 Fellows, 800 trainees, and five time zones. Their uncomplaining capacity for work, and their willingness to help, deserve appreciation.

A handwritten signature in black ink, which appears to read 'Teik Oh'. The signature is fluid and cursive, written in a professional style.

TEIK OH
PRESIDENT

FINAL EXAMINATION – APRIL 2000



Front L to R: *Drs Michael Jones, Brian Trainer, Doug Rigg, David Scott (Chairman), Judy Branch, Tony Weeks, John Madden, Michael Paech*
Centre L to R: *Drs Barrie McCann, Chris Johnson, Andrew Russell, Michelle Joseph, Vic Callanan, Pam Macintyre, Bruce Burrow, Greg Purcell*
Back L to R: *Drs Craig Morgan, Peter Peres, Michal Kluger, Greg Conner, Ed Loughman, Pat Farrell, David Sage, David Jones, Sandra Taylor*

PRIMARY EXAMINATION – APRIL 2000



Front L to R: *Drs Rob Henning, Linda Cass, Neville Gibbs (Chairman), Gillian Bishop, Neil Warwick*
Back L to R: *Drs Ted McArdle, Terry Loughnan, Michael Cleary, Stuart Henderson, Duncan Blake, Richard Morris, Mark Langley*

HONOURS AND APPOINTMENTS

Congratulations are extended to:

Dr Richard G Walsh, NSW – Honorary Fellowship of the College of Anaesthetists

Dr Paul Myles, Vic – Associate Professor, Department of Anaesthesia and Department of Epidemiology and Preventative Medicine, Monash Medical Centre

Dr Jacobus Ng, HK – Associate Professor, Department of Anaesthesiology, University of Hong Kong, Queen Mary Hospital

Professor Tess Cramond, Qld – Honorary Fellowship, Australasian Chapter of Palliative Medicine, Division of Adult Medicine, RACP. Honorary Doctor of Medicine, University of Queensland

Dr Duncan Galletly, NZ – Associate Professor in Anaesthesia, Department of Surgery, Wellington School of Medicine

DIVISION OF RESPONSIBILITY

A recent decision of the NSW Court of Appeal highlights the special duties and relationships of doctors to their patients, particularly where the doctor is part of a 'team', where another member of the team may be negligent. It is long established law that hospitals have a broad duty to patients who enter their system. They have, what is called a 'non-delegable duty' to the patients who come within their care. Whether it is a nurse, doctor or administrator who is negligent, the hospital is ultimately responsible for the system as a whole, owes a duty to the patient and can therefore be liable for harm which arises.

There may well also be circumstances where a doctor, particularly a surgeon, through the nature of the procedure and the way in which it is conducted, assumes this broader duty (and therefore liability) for the system as a whole. Where a surgeon is completely in charge of all procedures within his or her theatre, it could be argued that the surgeon assumes a 'non-delegable duty' which would leave him or her liable to any negligence which occurs within the theatre. This may be particularly so where surgeons conduct private surgery through private hospital arrangements. However, the recent NSW case (*Elliott v Bickerstaff* [1999] NSWCA 453) found in favour of the surgeon. The Court of Appeal determined that the surgeon was not responsible for the negligence of a member of his team, recognising that different parts of the team had separate responsibility and liability to the patient.

In this case, a surgical sponge remained in the abdominal cavity of the patient after a hysterectomy. The doctor, a specialist obstetrician and gynaecologist,

gave clear evidence of the procedures which he inevitably followed in checking for and recording swabs and equipment, to ensure that nothing remained or was missing. The Court accepted this evidence and on initial trial, the judge clearly found that the surgeon was not individually negligent. It was assumed that there must have been an error in counting by an assisting nurse. It was interpreted that the surgeon carried out his usual checks and clearances. However, the trial judge assumed that the surgeon was still liable for the actions of his team and had a 'non-delegable duty' or responsibility for the patient's safety.

On appeal, the Court thought otherwise. It accepted that the surgeon was not personally negligent for the particular complication. It also accepted that in this particular case, the surgeon was part of a team of operatives and acted as the 'master of ceremonies'. Notwithstanding that the surgeon was clearly a manager or supervisor in the process, he was nonetheless only a member of a team, each member of which was responsible for their separate responsibilities and duties. It was accepted that the surgeon had fulfilled his obligations in his duty to the patient in searching for sponges and following his careful system of ensuring that no instruments or equipment remained. He was found not to be responsible for the actions of another member of the team who was more directly responsible for the complication.

It should be stressed that although the Court, in this instance, found for the doctor, it was determined on the particular facts of the case. It is clear from the Court's decision that there may be circumstances where the 'team approach' is not recognised, and where the surgeon will be assumed to be in a

**Michael Gorton, B.Comm, LLB.,
FRACS (Hon), FANZCA (Hon)**

College Honorary Solicitor

**Partner - Russell Kennedy,
Solicitors**



position where he or she controls the entire process and therefore has responsibility for the team as a whole. Where a surgeon is fully responsible for the patients care, engages the theatre staff, separately contracts to use the theatre from a private hospital and otherwise has a broad supervisory/management role, it may well be that the courts will assess the doctor as having a 'non-delegable duty' of care to the patient, and therefore be responsible for all actions of the team as a whole.

This decision is more likely to provide comfort to doctors who undertake procedures in public hospitals, where the hospital has a greater role of supervision and management of the patient's care and engagement of the team. The case offers a warning to doctors undertaking private theatre work where they assume full responsibility for the actions of the team in a practical sense; where they are also likely to be regarded as responsible for the team in a legal sense.

Recent Development in Patient Confidentiality

A recent UK decision again considered the issue of the use of patient information for the purposes of research and collection of statistical information. There are many instances in public and private hospitals where doctors use patient information, on a confidential and non-identifying basis, to support their own research, papers, etc. Lawyers have always warned that there is a risk in relation to such procedures where the consent of the patient has not been obtained to the use or release of their information, even on a non-identifying basis. The use of patient information, without the patient's consent, has always been regarded as a breach of patient confidentiality.

In the UK case (*R v Department of Health, ex parte Source Informatics Limited*) anonymous patient information was used by doctors and pharmacists. The information was collected in relation to the prescribing habits of GPs, where the information may have been of commercial value to certain businesses. In this case, software

was to be provided to pharmacists who, for a payment, would download certain information including the names of GPs and the identity and quantity of drugs used. There was no suggestion that the information downloaded would identify patients.

The Court was required to determine the extent to which a breach of confidence, of patient confidentiality, was involved. Clearly, patients were not notified, and therefore did not give any consent.

The Court conceded that many patients would not be concerned by the use of this information on such an anonymous basis. However, there could well be sensitivity, given particular circumstances or the rare nature of certain conditions, where patients could well be upset or concerned.

In its decision, the Court upheld the public interest in ensuring that confidentiality between doctor and patient was retained. The Court recognised the need to ensure that medical treatment was available to all patients, and not inhibited by any suggestion that medical information of

the patient might be subsequently revealed.

The UK case was a clear decision in favour of patient confidentiality. This is probably so given the commercial use to which the information was to be put and given that no real risk of injury to patient or third parties was involved.

However, the Court also considered whether the situation may have been different where the information taken from the patient's records was to be used purely for the purposes of medical research and literature. It is implicit in the decision that the Court may well have found otherwise if the information were being used for beneficial research, where the information was entirely anonymous and non-identifying, and accordingly, where some public benefit could be shown. However, the Court was not required to determine this point, and the issue was left open.

The case again highlights the need for care, and perhaps legal advice, before projects are undertaken which use patient records and information (even on a non-identifying basis), without the patient's consent.

ADMISSION TO FELLOWSHIP BY EXAMINATION

FEBRUARY 2000 – MAY 2000

Julia Victoria	CLARKE	VIC	Paul Philip	McCONKEY	NSW
Alun Sion	DAVIES	CAN	Shay Patrick	McGUINNESS	NZ
Hugh William	DOUGLAS	NSW	Gary Alexander	McKENZIE	VIC
Michael John	FREDRICKSON	CAN	Fiona	McWHINNIE	QLD
Jean-Marie Delmay Gilles	FRICOT	NSW	Hugh Charles Richard	PLATT	VIC
Michael James	GILLHAM	CAN	Laurence Brendan		
Don Francis Chandana	JAYAMAHA	VIC	Yew Cheong	POON	VIC
Susan Jane	KELLY	VIC	Frank George Peter	RAYMOND	VIC
Chi Hung	KOO	HK	Martin Nicholas	SCHUITEMAKER	NZ
John Stephen Noel	KEYS	QLD	Karlo Anton	TESTEN	VIC
Haralabos Harry	KOUMOUKELIS	NSW	Jane Mary	THOMAS	NZ
Michael Robert	LORIMER	NZ	Gerard Peter	WILLEMSSEN	NZ

HIGHLIGHTS OF MAY 2000 COUNCIL MEETING

WELCOME

Prof Teik Oh congratulated Dr Leona Wilson, New Zealand, on her election to Council and welcomed Dr Wilson to her first meeting and congratulated Prof John Gibbs, Queensland, on his re-election to Council.

COUNCIL ELECTION

The following Office Bearers and Officers were Elected.

President	Prof Teik Oh
Vice President	Dr Richard Willis
Assessor	Prof John Gibbs
Education Officer	Dr Steuart Henderson
Chairman of Examinations	Assoc Prof Greg Knoblanche
Treasurer	Dr Richard Willis
Chairman of Executive	Dr Richard Willis

EDUCATION

Council is undertaking a review of the current In-Training Assessment process in an attempt to make it more user friendly. Council has agreed to promulgate a College policy document on In-Training Assessment which, hopefully, will be formalised by Council in October for implementation of the new process at the commencement of the 2001 hospital training year.

Variations to the current process being considered include:

- It will be the trainee's responsibility rather than the Regional Education Officer, to return the forms to the College.
- A review of the assessment categories to assist unsatisfactory trainees being identified by their training department.
- Proposed assessment categories include insufficient knowledge of the trainee, performance above average for trainee's stage of development, average performance for a trainee's

stage of development, below average performance for a trainee's stage of development, serious deficiencies in performance.

- Attributes assessed and the place of trainees in that assessment include: commitment to tasks as a trainee, work organisation, technical skills including hygienic work practices, vigilance and crisis handling, record keeping, appropriate guidance seeking, professional interaction with patients and others.

A draft document will be available for Regional/National Committees and Regional Education Officers feedback for further consideration by the July Executive.

INTERNAL AFFAIRS

Council has agreed to hold a half-day strategy planning meeting immediately prior to the October Council Meeting.

Upgrade of College Computer Hardware and Software

Council accepted a recommendation from the IT Committee that an upgrade of computer hardware and software be approved.

Change in dates for Council meetings

As a result of the Council holding its Annual General Meeting immediately following the Annual Scientific Meeting it has been necessary to re-schedule Council meetings. In future, Council meetings will be held in April, August and December.

Executive Meetings – Regional Rotations

In order to provide the Fellowship closer access to and communication with Council, it has been agreed that the

Executive Committee will hold three meetings a year in various regions, which will be attended by the host Regional/National Chairman. The Executive will then also meet with the Regional Committee and provide an opportunity to meet in a social atmosphere with the Fellows of the Region.

RACS Critical Care Sub Committee for Establishment of CCRISP

Dr Wally Thompson has been nominated as the College representative to the Critical Care Sub Committee of the Board of Basic Surgical Training.

College nominees to the RACS Trauma Accreditation Process

Council nominated Dr Allan MacKillop, Dr Richard Morris, Professor Garry Phillips and Dr Jamie Cooper to represent ANZCA in the RACS Trauma Accreditation Process.

Pilot Study for Personal Professional Performance Monitoring Project

The proposal by the Department of Anaesthesia at Geelong Hospital for support for a pilot study towards the development of a Personal Professional Performance Monitoring Program for the specialty of anaesthesia was accepted by the Executive. Substantial sponsorship for this initiative has been obtained by Professor Steven Bolsin and Dr Andrew Patrick from the Geelong Hospital and the College has approved this pilot study as a College initiative. The proposed College funding is up to \$10,000.

The four initial areas for the pilot project involve spinal anaesthesia, epidural anaesthesia, arterial line insertion and central venous catheter insertion. Other relevant areas may be included if

required. Three Departments will be involved in the pilot and it is anticipated that the results of the pilot study will be available in August next.

PROFESSIONAL

A statement on the re-use of single use equipment is appended and will be published elsewhere in this issue of the *Bulletin*.

Policy Documents

Clinical Guidelines Promulgated by the College

In considering policy documents in general, the Council believed that as such documents do provide guidance on clinical methodology, the title should be reviewed. Council resolved that all clinical policy documents be renamed "Clinical Statements" and revised in an evidence-based format.

Overseas Trained Specialists

Following promulgation of the assessment process for overseas trained specialist, which includes an OTS examination, Council has now approved a process for assessment of Area of Need positions. The latter document provides a fast tracking system for Area of Need positions, however, the occupants will then be required to complete the full overseas trained specialist assessment and examination.

Indigenous Health Issues and Cultural Awareness

Council is currently reviewing its position and involvement with indigenous health issues and cultural awareness.

Clinical Guidelines Promulgated by ANZCA – Renaming and Numbering of Policy Documents

Council accepted a recommendation by The Director of Professional Affairs with regard to the issue of renumbering and redefining the College Policy Documents. This involves progressively retitling the documents as TE (Training

and Educational), EX (Examinations), PS (Professional Standards), T (Technical) and to categorise these publications as either Policy, Recommendations, Guidelines or Statements.

The Duties of an Anaesthetist

The Policy document 'The Duties of an Anaesthetist' was reviewed and approved by Council and is appended to this report.

Protocol for the Use of Autologous Blood

The policy document 'Protocol for the Use of Autologous Blood' was withdrawn.

RESEARCH COMMITTEE

Council has agreed that for Fellowships tenable from 2002 onwards, applicants must apply both to the NHMRC and ANZCA. Fellowship application forms for NHMRC can be obtained directly from the NHMRC. Applicants who are successful in attaining NHMRC support may receive supplementary support from ANZCA, which will permit the payment of a research Fellow at an appropriate level for a clinically qualified research Fellow.

Applications not receiving NHMRC support but considered by the Research Committee to be of an acceptable level, may be funded directly from the Anaesthesia, Intensive Care and Pain Medicine Foundation.

IT COMMITTEE

College Mailouts

Council agreed that provision be made for Fellows and Trainees to elect to receive College mailouts electronically.

College Database

The College database will be published online to permit individual Fellows to update certain areas of their details.

Education Unit

Council accepted the following recommendations of the Education Committee:

1. That the College investigate the various implications of developing a centrally based educational program with a major in the education of its trainees and Fellows.
2. That a Melbourne based University consultancy be identified to review and enhance the central role of ANZCA as an educational body for trainees and Fellows.

FINANCE

Following introduction of the Goods and Services Tax, as from the 1st of July 2000, the system of a payment of a per diem allowance for Fellows requiring to be away from home overnight on College business will cease. In future, accounts will be opened with various hotels for Council and Committee meetings, examinations and other activities where a number of representatives are required. Fellows will be responsible for authorising their individual accounts with the hotels, which will be forwarded to the College for payment. In isolated activities, such as hospital inspections, Fellows will be reimbursed on production of receipts for their accommodation and incidental expenses.

Fellows will appreciate that it is necessary for the Council to provide accurate GST reports to the Australian Tax Office and therefore, on the advice of the College Auditors, this process has been recommended as the most efficient and accurate for all concerned.

ASM 2003

Council has agreed to convene the Annual Scientific Meeting in 2003 in Hobart with the main venue being at the Grand Chancellor Hotel.

Faculty of Intensive Care Subscriptions

In an endeavour to provide financial independence for the Faculty of Intensive Care, Council accepted the following recommendations of the joint Working Party comprising College and Faculty representatives:

- That the College will create a separate accounting system within the College books to identify both incoming and outgoing financial activities relating to the Faculty of Intensive Care.
- That the budget for the 2002 financial year to be invoiced in December 2000 will include a subscription set by the Faculty of Intensive Care payable by Fellows of that Faculty.

The number of Fellows involved in practising both anaesthesia and intensive care was taken into account by the Working Party when making the appropriate recommendations:

1. Fellows who hold both the FANZCA and FFICANZCA and who spend the equivalent of two or more notional sessions per week in each specialty will be required to pay both a full College subscription and a full subscription to the Faculty of Intensive Care in order to maintain both Fellowships.
2. Fellows who hold both the FANZCA and FFICANZCA and who spend less than two notional sessions per week in one or other of the specialties will be required to pay a full subscription to the body representing the specialty of major clinical activity and 50% of a full subscription to the

body representing the specialty of less clinical activity. This decision is in line with the College's current list of concessions.

3. For Fellows of FICANZCA and ANZCA who practise solely in intensive care and who wish to maintain their FANZCA diploma, the full Faculty subscription will be payable to the Faculty and 20% of the full College subscription will be payable to the College. Similarly, for Fellows who hold FANZCA and FFICANZCA who practise solely in anaesthesia and who wish to maintain their FFICANZCA diploma, the full College subscription will be payable to the College and 20% of the full Faculty subscription will be payable to the Faculty.

The concessions described in points (2) and (3) above will be subject to review in the event the Faculty becomes fully independent from the College.

4. When one or other Fellowship is withdrawn due to non-payment of subscriptions, restoration of Fellowship could be undertaken at the discretion of the Council or Board by full payment of arrears plus a full subscription to the relevant body in accordance with the College Articles of Association. The

subscription in subsequent years would be determined as in (2) and (3) above according to the Fellow's pattern of practice.

5. For holders of the FFICANZCA alone, the subscription will be payable to the Faculty of Intensive Care.
6. Council agreed in principle that (subject to financial responsibilities being established) any funds or assets accumulated by the Faculty after introduction of these subscriptions will be made available to the Faculty in the event of separation from the College.
7. Notwithstanding the above recommendations, Fellows are eligible to apply for other subscription exemptions and concessions available under College Regulation 7.1 – Remission and Exemptions. The exemptions and concessions will be applied to the total subscription payable. For holders of the FFICANZCA alone, the subscription will be payable to the Faculty of Intensive Care.

Election to Fellowship

Professor EA Shipton was elected to Fellowship under Regulation 6.3.1(a).

DEATHS

Council noted with regret the deaths of the following Fellows:

- Dr Tin Choo (Marcus) Koh, SA – FFARACS 1974, FANZCA 1992
- Dr Cecil Stanley Jones, South Africa – FFRARACS 1964, FANZCA 1992
- Dr Brian Thomas Jordan, Vic – FFARACS 1959, FANZCA 1992
- Dr Leonard David Fisher, Vic – FFARACS 1969, FANZCA 1992
- Dr Frederick Cecil Donald Jollow, NSW – FFARACS 1973, FANZCA 1992
- Dr James Edward Fiels, Vic – FFARACS 1975, FFANZCA 1992

ROBERT ORTON MEDAL

CITATION - WALTER JOHN RUSSELL

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

Mr President, I have the honour to present to you, Dr Walter John Russell, for the award of the Robert Orton Medal.

Born and educated in Adelaide, 'Prof Russell', as John was known at school and during his uni days, graduated MBBS, from the University of Adelaide in 1961.

Following resident posts in Adelaide, he moved to Sydney to begin his anaesthesia training at Sydney Hospital. It was here that he met a young physiotherapist, Jan, who became his wife in 1965.

An early clue to John's eventual substantial contribution to anaesthesia practice is found when one notes John was awarded the Australian Society of Anaesthetists' Gilbert Troup Medal way back in 1967.

After three registrar years in Sydney, John took the long route to England, fulfilling clinical and teaching posts in Hong Kong, Japan and Russia before arriving in London in 1968. This work in Asia on the way to the UK is significant, in that it set the pattern for John's ongoing commitment to improving the standards of anaesthesia not only in Australia, but also for our regional neighbours and beyond.

In all, John spent eight years in England at the Hammersmith Hospital and the Royal Post-graduate Medical School. During this time he gained Fellowship of the Faculty of Anaesthetists of the Royal College of Surgeons, Diploma of the Imperial College (Electrical Engineering in Medicine) and a PhD in Physiology at the University of London. This study paved the way for John to become a giant in the disciplines of equipment for anaesthesia, standards in bio-medical engineering and the post-graduate teaching of these demanding fields. In this regard, John emulated one of his own heroes, the pioneer Australian anaesthetist, Dr Geoffrey Kaye, whom he met on several occasions.

Returning to Adelaide in 1976 with Jan and their three children, John began working in the Department of Anaesthesia and Intensive Care at the Royal Adelaide Hospital. He

passed the Fellowship of the then Faculty of Anaesthetists of the Royal Australasian College of Surgeons in August of that year and in 1978, was appointed Director, Research and Development, in the Department – the position he holds today.

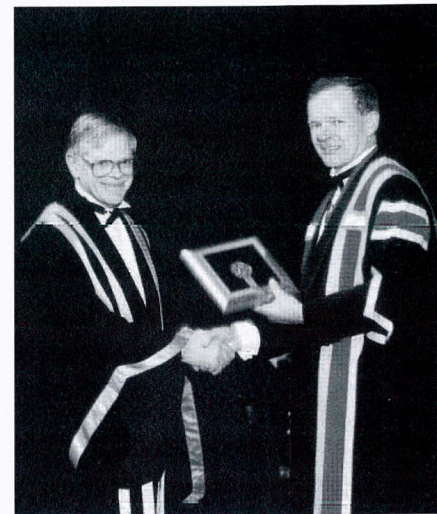
In the University of Adelaide, John is Clinical Reader to the Department of Anaesthesia and Intensive Care, the Department of Surgery and also to the Department of Clinical and Experimental Pharmacology.

At the Royal Adelaide Hospital, John is a busy Consultant, with regular anaesthesia commitments in which he incorporates research and teaching into patient care. He also runs the Anaesthesia Allergy Clinic and coordinates the cardiac anaesthesia service.

John is an excellent teacher and tutor as the many anaesthetists who have benefited from his lectures and courses can attest – he has lectured at courses in New Zealand, Malaysia, Hong Kong, Singapore and India. In the last two years, John has also been heavily involved in the establishment of Bangladesh's first open heart surgical unit. It is little known that John has often paid his own airfares and other expenses so that these courses and his valued input could occur. John's continued and largely unheralded generosity, both with his time and his resources, has done much to further anaesthesia within Australia, New Zealand and Asia.

As an examiner for the College over 12 years, John's reputation for detail often filled candidates with trepidation but they soon found him to be a fair and considerate task master, ready to discover what they knew, rather than what they did not.

Since his return to Australia in 1976, John has been a regular and enthusiastic contributor at Australasian scientific meetings, both presenting papers and asking pertinent questions. It was in this latter role that he became affectionately known as 'Russell, Adelaide'. In 1995, he was the Australasian Visitor to the College Annual Scientific Meeting in Townsville.



Since 1969, John has published extensively on many topics. His textbook, 'Equipment for Anaesthesia and Intensive Care', is now in its second edition and continues as a major reference text, particularly for candidates sitting the College's final examination.

John has always had a major interest in anaesthesia safety through his work in the fields of Engineering, Standards and the Australian Patient Safety Foundation. He is the Australian representative on several committees of the International Standards Organisation and has coordinated Australia's input into such areas as 'hospital pipelines', 'flammable agents', 'anaesthetic equipment', 'electromedical safety' and 'therapeutic goods, equipment and device labelling'.

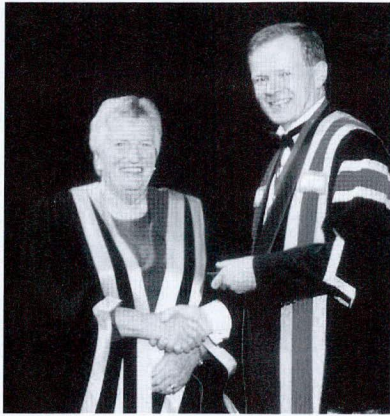
By his many endeavours, John has produced safe anaesthetists, and made for them a safe environment within Australia, New Zealand, and beyond. He richly deserves the award about to be bestowed upon him.

Mr President, it is my great honour and pleasure to present Dr Walter John Russell for the award of the Robert Orton Medal.

RICHARD D WILLIS
SALLY E DREW
ROBERT J SINGLETON

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS' MEDAL

CITATION - PATRICIA MACKAY



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

'Pat' Mackay was born and educated in New Zealand, demonstrating her academic prowess at an early age as dux of the South Otago High School. She was awarded a Government scholarship to study medicine at the University of Otago where she graduated in 1948.

Pat then spent two years as a medical officer at Dunedin Hospital, leading to a third year as anaesthetic registrar. In 1952, she decided to broaden her horizons and journeyed to Melbourne where she became Clinical Assistant in Anaesthesia, first at the Royal Melbourne Hospital and then at the Alfred, while obtaining the Diploma in Anaesthetics.

Seeking experience further afield, Pat proceeded to Oxford, where she studied and worked under the watchful eye of another New Zealander in Professor Sir Robert Macintosh. While there, she obtained both the Diploma and Fellowship. In 1954, Pat returned to New Zealand to take up the position of Junior Specialist in Anaesthesia at Otago Hospital. It was a brief stay, for she returned to Australia later the same year to become Assistant Director of Anaesthesia at the Royal Melbourne Hospital. Very soon she attained Fellowship of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons and became active in clinical research.

She promoted emerging concepts for mechanical ventilation in patients with impaired respiration due to head injuries, polyneuritis, tetanus and myasthenia gravis. This established the beginnings of modern intensive care management in the Royal Melbourne Hospital and foreshadowed the development of dedicated intensive care units worldwide in the 1960s. A widely-cited paper emanating from this work was a description of bone marrow depression due to prolonged sedation with nitrous oxide.

From 1959 to 1984, Pat maintained an active consulting anaesthetic practice while she and her husband Ian raised five children.

In 1966, she returned to teaching and administration, becoming an examiner for the Faculty in 1971. She was invited as a guest lecturer at numerous national and international meetings. One particularly influential paper, presented in 1965, described the concept and content of a pre-anaesthetic questionnaire at a time when pre-operative preparation of patients was poorly organised. This proved to be an extremely useful innovation and a questionnaire based on her model was subsequently introduced in many hospitals, both in Australia and overseas.

In 1984, Pat became Chairman and Head of Department at the Royal Melbourne Hospital, a post she held until 1992. She was responsible for teaching and research in anaesthesia and the personal development of junior staff. In attracting many of the most talented of graduate students, she was successful in effecting a major change in the image of anaesthesia at that time and securing appropriate recognition of the specialty by all other groups in the hospital. She also facilitated the development of the first Acute Pain Unit in Victoria, also the forerunner of many similar units in Victorian hospitals.

Pat has always been active in academic anaesthesia, education and medical politics. During her brief return to New Zealand in 1954, she was secretary of the New Zealand Society of Anaesthetists, and soon after her return to Melbourne she became Treasurer

of the Australian Society of Anaesthetists. She went on to be Secretary for five years and President from 1966 to 1968. She represented Australia at the World Federation of Anaesthesiologists and was made a Life Member of the Society in 1985.

Pat has had a long and active involvement in Faculty and College affairs, notably as an examiner from 1971 to 1985. As Deputy Chairman of the Appeal Committee, she was a driving force in securing support for the establishment of Victoria's first Chair of Anaesthesia. Since 1991, Pat has been a co-opted member of the Victorian Regional Committee of the College.

Pat has had a longstanding interest in anaesthesia safety and is a founder and Core Committee member of the Australian Patient Safety Foundation. She has exerted a major influence in this area and was appointed in 1991 by the Minister for Health to Chair the Victorian Consultative Committee on Anaesthetic Mortality and Morbidity. That she still holds this post, is an indication of the esteem in which she is held, not only in Victoria but also nationally. Pat has lectured on many subjects in many locations and is responsible for more than 20 significant publications, eight of them since retiring from her hospital post!

She has been responsible for three public reports from this Council, the most recent in April 2000. These reports have a major influence on practice in this country and are received abroad as testimony to the extremely high standard of anaesthetic practice in Australia and New Zealand. Pat is known to many anaesthetists in Australia, New Zealand and internationally. To all, she is loved and respected for her wisdom, her compassion, and her tireless enthusiasm for her work and her chosen specialty.

Mr President, it is with great pleasure that I present to you, Patricia Mackay, for the award of the Australian and New Zealand College of Anaesthetists' Medal.

ROD N WESTHORPE

OBITUARIES

DR JAMES EDWARD (TED) FIELD

**Victoria – FFARACS 1975
FFANZCA 1992**

It was on Wednesday morning that my father Ted Field died at only 63 years of age. That he has been taken from us at a time when he should have been preparing for the enjoyment of a quieter life with my mother and his friends, pursuing his other interests, seems unfair. That he has been denied the final fruits of a good working life, a retirement, a chance to reflect, and all of the things that go with this pains us all. And the fact that it does pain us is a reflection of the high regard in which Dad was held by us all.

After attending a single teacher primary school in Tennyson near Echuca, he went to board at Assumption College in Kilmore. He matriculated at the age of 16, a young age to finish secondary schooling even

in 1952, so he spent the next two years working on the farm, where he also developed his interests in botany and photography.

Dad decided, after years of admiring the work of his uncle that his vocation lay in the medical profession. So from the farm he went to the University of Melbourne. It was here where he met Mum, a commerce student, and they were married in 1962.

Soon after the wedding, Dad commenced his residency at the Geelong Hospital and by 1964 was an anaesthetic registrar at the Royal Children's Hospital, Melbourne and ultimately became a Fellow of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons in 1975.

He was held in high regard by those who have worked with him in nearly 40 years of medical practice, including time at the Women's, Epworth, St Vincent's and The Royal Victorian Eye and Ear Hospital. He was also held in high regard by his patients as evidenced by the file Mum started many years ago labelled "Ted's fan mail".

I think he lived a life of quality and experience, and touched many people. To make your life's work the care of the sick, and then to see them healed through your own efforts must be a great reward. And I know that he frequently felt the reward in seeing them healed, and who can ask for a greater reward than that.

ANDREW FIELD

I attended the memorial service for Ted Field where his son Andrew gave a most moving obituary, above is an excerpt. *Ian Reichtman*

DR LEONARD DAVID FISHER

**Victoria – FFARACS 1969,
FFANZCA 1992**

David Fisher qualified with MBBS from the University of Queensland in 1961 and recently married to Shirley, David did his term as Junior Resident Medical Officer at the Royal Brisbane Hospital in 1962 and this was followed by a commission with the Royal Australian Navy with the rank of Surgeon Lieutenant. Whilst posted at HMAS Cerberus he undertook anaesthetic training at the Royal Melbourne Hospital. Following his

discharge from the Navy, he was appointed an Anaesthetic Registrar at the Alfred Hospital where he completed his training.

He took up sessions at the Alfred Hospital, Footscray and District Hospital and the Preston and Northcote Hospital. Whilst at the Alfred, he had a significant involvement with the Officer Brown Cardiac Unit. At Footscray he gave anaesthetics for Mr George Thoms,

among others, which involved him in a large amount of obstetrics and gynaecology.

In addition, David served with some of the early Interplast Surgical Teams in the supply of plastic surgical expertise to Fiji and the Solomon Islands. Amongst the patients treated on these trips were a number of children with hare lips and cleft palates but much older and less well-nourished than the patients we see in our local practice. There were also patients with old machete wounds requiring surgical repair.

David was a quiet achiever. Nothing was too much bother for him and he would always be ready to put himself out. His outward quietness was often matched by a disarming quizzical manner and a delightful smile. His great concern for his patients was manifest in his diligence about his pre-anaesthetic visits, the manner in which he managed the worried patient and his insistence on calmness at all times, most especially in difficult situations. He disapproved of getting tense in these situations. This attitude was

passed on to his Registrars and he was well-known for this attribute which was admired by many.

I have great admiration for David who was well respected by his colleagues and surgeons across a wide range of specialties, attending many of our prominent private hospitals. He was most obliging in all his dealings with our secretarial staff who found him, as they would describe, 'easy to manage'. He was always dressed smartly in a dark blue jacket and trousers, he had a pleasant

gentle disposition and he got things done with a quiet efficiency. One thankless task that he performed over a number of years was the 'out of hours roster' which he managed masterfully, fairly and amicably - no mean achievement.

I would like to extend my sincere sympathy to Shirley and their children - Ian, Lindsay, Alister, Graeme and Kathryn on the sad loss of a wonderful husband and father.

ROBERT GILLIES

DR FREDERICK CECIL DONALD JOLLOW

**New South Wales – FFARACS 1973,
FFANZCA 1992**

Dr Fred Jollow died recently aged 72 years following a short illness due to gastric carcinoma. He will be sorely missed by all those who knew him. Dr Jollow, who died at home, had devoted his life to anaesthesia in the inner Sydney areas surrounding Strathfield. He had initially graduated from the University of Sydney with a Pharmacy degree and practised in pharmacy for a period of time before commencing medicine at Sydney University from which he graduated with honours in 1960.

Anaesthesiology was his chosen specialty and he began studying anaesthesia subsequent to his residency. He was a resident and

registrar at the Royal Prince Alfred Hospital. He obtained the Fellowship of the Faculty of Anaesthetists, Royal Australasian College of Surgeons and subsequently spent 40 years in the practice of anaesthesia.

Dr Jollow was head of Department of Anaesthesia at the Western Suburbs Hospital in Sydney before its closure and thereafter continued in practice in a number of private hospitals in the Strathfield area. He was a major contributor to the Department of Anaesthetics and the wider hospital at Strathfield Private Hospital, which was the first private hospital to become a teaching hospital of the University of Sydney. In this hospital he was the Vice

Chairman of that Department from its inception and the secretary of the Medical Staff Council of the hospital.

Dr Jollow is survived by his five children: Mark, David, Katherine, Susan and Adrian. His son David is a specialist obstetrician and Mark an anaesthetic technician. Adrian is a physiotherapist. It caused him great joy that his children followed him in a medical career. He was predeceased by his wife, Val MacInerney, who was a well-known general practitioner in the area around Strathfield.

Dr Jollow was a fine anaesthetist and a caring human being who also sought the best for his patients. He had a particular skill in languages, in which he was fluent in five and this enabled him to communicate with and reassure the large numbers of patients in this area of Sydney who had English as a second language.

DR TING CHOO (Marcus) KOH

**South Australia –
FFARACS 1974, FFANZCA 1992**

Graceful, intricate Tai Chi manoeuvres in the operating Theatre

corridors while waiting for the surgeon. Regular pearls of oriental philosophies.

Hypnotic chants of 'You Have Done WELL' compliments to awaking patients. No more. TC (Marcus) Koh died on 5 January 2000, two years after being diagnosed with adenocarcinoma of the lung. All the staff at The Queen Elizabeth Hospital, Adelaide who have worked

with him over the last 25 years will remember him fondly.

Even the most impatient of surgeons learnt to accept that Marcus would always be there, relaxed and fully prepared, before they arrived. His anaesthetic colleagues, anaesthetic trainees and medical students knew that they could rely on him for sound advice, constructive criticism and for appropriate encouragement. He loved teaching and was a joy to those preparing a teaching program. He was always years ahead of his time in foreseeing and promoting the need for change, promoting the need for 'Policies' and 'Protocols', for 'Quality Improvement', and for the Department of Anaesthesia at The QEH to become an academic department.

He was loved by the Theatre Nursing Staff, the Theatre Orderlies and the

patients. As well as maintaining a full anaesthetic workload, he single-handedly ran a busy Acupuncture Clinic. He was a Fellow of the Australian Medical Acupuncture Society, and had been its President, an examiner for the Fellowship, Editor of its Bulletin and Member of the Editorial Board. He published articles and gave lectures on Medical Acupuncture, Chinese Medicine and relaxation exercises. Since 1990 he made 10 medical missions overseas, eight with 'Operation Rainbow' providing cleft lip and cleft palate surgery to children in the Philippines and China.

Marcus was himself deeply religious, although prior to his funeral some of the many who attended may not have realised. He conveyed his religious convictions by manner and deed, rather than by force of argument. Perhaps his own physical handicaps honed his

awareness of what was really important in life and at work. If there is any truth in religion, Marcus will certainly have gone to a better place.

Marcus remained clear thinking right to the end. True to form, he typed a short speech for his own funeral, characteristically full of subtle philosophy and gentle humour. To quote from the first four sentences, 'As an anaesthetist, the two things your patient first hears upon waking from an operation are 'open your eyes', and 'take a deep breath'. Neither of which I can do now. I am an ET (an extra-terrestrial), somewhere in another dimension where there is peace, joy and glory. Whereas you have to go back to work'.

Marcus is survived by his wife Ying, his daughter Karen, son Robert and son-in-law Jarrod.

JOHN PFITZNER



President, Dr Richard Walsh (L) and Mr Lincoln Clifford, Product Manager for AstraZeneca (R) with Dr Guy Ludbrook, recipient of the Australasian Visitors Medal

REGIONAL COMMITTEES

ANNUAL REPORTS

1999 – 2000

Australian Capital Territory

Office Bearers

Chairman:

Dr Paul Burt

Secretary/Treasurer:

Dr Frank Lah

Continuing Education Officer:

Dr David Kinchington

ASA representative:

Dr Vida Viliunas

Committee member:

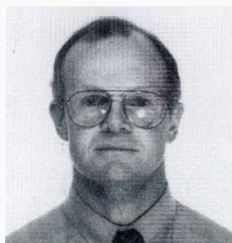
Dr Ray Cook

New Fellows Representative:

Dr Nicola Meares (November 1999)

Administration Officer ACT

Ms Eve Edwards



Dr Paul Burt

Total no. of Regional Committee Meetings for Year 3

All regional committee members attended all meetings.

Report

1999 saw major changes in the ACT region for College members. College approval for a Canberra-based regional training scheme came after the College inspection in April. The initial result has been an increased number of registrar training posts. Rotation of registrars now occur to Calvary Hospital (Bruce, ACT) and Albury Hospital. The College also approved the opening of a regional office in conjunction with the College of Surgeons. The welcome help of Eve Edwards as Executive Officer should provide for the efficient running of the Regional Committee.

The intensive care training program has been disrupted with the resignation of three staff specialist intensivists. A rotation of Sydney Intensivists now provide Intensive Care services to both the private and public hospitals supported by a hospital appointed Director.

The appointment of the Director of the Department of Anaesthesia and Pain Management at The Canberra Hospital has been protracted with Dr David Kinchington being offered the appointment. This should give some stability to the anaesthetic services and education opportunities for registrars and Fellows.

PAUL BURT
CHAIRMAN

New South Wales

Office Bearers and Members

Chair:

Dr Matthew Crawford

Vice Chair:

Dr Frank Moloney

Hon. Secretary:

Dr Jenny Beckett-Wood

Hon. Treasurer:

Dr Michael Jones

Regional Education Officer:

Dr Ross Kerridge

Formal Project Officer:

Dr Brian Horan

Continuing Education Officer:

Assoc Prof Peter Klineberg

Ex-Officio Members:

Councillors:

Professor Michael Cousins, Assoc Prof
Greg Knoblanche, Dr Richard Walsh

Faculty of Intensive Care Representative:

Dr Gillian Bishop

ASA Representative:

Dr Genevieve Goulding

Course Organiser Primary:

Dr Peter Kam

Course Organiser Final Fellowship:

Dr Michael Bookallil



Dr Matthew Crawford



Dr Jenny Beckett-Wood

Total No. of Regional Committee Meetings for Year: 6

Committee Members: Meeting Attendance

Dr Jenny Beckett-Wood	6 out of 6
Dr Matthew Crawford	5 out of 6
Dr Richard Halliwell	4 out of 6
Dr Brian Horan	4 out of 6
Dr Michael Jones	6 out of 6
Dr Michele Joseph	6 out of 6
Dr Ross Kerridge	5 out of 6
Assoc Prof Peter Klineberg	5 out of 6
Dr Ed Loughman	5 out of 6
Dr Frank Moloney	6 out of 6
Dr Richard Morris	4 out of 6
Dr Tony Quail	6 out of 6

Financial Report – Dr Michael Jones

The accounts of the New South Wales Regional Committee (business account, course account and NSWACE combined CME accounts) remain with sufficient funds for the expected operating activities of New South Wales. Both the College and ASA have audited NSW accounts to their satisfaction.

Education – Dr Ross Kerridge

Anaesthetic training in NSW is organised in nine rotational schemes covering over 30 hospitals across the state, with over 160 positions. The coordination of these schemes is a major logistical task, and the importance in this of the work of Jan Taylor in the regional office in Sydney cannot be overestimated.

There is now a reasonably stable group of Supervisors of Training. One of the challenges that Supervisors have is dealing with ongoing assessment and feedback to trainees. It is clear that the greatest value in ongoing assessment arises from the assessment/interview process itself, rather than the 'marks' recorded on the assessment sheets afterwards. Clearly, this process needs to continue to develop, but the value of regular feedback interviews (and intervention if necessary) is great.

In early February the College conducted a two-day workshop focussing on the Education process. NSW was enthusiastically represented by Mark Priestley (Westmead) and Maggie Bailey (St George). A number of important issues were dealt with, and many valuable lessons learnt by all participants. The results of this workshop will be felt as ongoing modifications to the training and assessment process, and support/education for Supervisors of Training.

Rural rotations continue to expand appropriately. There seem to be few problems with acceptance of this by trainees, who appreciate the enthusiasm of the rural anaesthetists as teachers, and the variety of clinical experience that can be gained from these rotations. There remain some rural areas that are yet to develop trainee rotations, and it must be hoped that these will develop.

Subspecialty training continues to be a challenge. Paediatrics is a particular problem, although a survey of recent graduates found that most were satisfied with the adequacy of training in paediatrics that they had received. It is nevertheless clear that there is no scope for expanding training positions in Sydney until it can be certain that all trainees will receive an equitable and satisfactory amount of paediatric training. This issue has been well recognised by the Regional Committee and the paediatric hospitals in Sydney. A number of options for addressing the issue are being pursued, and I am confident

New South Wales (continued)

Representatives on External Committees:

Dr Matthew Crawford

Committee of Chairmen of NSW
State Committees of Medical Colleges
Standing Committee of College
Chairmen

Committee of Management,
Australian Society of Anaesthetists
NSW State Committee, Royal
Australasian College of Surgeons

Dr Frank Moloney

Joint Consultative Committee –
Anaesthesia
Executive Committee, Rural Special
Interest Group

Regional Administrative Officer:

Janice Taylor

Offices and Secretariat

Suite 603 Eastpoint Tower,
180 Ocean Street,
Edgecliff NSW 2027

that the goodwill and commitment being shown by all parties will enable an optimal solution to be developed.

Selection for anaesthetic training is highly competitive, reflecting the high desirability that 'junior' medical staff see in anaesthetic training. This is a great compliment to the commitment of anaesthetists generally, and supervisors of training in particular, in the role as teachers. This is a compliment that is well deserved, and augurs well for the future of the specialty.

Formal Projects – Dr Brian Horan

Twenty-one NSW trainees submitted Formal Projects during the last year of whom nine were asked to provide more information or to resubmit after modification. All nine were subsequently accepted. The overall standard of the submissions was slightly higher than in previous years.

With the release of Formal Project Guidelines Review TE11 (1999), the role of the Formal Project Officer has taken on an extra aspect, registering proposed projects. It is unclear whether the 'advice' to be sought by the trainee at this stage and mentioned in the Introduction is intended to cover more than whether the proposal is suitable or not, and if so whether it is expected to be given by the Formal Project Officer or someone else. In NSW the interpretation has been that the Formal Project Officer's role is only to adjudicate about suitability.

One point currently unclarified is whether the Project can be submitted after the end of the Provisional Fellowship Year. The two relevant sentences in the Introduction to TE11 (1999) appear to be contradictory.

Continuing Education – Assoc Prof Peter Klineberg, Chairman NSWACE

Continuing education in NSW had another good year in 1999.

CME Activities:

15th May

'Changing Anaesthetic Practice – the short stay patient' at Hilton Hotel, Sydney
220 registrations

4th & 5th September

'Confronting Our Myths' at Fairmont Resort, Leura
145 registrations

6th November

'Mishaps – can we improve our act!' at Wentworth Hotel, Sydney
240 registrations

27th November

'Anatomical Workshop' at University of Sydney
47 candidates

We look forward to another excellent year of the committee comprising Drs Matthew Crawford, Genevieve Goulding, Peter Isert, Michael Jones and Michele Joseph.

Professional Affairs

Since the last Annual Report the Regional Committee has changed in composition. Long time serving members including Ed Loughman and Brian Horan have come to the end of their terms. Richard Walsh in his ex-officio position has also retired from College Council. Their input will be greatly missed but undoubtedly in time, will be replaced by the talent in the newly elected members, Michelle Mulligan and Joanna Sutherland.

Again the Committee was involved in numerous hospital accreditation inspections. These included Auburn, Blacktown, Canberra, Gosford, Hornsby, Lismore, Liverpool, Mt Druitt, New Children's, Prince of Wales, St George, Tamworth, Westmead and the Careflight service. These inspections are an opportunity for the College to help Departments of Anaesthesia and their trainees achieve their objectives appropriately and safely.

The NSW Department of Health has finally circulated a draft of its revised Guidelines for the Handling of Medication in New South Wales Public Hospitals. This document should address many of the anomalies that previously existed regarding cardiopulmonary bypass and anaesthetic technicians. The Regional Committee circulated the draft document widely prior to drafting its response, before the deadline of May 19th.

The Standing Committee of College Chairmen continued to be a vital link to the State Government and the Health Department. It is comprised of the Chairmen of the various procedural and non-procedural craft groups within the state of New South Wales. It meets 10 times per year. Five of these are meetings with senior Health Department officials. It is a forum for frank and open discussion regarding matters of concern to the Department of Health and the Colleges and accordingly shortens the time taken to review and comment upon the various circulars and documents arising out of the Department. Before these documents now appear even in draft form they have had significant input from the various colleges. To help the Standing Committee perform its task, a Policy Analyst has been appointed to review most of these documents to determine what their overall impact will be to the various stakeholders. This committee is extremely valuable in its ability to present a unified approach to the NSW Department of Health.

The NSW Regional Committee has been concerned for some time about the apparent maldistribution of paediatric anaesthesia training in New South Wales. A survey regarding access to paediatric anaesthesia training was conducted during 1999. Our most recent Fellows were surveyed regarding their training experience during their first four years. This survey suggested that although paediatric training was not evenly distributed throughout the state, virtually all trainees had gained what they thought was adequate hands-on and theoretical exposure to pass the exam. Very few felt they had had adequate training to undertake sub-speciality paediatric practice. The survey did not identify any areas of untapped paediatric activity that could be suitable for trainees. As such the Regional Committee felt that it would be difficult to allow an increase in the number of paediatric anaesthetic training positions within the state.

The Regional Committee is currently working with the Royal Australasian College of Surgeons to develop a surgical skills facility in Sydney. This skills facility is likely to offer major advances in our ability to train anaesthetists. It is likely that an anaesthesia presence at the skills facility will provide major support for the project. The skills centre is likely to become a major focus for advanced training by most of the procedural craft groups.

The New South Wales Medical Board has decided that its current options in dealing with under performing medical practitioners is unsatisfactory as it allows them very few options. It believes that a Performance Assessment should be made of suspected under performing practitioners, such that remedial action can be put in place to prevent the loss of that person from the profession. The College, as well as the other medical colleges, was involved in the discussions regarding this process and it appears that a form of performance assessment will be included in the new Medical Practice Act due this year.

The process involves initial referral of what is thought to be a problem practitioner with a subsequent assessment by a team, usually from the appropriate college, and thence a review panel which will determine whether remediation or re-training is required. The panel will not have the power to recommend that the practitioner's name be removed from the register. However, if the panel is of the view that issues of impairment or misconduct are raised, it has the power to refer the matter back to the Medical Board with recommendations that the review process be changed to address these matters. Should a process of retraining be recommended this will be developed in association with the relevant college and this may occur within or outside the state.

Following retraining, a process of reassessment will be undertaken and should the practitioner's performance still be unsatisfactory, the panel has the power to recommend that the medical practitioner's name be removed from the medical register. College Council also has established a Professional Practice Review process, (PPR) which is available to Fellows as part of the MOPS Program. Details are published in the *College Bulletin* or available from the College office.

Rural Activities

The NSW Department of Health has developed a process whereby vacancies in Rural Medical Practices declared to be an 'area of need' will initially be filled by Overseas Trained Doctors, if qualified for the position. Only should the position not be able to be filled from within Australia, will medical practitioners from overseas locations be considered. These Temporary Resident Doctors would be given temporary approval to practice in the area of need, and would be restricted to the area. The whole process of declaration of 'area of need' and appointment, will be streamlined, such that once it is declared, the process of appointment will basically only involve the Medical Board and the appropriate College.

MATTHEW CRAWFORD
CHAIRMAN

New Zealand

Office Bearers and Members

Chairman:

Dr Malcolm E Futter

Deputy Chairman:

Dr Alan McKenzie

Honorary Secretary

Dr Sharon King

Honorary Treasurer:

Dr Peter Cooke

Education Officer:

Dr Hugh Spencer

Formal Project Officer:

Dr Alan McKenzie

Committee Members:

Dr Forbes Bennett

Dr Rob Burrell

Dr David Jones

Assoc Professor Alan Merry

Dr Jennifer Weller

Councillor:

Dr Stuart Henderson

Faculty of Intensive Care

Representatives:

Dr Jack Havill, Chairman, FIC, NZ

Dr Ron Trubuhovich, BOF



Dr Malcolm E Futter



A/Prof Alan Merry

Total Number of Committee meetings for year – 3

Attendance of Elected Members

June 1999 – apologies received from Dr F E Bennett; November 1999 – apologies received for part of meeting only from Dr P Cooke and A/Prof A Merry; March 2000 – all elected members attended.

Financial Report – Dr Peter Cooke

On the basis of the Statement of Operating Expenses the total expenditure for the 1999 New Zealand National Committee was 51% higher than the previous year. This figure though, is misleading, as both CECANZ and Council of Medical Colleges payments contained additional, retrospective, amounts due in previous years (see below). In terms of dollars the largest increases were in staff salaries and the associated superannuation, a levy to the New Zealand Council of Medical Colleges and increased travel costs for both the ANZCA and FICANZCA national committees.

The increased staff costs are a result of the employment of an additional staff member, the cost of this being slightly offset by 2/5 of one salary being met by NZSA. As the College workload has increased substantially, two full-time staff are now required by ANZCA and it is anticipated that in future NZSA will employ its own staff member.

The CECANZ deficit payment is for the years 1998 and 1999. NZSA had already supported CECANZ to this same dollar value and the 'deficit' payment results from our obligation to pay an equal share of the CECANZ costs. It had been included in the budget for 1998 and 1999. Set against these costs but not meeting them, are any profits obtained from conferences in New Zealand.

The New Zealand Council of Medical Colleges has placed additional levy demands on member colleges and this levy has substantially increased. Again, the payment made related to both the 1998 and 1999 years. I am unaware of the proportional figure that is payable to the Australian equivalent of this body.

Increases in travel costs have occurred for both committees, substantially as a result of other health sector meetings that have been required. The FIC travel costs (which lay outside the scope of this report) more than doubled in 1999 whereas the ANZCA costs increased by 40%.

Another item worthy of note is the accountancy costs. These remained high due to further consultancy costs leading, thankfully, to resolution of the GST issue. It appears that the present arrangement for Fellows to pay fees to Australia and trainees in New Zealand is working thus far.

Overall, in spite of the increase in expenditure over the previous year, the total was significantly less than the budget. One of the reasons for this is that the budget had been adjusted to allow for a contribution to a new body, the NZ Perioperative Death Survey. Discussions regarding this work are still continuing and as yet no levy was charged in 1999.

In terms of clearer indication of expenditure in New Zealand this year, I plan to ensure that budget figures are displayed on our charts of accounts, so that any variations can be more readily appreciated.

Income for the year came from annual training fees and reimbursement of costs from NZMA. Melbourne funds were made available for purchase of a photocopier for the new ANZCA NZ offices now situated on the ground floor of Elliott House and reimbursement was made for Melbourne costs incurred in New Zealand.

The last items to highlight are in relation to Elliott House. This has recently been valued substantially lower than our book value/purchase price and consideration should

New Zealand (continued)

NZSA Representative:

Dr David Chamley

New Fellows Representative:

Dr David Sidebotham

Administrative Officer:

Lorna Berwick

Administrative Assistant:

Jan Graham

be given to showing this change in our accounts. In addition, quotations are currently being obtained for a very modest alteration that will result in a new office being formed to accommodate the NZSA and CECANZ secretariat, the cost of the alterations being shared with our co-owner RACS.

Education Officer's Report – Dr Hugh Spencer, Education Officer, NZ

TE17 Document – Advisors of Candidates for Anaesthesia Training

In the absence of interest for this position, as an interim arrangement it has been recommended that in NZ existing supervisors of training in the regions take on this role, and that in cases of enquiry to the National Office, the Regional Education Officer. After further communication from Melbourne, another effort is being made, with more success.

Workshop on New Zealand Training Rotations August 1999

A good attendance indicated that clinical directors and supervisors of training were committed to this important concern. Associate Professor Greg Knoblanche attended.

The meeting reviewed the viability of the old rotations in the light of recent developments. HAC's position was clearly outlined by Prof Knoblanche, including the problems of sub-specialty exposure. He felt that an interim arrangement of three rotations would be best for New Zealand but that Waikato may evolve as the centre of a new fourth rotation.

New ways of interviewing and choosing candidates for anaesthesia training were discussed as well as compulsion and subspecialty training. National training distribution and the availability of subspecialty training was extensively reviewed and problems identified.

Agreement was reached that three rotations should be recommended: South Island, the current Wellington rotation, and teaching hospitals north of Taupo. Each rotation must identify its own subspecialty 'bottlenecks' and structure training accordingly. An environment of consistent national standards should develop. The NZNC endorsed the recommendations and three rotations in NZ were formed.

Standardisation of rotation policy within NZ

This is proceeding and includes: entry to training; selection and interview process; a standard approach to ITA; ensuring that trainees know national rotation policy before entering the scheme; trainee numbers; rotation to non-metropolitan hospitals; developing non-training; policy on involving the RDA.

Education Workshops 2-3 February 2000, Ulimaroa

The NZ Education Officer attended these.

Education Subcommittee Teleconference 23 March 2000

Items raised included: training recognition for overseas graduates without full, or even any, NZ medical registration; changes in trainee numbers; subspecialty opportunities; effects of increasing trainee numbers on the whole rotation and future applications from other centres; the wide definition of subspecialty exposure accepted; over-exposure (eg ICU) to suit employers; progress in the new rotations; Melbourne education workshop and Brennan; ITA.

Courses

Primary courses have been held in Hamilton (June) and Christchurch (February), and a finals course in Auckland (July). All were successful, though Christchurch had problems with sufficient enrolments, which may have been partly due to the earlier dates than normal.

Formal Projects Report – Dr Alan McKenzie, Formal Project Officer

The following projects were approved in New Zealand during the 1999 calendar year.

Author: Dr Aengus O'Leary
Title: Important Determinants of Stress Levels of Junior Anaesthetists in New Zealand

Author: Dr Mary Faigan
Title: Intravenous Anaesthetics and Anaesthetic Vapours
Published in: "Mylers Side Effects of Drugs"

Author: Dr Adele E Meads
Title: Insertion of Laryngeal Mask Airway: Comparison of a Single Breath Sevoflurane vs Propofol Induction

Author: Dr Alastair McGeorge
Title: Sevoflurane anaesthesia for the removal of chest drains: a case series
Presented: Intensive Care Society & Riverside Group "State of the Art", London, England, 17-18 Dec 1998

Author: Dr Andrew John Haughton
Title: Unintentional paediatric subdural catheter with oculomotor and abducens nerve palsies
Accepted by "Paediatric Anaesthesia"

Author: Dr Terry Hercock
Title: The Addition of Ketamine to Patient Controlled Analgesia Morphine After Total Abdominal Hysterectomy - A Comparative Study
Submitted to "Acute Pain"

Author: Dr Cornelis Kruger
Title: Personality Traits of New Zealand Anaesthetists: An Evaluation using the Cloninger Temperament and Character Inventory (TCI-125)
Presented: ANZCA ASM Adelaide 1999 - Formal Project Prize Session (6a), Submitted to "Anaesthesia"

Author: Dr Ewa Johannsen
Title: Remifentanyl in Emergency Caesarean Section in Pre-Eclampsia Complicated by Thrombocytopenia and Abnormal Liver Function
Published: Anaesthesia & Intensive Care 1999; 27: 527-29

Author: Dr G Baker
Title: EEG Indices Related to Hypnosis and Amnesia During Propofol Anaesthesia for Cardioversion
Presented: ANZCA ASM Adelaide 1999, Poster presentation

Author: Dr Charles Bradfield
Title: General anaesthetics and therapeutic gases
Published in: "Mylers Side Effects of Drugs", Ed Prof J Aronsen

When necessary in the process of project approval, a number of New Zealand Fellows acted as reviewers. Because most of the approved projects were presented or published it is not possible to publicly name and thank these people without potentially breaking the anonymity of the review process.

CECANZ Report – Dr Trevor Dobbinson, Medical Director, CECANZ

The 1999 CECANZ ASM in Wellington, opened by Sir Michael Hardie Boys, Governor General of New Zealand, was a great success. "Cardiac Disease and Obstetrics"

highlighted a comprehensive program. The Single Theme meeting entitled "Trauma and the Anaesthetist" recently held in New Plymouth was well received. Invited speakers from both meetings travelled to other centres.

Three HELP Modules were produced in the 1999 year "Orthopaedic Surgery, Chronic Pain and The Kidney."

The BTW Ritchie Scholarship was awarded to Dr Michael Frederickson.

Dr Vaughan Laurenson completed his three-year term as Medical Director of CECANZ in December. His unstinting contribution was acknowledged with acclamation at the Combined NZC/NZSA Executive Meeting in November. The incoming Director is Dr Trevor Dobbinson.

Faculty of Pain Medicine – Dr David Jones

The first exam was conducted in November 1999. There are now nine NZ Fellows of the Faculty of Pain Medicine, some being from the associated disciplines. Approved training in NZ is still in a formative state, but there is some scope for increase. Details of training requirements can be obtained by contacting the Faculty Executive Officer painmed@anzca.edu.au. The first Annual Scientific Meeting of the Faculty will be held in conjunction with the College ASM in Melbourne in May, where Prof Daniel Carr is the invited speaker, supported by the ANZCA Foundation.

Chairman's Report - Dr Malcolm Futter

To nobody's surprise the millennium has as yet brought little that is new. New Zealand has seen a change of government, but so far this has resulted in no major changes to the healthcare system of consequence to anaesthesia.

Although the 1995 Medical Practitioners Act came into effect almost four years ago there appears a continuing need by the Medical Council for review of its implementation. Three particular areas have been of relevance to ANZCA.

In assessing the suitability of overseas specialists for vocational (specialist) registration ANZCA's stance, whilst more consistent than that of some Colleges in New Zealand is the most 'hard line', leaving minimal room for discretion. A consequence of this has seen our advice, particularly with respect to UK specialists, consistently set aside. The resultant reduction in credibility of ANZCA has possibly been the reason for the Medical Council's unilateral decision to grant vocational registration to some applicants who clearly had not undergone training and assessment equivalent to that expected for the award of FANZCA. It is hoped that ANZCA's review of its processes for assessment of overseas specialists may go some way to answering these problems. However the situation may become more complicated if the Medical Council pursues its suggestion that vocational registration should not be equated with specialist training and practice but rather reflect the practitioner's ability to work unsupervised in a particular branch of medicine.

Next year will see the first cohort of specialists reach the end of their first five years of vocational registration and thus require 'recertification'. It is anticipated that the Medical Colleges will be asked to advise on this and that they may well use participation in their maintenance of standards programs as a criterion for supporting an individual's recertification. Whilst the problems inherent in this are well recognised there currently appear few alternatives.

The third, but most topical, of the questions thrown up by the 1995 Act is that of practitioners' competency. Some well-publicised cases of medical mishap have resulted in calls for better ongoing review of competency. Rather than acting only after problems have occurred attempts are being made to identify practitioners at an earlier stage and

New Zealand (continued)

then, depending on circumstance, have their competency reviewed.

Despite the interest being shown in individuals' competency the Ministry of Health has, at the time of writing, shown little material support for the establishment of a review of anaesthesia related deaths. With the effective abandonment of the Anaesthetic Mortality Assessment Committee it had been hoped that something akin to the UK's CEPOD could be established. Wavering enthusiasm on the part of some other Colleges has meant these plans became financially non viable, however the New Zealand Committee of ANZCA is continuing to lobby for some sort of audit.

Trainee numbers have continued to slowly rise. The need to ensure subspecialty experience has seen the establishment of three rotations for the country. One based on Auckland and Hamilton; another on Wellington, Palmerston North and Hawkes Bay; and the third covering the whole of South Island. In practical terms this will result in little change except to formalise the co-operative approach to registrar placement that has operated for several years. In a similar way, ANZCA's draft policy for the selection of trainees, which grew out of the need to respond to Australia's Brennan Report, now endorses discussions about appointments that previously ANZCA insisted it could not be involved in.

The work of the New Zealand Committee has continued to grow inexorably. In an attempt to avoid duplication of effort and encourage closer liaison, the New Zealand Committee has begun to hold part of its meeting in conjunction with the executive of the New Zealand Society of Anaesthetists. An early success resulting from this co-operative approach was the adoption by the Health Funding Authority of the College's policy on referral criteria for obstetric epidurals.

I would like to thank all the members of the NZ Committee for their continued commitment to the ever-increasing workload and finally, thanks have to go to College Council for the support shown to the New Zealand Committee as it consolidates its status as a National Committee.

MALCOLM FUTTER
CHAIRMAN

Queensland

Office Bearers and Members

Chair:

Dr Robert Whiting

Vice chair:

Dr Jennifer Parslow

Honorary Secretary:

Dr Geoffrey Gordon

Honorary Treasurer:

Dr Ken McLeod

Regional Education Officer:

Dr Kerry Brandis

Formal Project Officer:

Dr Gerard Handley

Continuing Education Officer:

Peter Moran

Committee members:

Dr Mark Gibbs, Dr Anton Loewenthal,

Dr Malcolm McSorley,

Dr Di Khursandi (Councillor)

Ex-officio Members:

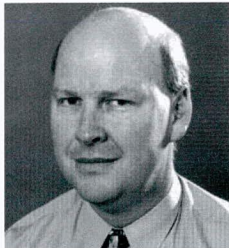
Prof John Gibbs (Councillor)

Dr Robert Whiting (Faculty of Intensive Care Representative)

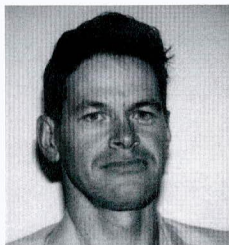
Assoc Prof Alison Holloway (ASA Representative)

New Fellows Representatives

Ian Cameron



Dr Robert Whiting



Dr Geoffrey Gordon

Representatives on External Committees

Robert Whiting

Advisory Panel to Health Rights Commission

Committee of Queensland Medical Colleges, Medical Workforce Specialist Working Party

Staff Panel of Peers, Senior Staff Specialist Status, Queensland Health ANZCA/RACS Building Committee

Jennifer Parslow

Chair, Queensland Health Theatre Utilisation Steering Committee

State Health Departments Committee Elective Surgery Project

Ministerial Task Force on Elective Surgery

Peter Moran

Editorial Committee Representative "Australasian Anaesthesia"

Postgraduate Diploma in Anaesthetic Nursing, Queensland University of Technology

ANZCA/RACS Building Committee

Bart McKenzie

Medical Workforce Specialist Working Party

Queensland Ambulance Medical Advisory Committee

Mark Gibbs

Queensland Committee to Investigate Perioperative Deaths

Geoffrey Gordon

Emergency Services Specialist Advisory Panel

Di Khursandi

Post-graduate Medical Education Committee, University of Queensland

Alison Holloway

Chairman, ANZCA Sub-committee on Anaesthetic Training (which includes Anaesthetic Technician Training Committee)

Ian Stephens

Maternal Morbidity and Mortality Sub-committee of Queensland Council on Obstetric and Paediatric Morbidity and Mortality

Paul Mead

Australian Resuscitation Council

Ken McLeod

Queensland Council for Rural Medicine, Rural Specialists Steering Group

Norris Green

RACS Queensland Trauma Committee

Total Number of Regional Committee Meetings for the Year

March 1999 to March 2000 = nine meetings

Attendances of Elected Members:

Dr Robert Whiting	9	Dr Kerry Brandis	8	Dr Malcolm McSorley	7
Dr Jennifer Parslow	7	Dr Mark Gibbs	5	Dr Alison Holloway	7
Dr Geoffrey Gordon	9	Dr Di Khursandi	8	Prof John Gibbs	7
Dr Ken McLeod	6	Dr Gerard Handley	7	Dr Ian Cameron	5 of 5
Dr Peter Moran	9	Dr Anton Loewenthal	8		

Queensland (continued)

Course Organisers:

Primary Short Course

Dr Kerry Brandis

Primary Long Course

Dr Cameron Hastie

Practise Viva Sessions

Dr Rhonda Boyle

Final Fellowship Short Course

Dr Stephen Bruce

Final Fellowship Long Course

Dr Kerry Brandis

Practise Viva Sessions

Dr Peter Moran

Welfare Officer:

Dr Di Khursandi

Regional Administrative Officer:

Ms Joyce Holland

Administrative Assistant:

To be appointed

Financial Report

The accounts of the Queensland Regional Committee (Business account, Courses account and ANZCA/ASA Combined CME account) remain with sufficient funds for the anticipated operating activities of the committee.

The courses conducted by ANZCA, and the Combined CME meetings (reported elsewhere) have all been run at a surplus and continue to attract the interest of Fellows and Trainees.

Major purchases this financial year included texts for a regional reference library and software upgrades for the various computers. These have been an asset to our courses and educational activities.

Education Report

Trainees

The number of accredited trainees (AVT years 1-4) in Queensland for 2000 is 78. The trainees are organised into two rotational training schemes known as the Northside Scheme (39 trainees) and the Southside Scheme (39 trainees). Trainees are appointed and employed by the individual hospitals but the individual trainee rotations are planned under the stewardship of the Regional Education Officer.

Three month sub-speciality rotations in Intensive Care, Paediatric Anaesthesia, Obstetric Anaesthesia and Cardiothoracic Anaesthesia are currently adequate for the number of available trainees. Experience in Neurosurgical Anaesthesia is obtained at six hospitals on the rotations. Involvement in Acute Pain services is widely available but opportunities for experience in Chronic Pain is more limited.

Recommendations for trainee selection are determined at an annual meeting to which the Director of Anaesthesia and the Supervisor of Training from each of the 19 hospitals with trainees are invited. The selection process is merit-based and scored against Selection Criteria.

Provisional Fellows this year total 11.

Registrar Training Courses

Three types of courses are available for registrars:

- Hospital Departmental meeting programs
- Long Courses
- Short Courses

All the Long and Short Courses are planned and administered by the College under the general direction of the Regional Education Officer.

The Long Primary Course is held on Monday nights at the College Building in Spring Hill. This well-attended and active course is organised by Dr Cameron Hastie.

The Long Part 2 Course is a series of tutorials on Thursday nights at the College building. This course is organised by Dr Kerry Brandis.

The Short Primary Course is a two week full-time course held annually. This course is organised by Dr Kerry Brandis. Due to the huge demand from local, interstate and overseas registrars, the course is run using current sessions utilising both available lecture areas. Several volumes of printed course notes are distributed to registrars.

The Short Part 2 Course is a one week full-time course organised by Dr Stephen Bruce. The course is held twice during the year and in view of the essentially tutorial nature of this program, the numbers are limited to a maximum of 20 registrars.

Other Training Issues

Viva Practice sessions for both the Primary examination (organised by Dr Rhonda Boyle) and the Part 2 examination (organised by Dr Peter Moran) have continued to be popular throughout the year.

Other Training Matters

The Queensland Regional Committee has been tasked by the College Council with the trial of a Log Book for trainees in 2000. This is scheduled to take place from May to August 2000, with a subsequent report on the trial being reviewed by the Executive in September. The sub-committee has worked very earnestly on this project and have considered the failings of similar projects in its determination of endpoints for the Log Book Project.

Continuing Education

The 23rd ANZCA-ASA Combined Continuing Education Committee of Queensland's meeting was held on Saturday 3 July 1999 at the Bardon Conference Centre, Brisbane. Guest Speakers were Dr Rod Westhorpe, President, Australian Society of Anaesthetists and Dr Scott Simpson, Staff Specialist, Townsville General Hospital. 115 delegates attended the meeting which was well supported by the Industry with 17 companies exhibiting. The Convenor was Dr Anton Loewenthal.

The 3rd ANZCA-ASA Annual Registrars' Meeting was held at College House, Spring Hill on Saturday 27 November 1999. Dr Graham Mapp was the recipient of the 'Tess Cramond Prize' for Formal Projects presented on that day.

Acknowledgements

The Queensland Regional Committee once again would like to acknowledge the extraordinary contribution made to the activities of the Committee, Fellows and Trainees in Queensland by Joyce Holland, the Regional Administrative Officer. Without her organisation, thoughtfulness and day-to-day management of our affairs, we would not be able to engage ourselves in the range of activities that are currently available to the Fellows and trainees in Queensland.

ROBERT WHITING
CHAIR

South Australia

Office Bearers And Regional Committee Members

Chair:
Dr Alan Rainbird

Vice Chair:
Dr Margaret Wiese

Hon. Secretary/Treasurer:
Dr Margaret Cowling

Committee Members:
Dr Neil Maycock
Dr John Richards
Dr Tony Laver
Dr Peter Woodhouse
Dr Lisa McEwin
Dr Robert Singleton

Formal Projects Officer (co-opted)
Prof Don Moyes

Northern Territory Representative
Dr Daryl Catt

Faculty of Intensive Care Representative
Dr John Myburgh
(until February 2000)
Dr Sandy Peake (from March 2000)

Faculty of Pain Medicine Representative
Dr Pam Macintyre

New Fellows Representative
Dr Tom Jaensch (from July 1999)



Dr Alan Rainbird



Dr Margaret Cowling

Total No. of Regional Committee Meetings for Year: 8

Attendances of Elected Members

Cowling	8	McEwin	7	Singleton	5
Laver	7	Rainbird	7	Wiese	6
Maycock	6	Richards	6	Woodhouse	7

Continuing Education

The Annual General Meeting of the South Australian Regional Committee was held on Wednesday, 7th July 1999 prior to the CME meeting at Wakefield Hospital.

Continuing Education Meetings - The South Australian Regional Committee thanks the Combined CME Committee for organising the following meetings throughout 1999/early 2000:

2nd June 1999 – “Malignant Hyperthermia” Speakers: G Newcombe, D Tomkins and D Fenwick

7th July 1999 – “Acute Pain Management in the Opioid Dependent Patient” Speakers: P Macintyre and P Briscoe

4th August 1999 – “Issues in Obstetric Anaesthesia” Speakers: S Simmons, M Andrew, A Cyna and R Lea

1st September 1999 – “Current ASA Issues – RVG” Speaker: G Deacon

3rd November 1999 – “Regional Anaesthesia, Analgesia and Anticoagulation” Speaker: M Priestley

1st March 2000 – “Risk Management and Legal Issues for Anaesthetists” Speaker: T Nelson, Medical Defence Association of SA

Peri-operative Mortality Committee

The Committee, under the leadership of Peter Gartrell, continues to perform sterling work. Both this Committee and the Regional Committee have been involved in the issue of provision of sedation by single operator endoscopists. While this is not new, the problem does seem to be worsening, especially in the area of the use of inappropriate drugs. Budgetary constraints have also contributed to the issue. Our attempts to influence practice have so far been unsuccessful, but our efforts will continue.

Independent Midwives

The State Committee of the College of Obstetricians and Gynaecologists sought support from the Regional Committee in their campaign opposing Independent Midwives being given practising rights in South Australian Hospitals. While the Committee believed that this was an issue for individual Anaesthetists to decide, eventually assistance was sought from the College. We have been advised that the matter is covered in College Policy Documents and this advice will be disseminated in due course.

Anaesthetic Museum

Two display cabinets have been purchased in order to establish a museum of historical anaesthetic equipment at the College offices. The Regional Committee is most appreciative of the support of Joan Sheales and Council in this endeavour. Bill Fuller has worked hard to catalogue all of the available equipment, and it will be a difficult task deciding which items will be on display.

Training Issues

The highlight of the year was the excellent results in the Primary examination, with 20 candidates successful, out of 25 attempts. Grace Koo, the organiser of the Primary

South Australia (continued)

Ex Officio

Member of Council

Dr Richard J Willis

Directors Representative

Dr Peter Lillie

Regional Education Sub-Committee:

Chairman - Regional Education Officer:

Dr Peter Woodhouse

Organiser - CME

Dr Lisa McEwin

Course Organiser - Primary

Dr Grace Koo

Course Organiser - Final Fellowship

Dr David McLeod

Regional Administrative Officer

Ms Sue Harrison

Course, is worthy of our congratulations. David McLeod has done an excellent job with the Second Part Course, having resuscitated what was quite sick two years ago. However, the financial position of both Courses has been under close scrutiny this year, without being clearly resolved. Trainees are reluctant to part with money for local courses, when they consider that they already pay the College a substantial amount in Training Fees. The Committee has suggested that Trainees be fully acquainted with the details of College finances. I have real concerns that a generation of disaffected Fellows could be produced unless some form of preventative action is taken.

Regional Committee

This is my third and final Annual Report. I would not wish it to degenerate into an acceptance speech at the Academy Awards. I do wish to thank all of the Members of the Regional Committee for their efforts over the last two years, especially the Office Bearers. Also Sue Harrison has, at all times, been a quite excellent Secretary. I could not have wished for better. Finally, I wish to express my gratitude to my Department Head, Professor Don Moyes. Without his unqualified support, I do not see how I could have adequately performed my duties.

ALAN RAINBIRD
CHAIRMAN

Tasmania

Office Bearers and Members

Chair: Dr Margaret Walker

Vice Chair:

Dr Phil Browne (responsible for morbidity and mortality issues)

Hon. Secretary:

Dr Richard Smith

Hon. Treasurer:

Dr Richard Smith

Regional Education Officer:

Dr Michael Grubb

Formal Project Officer:

Dr Michael Grubb

Education Sub-Committee:

Chaired by Regional Education Officer

Committee Member:

Dr Richard Waldron

Councillor:

Dr Mike Martyn

Intensive Care Representative:

Dr George Merridew

Representatives on External Committees

Ambulance Clinical Council:

Dr Daniella Eugster

Australian Anaesthesia Sub-Editor:

Dr Colin Chilvers

Australian Resuscitation Council:

Dr Malcolm Anderson

Postgraduate Medical Committee:

Dr Michael Hodgson

School of Medicine Advisory Committee:

Dr Malcolm Anderson

Surgical Services Advisory Committee:

Dr Ruth Matters

Administrative Officer:

Mrs Di Cornish



Dr Margaret Walker



Dr Richard Smith

Total Number of Regional Committee Meetings for Year: 4

Attendance of Elected Members

M. Walker	4 of 4	M. Martyn	2 of 4	R. Smith	1 of 1
R. Matters	3 of 4	R. Waldron	3 of 4		
P. Browne	3 of 4	G. Merridew	3 of 4		
M. Grubb	4 of 4				

Financial Report

The TRC accounts remain in order. The administrative and CME accounts have been combined to simplify operation. The combined ANZCA/ASA CME account continues to operate, pending a decision to split the account to simplify GST requirements of both organisations. The two state meetings in this reporting period have covered their own costs.

Education

There are 11 accredited training positions in Tasmania, with seven in Hobart, three in Launceston and one in Burnie. In their third or fourth year of training, three registrars rotate out of the region, two to Melbourne and one to Taunton, United Kingdom. The level of subspecialty training within the state is considered adequate for the current number of trainees, but probably not adequate for a further trainee position that was requested. As a result of the sub-specialty review, registrars are receiving more exposure to elective obstetrics and chronic pain.

All hospitals in Tasmania were inspected this year, and all received satisfactory reports. Problems identified are being addressed by the various hospitals.

The Pain Unit at Royal Hobart continues to expand and progress, with the view to achieving accreditation for training by the end of the year.

Tasmanian candidates have continued to perform well at the Primary exam, with five out of six of the candidates being successful in the last two exams. At the last Final Fellowship exam our candidate was successful.

Continuing Education

Two State Meetings were held. Hobart, November 1999 (Theme: Trauma) combined with ACEM and was financially viable despite disappointing registrations. Freycinet Lodge, February 2000 (Themes: Pre-Admission Issues and Welfare of Anaesthetists) attracted interstate delegates and was also self-funding.

The second Annual Registrars' Meeting in November 1999 was well attended and looked at the different challenges facing registrars following Fellowship.

A highly successful "draw-over" anaesthesia course was held in March 2000 in Launceston, organised by Hadyn Perndt and George Merridew, and will continue to be offered. The next course will be in Hobart.

The ASM 2003 is due to be held in Hobart. A recent inspection by the College of the proposed venue was favourable, and a decision will be made by Council at the next meeting in May.

Professional Affairs

Due to the small pool of Fellows in Tasmania, the Tasmanian Regional Committee requested the College appoint Margaret Walker for a further two years as Chair of the Committee. The College has agreed to this request, recognising Dr Walker's contribution to the Committee.

Ruth Matters has retired from the Committee due to other work commitments. The Committee thanks her for her contribution as Honorary Secretary to the work of the Committee and the College. She has been replaced on the Committee by Richard Smith.

RICHARD SMITH
HONORARY SECRETARY

Victoria

Office Bearers:

Chairman:

Dr Mark Buckland

Deputy Chairman:

Dr Kate Leslie

Honorary Secretary:

Dr Rowan Molnar

Honorary Treasurer:

Dr Mark Fajgman

Education Officer – (Anaesthesia):

Dr Elizabeth Ashwood

Formal Project Officer:

Dr Brendan Flanagan

CME Officer:

Dr Peter McCall

Paramedical Personnel:

Dr Philip Ragg

VMPPF:

Dr Steve Chester

Safety Officer:

Dr Graham Cannon

Road Trauma/Electronic Media/Web Page:

Dr Joseph Novella

Rural Representative:

Dr Mark Tuck



Dr Mark Buckland



Dr Rowan Molnar

Total No. of Regional Committee Meetings for Year: 1999 = 11
2000 = 3

Attendances of Elected Members

Dr Buckland	10	Dr Leslie	11	Dr Molnar	10	Dr Fajgman	9
Dr Ashwood	9	Dr Flanagan	9	Dr McCall	9	Dr Ragg	8
Dr Chester	6	Dr Cannon	5	Dr Novella	10	Dr Tuck	7

Introduction

The VRC has had another busy year. The organisation and planning of the College ASM has been a major focus, along with all the routine activities related to education of Fellows and Trainees. At a time when the public image of anaesthesia appears to be under some scrutiny, the importance of some of these activities such as representation on hospital accreditation and appointment committees cannot be underestimated.

Our Primary and Fellowship courses remain popular and, despite some geographical inconveniences due to the College building project, continue to be very well supported by the region's Fellows.

Consultative Council on Anaesthetic Mortality

There were 10 meetings of Council with 78 cases of mortality and 54 cases of morbidity being considered. Thirty-two of these deaths were residual cases from 1998 and 46 occurred during 1999. At this stage approximately eight deaths from 1998 remain to be resolved and it is assessed that a further 35 from 1999 have yet to be discussed. None of the 1998 or 1999 cases are yet entered into the computer data bank so no accurate assessment of the anaesthetic associated deaths or contributory factors can yet be made. At this stage it would appear that 12 cases of mortality were considered to have some relationship to anaesthesia and this number would be slightly higher than in previous years. This may be related to a more vigorous follow-up and critical analysis of cases but also to the increasing age and co-morbidity's of the patients undergoing interventional procedures. More accurate information will be reported as soon as the 1998 figures are complete.

The major report for the years 1993-1996 on 360 cases of mortality and 135 cases of morbidity was completed in November 1999, is now in press and will be distributed early in 2000. The Chairman will then arrange a meeting with the Minister to discuss the main recommendations of the report.

No information Bulletin was issued in 1999 due to the imminent release of the main report. However some important issues were publicised through the regular Newsletter of the Chairman of the Victorian Regional Committee of the Australian and New Zealand College of Anaesthetists (ANZCA) and also the National *Bulletin* of the ANZCA which is issued quarterly. The Chairman of the Council is co-opted to the Victorian Regional Committee and attended eight meetings in 1999. A report on the activities of the Consultative Council is a permanent item on the agenda of each meeting.

In preparation of the National Report on Anaesthetic Mortality (1994-96) there were two full day meetings and one teleconference of the Mortality Committee of the ANZCA, on which the Chairman is the Victorian representative. Thirty-five of 155 cases of anaesthesia related mortality were contributed from Victoria and the provision of information was greatly facilitated by the computerised database although lack of standardisation of terms and of classification still made the exercise tedious. The Report of this Committee was published in October 1999 and was generally well received although there were the usual sensational headlines from the press.

Victoria (continued)

Ex-Officio Members:

Councillors:

Dr Ian Rechtman
Dr Rod Westhorpe

Co-opted:

RACS

Mr Peter D Danne

*Consultative Council on Anaesthetic
Mortality and Morbidity*

Dr Patricia Mackay

*Australian Society of Anaesthetists
Representative*

Dr Mark Sandford

Faculty of Intensive Care

Dr Megan Robertson

New Fellows Representative

Dr Colin Iatrou

Administrative Officer:

Ms Corinne Millane

The plan for 2000 is to attempt to devise a standardised glossary of terms and Drs B Horan and P Mackay as representing the largest States will undertake this.

Education

The Victorian Regional Committee again ran its usual courses leading up to the examinations and, as mentioned, were very popular and successful.

The Annual Registrars' Scientific Meeting was held in August on the eve of the ANZCA/ASA Combined Continuing Medical Education Meeting. It was highly successful with many high quality papers presented. It is planned to continue linking the two events where possible.

The Education Officer and Chairman attended the College Workshop on education, along with several Supervisors of Training from the State. This was an interesting meeting, which probably raised as many questions as it answered.

Finance

Whilst building extensions are taking place at Ulimaroa, the Committee has agreed to pay the additional cost of running first and second part courses offsite. Otherwise the VRC accounts remain in order.

Continuing Education

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

- | | |
|------------------|---|
| 13 May 1999 | "Management of the Difficult Airway", Associate Professor George Arndt |
| 15 July 1999 | "Crisis Management in Anaesthesia", Dr Brendan Flanagan |
| 13 August 1999 | Annual Registrars' Scientific Meeting
(Held in conjunction with Combined ANZCA/ASA Meeting. The altered format of the meeting being held on a Friday afternoon and evening proved very popular with increased attendance.) |
| 9 December 1999 | "Local Anaesthesia for Head and Neck Surgery", Dr Joe McGuinness |
| 24 February 2000 | "Iatrogenic Injuries and the Anaesthetist", Professor Bill Runciman
(This presentation was a first for the College - a virtual as well as "real" material being presented concurrently. A taste of the future and of the ASM 2000 Virtual Congress.) |

All of these topics have been videotaped and may be borrowed from the ANZCA Library.

The Combined ANZCA/ASA CME Meeting was held on 14th August 1999. It was presented in conjunction with the Australian Red Cross Blood Service, Victoria. The topic was "Transfusion Medicine: An Update". Areas covered included physiology of transfusion and coagulation, drugs and disease affecting coagulation, current transfusion recommendations and relevant clinical scenarios. Due to the unfortunate incident of transfusion related HIV prior to the meeting, attendance swelled to over 450 registrants.

The next Combined ANZCA/ASA CME Meeting will be on 22nd July 2000. The theme of this meeting will relate to Perioperative Medicine and the management of related problems.

A local register of meetings is maintained. Anyone with details of planned meetings wishing inclusion on this list should contact the VRC Administrative Officer via e-mail victoria@anzca.edu.au, phone (03) 9510 6441 or fax (03) 9510 6786.

Victorian Medical Postgraduate Foundation Inc.

Late in 1999 the Postgraduate Medical Council of Victoria was established. Its responsibilities include postgraduate medical education and computer matching of intern and resident appointments. As from 2000 funding for these responsibilities, formerly conducted by the VMPF has been withdrawn. Consequently, the VMPF has had to make a reduction in size and readdress its role as an umbrella organisation, which can act as a co-ordinator of all specialty and general practice colleges. In 2000 VMPF will organise metropolitan postgraduate education meetings as well as bridging courses for doctors trained overseas.

From April 1st, 2000 VMPF will be located on the 8th Floor of the Mary Aitkenhead Centre (St Vincent's Hospital), Victoria Parade, Fitzroy.

Electronic Media and Web Page

The year has been spent establishing and maintaining the website. Currently negotiations for a secure area on the VRC website continue, to allow "electronic" presentation of items of interest only to Fellows. The VRC members now routinely have the agenda and minutes e-mailed. Dr Joseph Novella has also been actively involved in the establishment of the ASM Website, as well as launching the Virtual Congress 2000 – a new and exciting initiative that will publish many of the ASM2000 presentations on an online website <http://virtualcongress.anzca.edu.au>. Those who attended the CME meeting of Prof Runciman will have received a taste of this.

Rural Activities

There have been a number of ongoing issues within the rural portfolio during 1999. Early in the year Dr Richard Willis, on behalf of the JCCA, asked for Victorian Fellows to make themselves available to act as assessors for rural GPs taking part in the JCCA's maintenance of standards program. There was a gratifying response from individual Fellows and Departments of Anaesthesia in all the major regional and metropolitan hospitals.

A significant number of Fellows contributed to the RACGP Annual Update in Anaesthetics held in October 1999. Despite whatever philosophical concerns that individual Fellows and the College may have towards the delivery of anaesthesia by rural GPs this level of involvement goes a long way to maintaining dialogue and hopefully clinical standards with a substantial number of practitioners of anaesthesia.

There were several multidisciplinary teleconferences on rural issues in which the VRC was asked to participate. The meetings were aimed more at primary care, but there are a number of issues that are applicable to rural Fellows. These issues are access to continuing medical education, locums and acute care funding in regional centres. With the increase in medical indemnity costs there is a concern that there will be a despoiling of more isolated regional centers as long term practitioners retire with little chance of attracting recently qualified anaesthetists.

In summary, rural issues continue to be focused on workforce numbers and access to continuing medical education. The difficulties those more isolated practitioners will face, especially in relation to the QA components of the MOPS program is an issue that needs to be addressed in the near future.

Safety

The passing of the Y2K phenomenon and its lack of impact on the anaesthetic community was gratifying and quite possibly due largely to meticulous preparation by those responsible for the maintenance of our equipment.

There have been no major events reported to the VRC and as a result the role of the Safety Officer in the last 12 months has thankfully been a quiet one.

ASM 2000 Melbourne

The excellent response in registration for the ASM suggests that the Organising Committee has done a great job, under the leadership of Convenor Dr Philip Ragg and Scientific Program Coordinator Dr Kate Leslie.

Formal Projects

Victorian trainees have produced some interesting Formal Projects this year. Many were presented at the Annual Registrars' Scientific Meeting organised by the Regional Education Officer, Dr Elizabeth Ashwood. Several trainees presented their projects at national meetings, whilst others submitted published work.

Formal Projects approved were:

Dr Fabian Purcell	Anaesthetic Simulators in Australasia
Dr Belinda Schramm	Coagulation Studies in Pre-operative Neurosurgical Patients
Dr Alexandra Evans	Dynamic Hyperinflation: Comparison of Jet Ventilation versus Conventional in Patients with Severe End-Stage Obstructive Lung Disease
Dr Cindy SY Lai	Audit on the Use of Intrathecal Midazolam in Clinical Practice
Dr N Johann Colin-Thome	The effect of Sevoflurane on Hypoxic Vasoconstriction and Arterial Oxygenation in One Lung Anaesthesia
Dr Francis Jayamaha	Clonidine for Co-induction of Anaesthesia with Propofol
Dr Amanda Baric	Oesophageal rupture in a patient with post-operative nausea and vomiting
Dr Ian FJ D'Cruz	Central Venous Line Audit 9/96-5/97 – Launceston General Hospital
Dr Adam Tucker	An Evaluation of the Contribution of Spinal and Supraspinal Actions of Drugs to their Overall Analgesic Effects in Man
Dr Michael A Boquest	The Pain Visual Analogue Scale – Is It Linear or Non-Linear?
Dr Robert P Grauer	Patients Experiences with Different Anaesthetic Techniques for Lithotripsy
Dr David R McIlroy	Do Passive Humidifiers Keep the Anaesthesia Circuit Dry?
Dr Diobhan A Dobell	Epidural Blood Patch Audit September 1997-May 1999
Dr Dean A Cowie	Supplemental Oxygen via the Laryngeal Mask Airway: a Comparison of Four Devices
Dr Alicia T Dennis	An Audit of Serum Magnesium Levels in an Intensive Care Unit
Dr Keith Rees	The use of Incremental PEEP in the Management of Respiratory Failure in the Post Cardiac Patient
Dr Elizabeth J Pemberton	Rupert Walter Hornabrook – Australia's first full-time Anaesthetist
Dr Stephen Hams	Combined caesarean section and resection of bilateral Pheochromocytoma

Victoria (continued)

Dr David Kirton	Nitrous Oxide in Patients at High Risk of Postoperative Nausea and Vomiting
Dr Gary A McKenzie	Comparison of 0.5% Bupivacaine with 0.25% Bupivacaine for spinal Anaesthesia in elderly patients undergoing surgical correction of Fractured neck of femur
Dr Saskia Hensen	Validity and Reliability of a Postoperative Quality of Recovery Score: The QoR-40
Dr Fiona J Johnson	Is Anaesthesia evidence-based? A survey of anaesthetic practice
Dr Jamie A Smart	The Effect of Anaesthetic Technique on Time to Awakening
Dr Richard J McMahon	Is anaesthesia evidence-based? A survey of anaesthetic practice
Dr David J Olive	Amicar in first-time CAGS – pre-incision or post-heparin?
Dr Ben J Di Luca	Anaesthesia in a Child with Autosomal Recessive Omodysplasia
Dr Geoff G Steele	The Effect of Microwave Heating on the Acidity of 0.0% Saline in 1 Litre and 100 ml Polyvinyl Chloride Packaging
Dr Stephen J Worboys	The effect of body temperature on blood loss during Total Hip Replacement under regional anaesthesia
Dr Brett A Pearce	Implementation and Evaluation of a Simulator-based Introductory Anaesthesia Program
Dr Mark Lai	Paraesthesia after combined spinal-epidural anaesthesia: a diagnostic dilemma
Dr Ginette M Falcone	Audit of Manual versus Automated Record Keeping Systems
Dr Karlo Testen	The Influence of the Rate of Induction on Post-operative Recovery
Dr Hugh CR Platt	A Comparison of conventional Intubation versus Intubating via the Intubation Laryngeal Mask: Haemodynamic Changes
Dr Laurie Poon	A Comparison of conventional Intubation versus Intubating via the Intubation Laryngeal Mask: Haemodynamic Changes
Dr Robert Watson	Nerve Blocks Versus Local Infiltration for Stereotactic Frame Replacement
Dr Susan J Kelly	Intraoperative BIS Monitoring and Early Extubation after Cardiac Surgery in Patients with a History of Awareness Under Anaesthesia

Finally, the VRC would like to thank the all the staff at “Ulimaroa” for their valuable assistance during the year. Our particular thanks to our Administrative Officer, Ms Corinne Millane, and to Ms Jennifer Ellis for their excellent help.

Western Australia

Office Bearers

Chairman:

Dr Leigh Coombs

Deputy Chairman:

Dr Grant Turner

Honorary Secretary:

Dr Stuart Inglis

Honorary Treasurer:

Dr Michael D'Souza

Continuing Education Officer:

Dr Michael Paech

QA Officer:

Dr Neville Gibbs

Regional Education Officer:

Dr Grant Turner

Members:

Dr Nedra vanden Driesen

Dr Gavin Coppinger

Councillors:

Prof Teik Oh

Dr Wally Thompson

Co-opted

New Fellows Representative:

Dr Lindy Roberts

Welfare Officer:

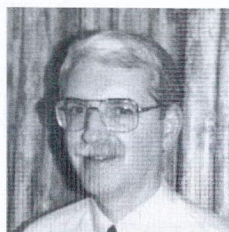
Dr Lindy Roberts

Country Representative:

Dr Wilson Lim



Dr Leigh Coombs



Dr Stuart Inglis

Attendance at Regional Committee Meetings

Dr L Coombs	6/6	Dr Gavin Coppinger	5/6	Dr Craig Schwab	1/3
Dr G Turner	6/6	Prof Teik Oh	4/6	Dr Stephen Watts	2/4
Dr S Inglis	6/6	Dr Wally Thompson	5/6	Dr Andrew Miller	0/4
Dr M D'Souza	5/6	Dr Lindy Roberts	5/6	Dr Richard Riley	1/1
Dr M Paech	5/6	Dr Wilson Lim	3/6	Dr Roger Goucke	2/6
Dr N Gibbs	3/6	Dr Simon Maclaurin	5/6	Dr Stephen Edlin	0/3
Dr N vanden Driesen	5/6	Dr Paul Tucker	0/3	Dr Bernice Ng	0/3

Dr Richard Clarke Chairs ASA Meeting concurrent with ANZCA WA meeting

Continuing Education Report – Dr Michael Paech

'Anaesthesia WA – Education Liaison Committee' was formed during 1999. It is a committee of continuing education officers of ANZCA WA, ASA WA and Centre for Anaesthesia Skills and Medical Simulation. Its purpose is to coordinate continuing education activities in WA.

The period of March 1999 to 2000 saw a number of presentations by visiting speakers from interstate and overseas and the continuation of the local tradition of Autumn and Winter Scientific Meetings. The 1999 Autumn Meeting held on March 20th & 21st was entitled "Infection and Anaesthesia". The Anaesthesia WA - Dr Peter Brine Lecturer was Prof Greg Knoblanche of Royal North Shore Hospital, Sydney. Our thanks to Abbott Australasia, Pall Australia and Hospital Supplies of Australia for their support of this Lectureship. The annual Winter Scientific Meeting was conducted in June 1999 with the Anaesthesia WA - Dr Ian Miller Lecturer being Assoc Prof Ian Power from Royal North Shore Hospital, Sydney. Professor Power made a series of presentations on topics associated with Pain Management, and conducted tutorials on Physiology and Pharmacology subjects, during his one week visit to regional and metropolitan hospitals. Anaesthesia WA Education Liaison Committee, with the assistance of industry sponsorship, continued to support rural visits with Dr Power visiting Bunbury for lectures and tutorials. These meetings provide an important source of education for Anaesthetists, general practitioner Anaesthetists and nursing staff who practise in rural centres and regions of Western Australia. Other activities during this period included a visit by Prof David Hatch, the Foundation Professor of Paediatric Anaesthesia, Institute of Child Health, London UK. In conjunction with Dr Craig Sims of Princess Margaret Hospital, Prof Hatch spoke on "Assuring good medical practice" at an evening meeting on 16th September 1999. Industry initiated meetings included talks on "Infection Control" and "Blood Transfusion and Leucocyte depletion". Planning and organisation of the National Scientific Congress of the ASA in Perth in September 2000 is currently in an advanced state of progress.

The Autumn meeting for 2000 was held on Saturday 25th March and consisted of workshops on regional anaesthesia and cardiac anatomy for transoesophageal echocardiography. This was followed by a tour of new Collaborative Training and Education Centre at the University of Western Australia. This centre sees the creation of the most advanced training centre for medical and surgical skills in the southern hemisphere. It was officially opened by Her Majesty the Queen on Saturday 1st April 2000. The centre incorporates the offices of the joint Regional Administrative Officer of the College, Society and the Centre for Anaesthesia Skills and Medical Simulation. The Winter Meeting 2000 will feature Dr. Suellen Walker of Royal North Shore Hospital, Sydney as the Anaesthesia WA - Dr. Ian Miller Lecturer. Our thanks to Boots Healthcare and GlaxoWellcome Australia for their support of this Lectureship.

Western Australia (continued)

Continuing Education:

Dr Simon Maclaurin

Dr Paul Tucker / Dr Craig Schwab

Day Care Anaesthesia:

Dr Stephen Watts

Medico Legal:

Dr Andrew Miller

Website Editor:

Dr Richard Riley

ASA Representative:

Dr Richard Clarke

Faculty of Pain Medicine:

Dr Roger Goucke

Faculty of Intensive Care:

Dr Stephen Edlin / Dr Bernice Ng

Regional Education Sub Committee

Chairman:

Dr Grant Turner

Dr Nedra vanden Driesen

Dr Lindy Roberts

Dr Leigh Coombs

Administrative Officer(s)

Ms Penny Anderson

Ms Diane Cook

(from February 2000)

Continuing Education for Rural GP Anaesthetists

The Anaesthesia WA Education Liaison Committee will launch its inaugural three day combined classroom and simulation programme in June 2000 specifically for rural GP Anaesthetists. This promises to be a high value educational activity.

Younger Fellows Report – Dr Lindy Roberts

Dr Elizabeth Avraamides and Dr Lindy Roberts were the WA representatives to the Younger Fellows Conference in the Barossa Valley in May 1999. From this meeting, Dr Roberts was elected as the Younger Fellow representative to the ANZCA Education Committee.

Welfare Officers Report – Dr Lindy Roberts

The inaugural First Year Anaesthesia Registrar Orientation Day was held on Saturday the 22nd of January, 2000 and was attended by eight of the nine new registrars. The function was sponsored by AstraZeneca and included presentations on ANZCA, the ASA, role of the REO, training requirements, the Primary examination and 'taking care of yourself during training'. Feedback from the participants has been very positive. Dr Grant Turner (REO) coordinated the Registrars Association with regular meetings to ensure that trainees issues are detected and addressed in a timely manner.

Gilbert Troup Prize for Undergraduates in Anaesthesia

ANZCA has added support to the long-standing Gilbert Troup Prize for Medical Students administered by the ASA WA.

Financial Report ANZCA WA Administration Account – Dr Michael D'Souza

The budgets were presented in accordance with College guidelines. Audit was performed and found to be satisfactory. A financial report will be presented to the ANZCA WA AGM.

Financial Report ANZCAASA Continuing Education Fund – Dr Paul Rodoreda

Budgets and Reports were prepared according to the respective Guidelines and forwarded to ANZCA and ASA according to their respective schedules. Financial Reports will be presented at the respective AGMs.

Regional Education Officer Report – Dr Grant Turner

WA Training Hospitals

Royal Perth Hospital

Sir Charles Gairdner Hospital

Fremantle Hospital

South West Health Campus

King Edward Memorial Hospital

Princess Margaret Hospital

Supervisors of Training

Dr Chris Cokis

Dr L Roberts

Dr J Bruce

Dr W Lim

Dr M Paech

Dr P Tucker

Dr John Akers, Dr John Storey and Dr Liz Avraamides completed their terms as Supervisors of Training over the past year and are thanked for their contributions.

The College accredited South West Health Campus at Bunbury for Anaesthesia training. Dr Wilson Lim and Dr Grant Turner are congratulated for their work in bringing Western Australia its first non-metropolitan training hospital.

Trainee Teaching

The WA Primary long course is conducted each Friday afternoon at Royal Perth Hospital by Dr Nedra vanden Driesen (Pharmacology) and Dr Jay Bruce (Physiology). The WA Final course is conducted by Dr Bill Weightman at Sir Charles Gairdner Hospital and supplemented with clinical and viva sessions at Royal Perth Hospital by Dr Chris Cokis. The candidates participating in these courses have again achieved excellent results in examinations over the past year. Dr Robert Wong stepped down from his position as coordinator of the WA Primary Course after 26 years of service

to ANZCA and generations of trainees. This is an outstanding contribution to our specialty.

Trainee Selection Sub Committee – Dr Lindy Roberts

In 1999 the Trainee Selection sub-committee instituted a more formal process for selection of registrars for the WA Training Rotation. Interviews for prospective candidates were undertaken for the first time in 1999. Plans to further refine the process in 2000 are underway.

Australasian Anaesthesia – WA Subeditor

Dr Neville Gibbs renominated for this position and continues his excellent work.

Australian Resuscitation Council – WA Branch

Dr Gavin Coppinger represents WA Anaesthetists in this regional committee.

Faculty of Pain Medicine ANZCA

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

Faculty of Intensive Care ANZCA

Dr Stephen Edlin, after representing the Faculty on the ANZCA WA Committee for many years has handed over to Dr Bernice Ng. Many thanks to Dr Edlin for his long service to the committee.

Centre for Anaesthesia Skills and Medical Simulation (CASMS)

ANZCA WA is represented on the CASMS Committee of Management and ANZCA WA committee members are represented on the panels of trainers and facilitators. ANZCA WA was represented by Dr Wally Thompson on the inaugural CCRISP (Care of the Critically Ill Surgical Patient) course sponsored by RACS and conducted at the simulation centre.

ANZCA and ASA in Western Australia

The longstanding collaboration between the Society and College reached new heights of achievement over the past year with the appointment of a joint Administrative Officer (Ms Diane Cook) also shared with CASMS and relocated to the new CTEC Building at the University of Western Australia. This development terminated our former arrangement with RACS WA and the service of Ms Penny Anderson to ANZCA WA and ASA WA. Our thanks are due to Penny for her years of professional administrative assistance to ANZCA WA. The ANZCA WA and ASA WA Committees continue their second monthly combined meetings to discuss issues of mutual interest in our region.

Western Australian Anaesthesia Mortality Committee

Dr Neville Davis is standing down from the Chairmanship of this Committee after years of distinguished service. The Anaesthesia and the wider community owe a debt of gratitude to Dr Davis for this outstanding contribution.

Anaesthesia WA Website – Dr Richard Riley Webmaster www.anaesthesia-wa.iinet.net.au

Anaesthesia in Western Australia has its own website. It offers information on institutions, services, education, news, links to other WA hospitals, national and international sites. The site is a joint project of ANZCA and ASA in WA and is sponsored by AstraZeneca.

Health Department of Western Australia Committees

ANZCA WA contributes to state committees on Endoscopy Services, Day Surgeries and Rural General Practice Anaesthesia.

Medico Legal Matters

The Anaesthesia WA – Medical Defence Society of WA (MDA WA) Liaison Committee

Western Australia (continued)

is a joint committee of ANZCA WA, ASA WA, CASMS and MDA WA aimed at integrating medico-legal matters into our continuing education programs and to ensure that ANZCA Policy forms the standard of practice for anaesthesia referred to by the major WA medical indemnity organisation.

Chair of Anaesthesia in WA

Professor Teik Oh (ANZCA President) is the inaugural Chair of Anaesthesia in Western Australia. He is based at Royal Perth Hospital and is developing the academic unit its foundation status with enhancement grants, laboratories, office space and equipment.

Western Australian Anaesthetists Support Group

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

ASA NSC Perth 2000

The Chairman and many members of the ANZCA WA committee are contributing to the organisation and management of this national meeting to be held in Perth 30 September – 4 October 2000. We greatly look forward to welcoming Fellows and Members to a very exciting scientific and social programme in our beautiful city. Come and visit the state of the art simulation centre at UWA.

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

LEIGH COOMBS
CHAIRMAN

ANAESTHETISTS IN THE MEDIA

By Eddie Dean,

College Communication Consultant

The College was busy on the media front in April and May, with major announcements on the Rural Anaesthetic Recruitment Service and performance monitoring for anaesthetists. As well, media attention was directed to the Annual Scientific Meeting in Melbourne. The relevant media releases are on the ANZCA website under *College News*.

Rural Anaesthetic Recruitment Service

A comprehensive media release was circulated announcing the initial success of the RARS program. RARS is a collaborative venture between the Australian and New Zealand College of Anaesthetists and the Australian Society of Anaesthetists, assisted by a Federal Government grant.

The RARS website address was promoted and 250 hospitals have been contacted to promote the scheme, which seeks to 'marry' anaesthetists looking for positions outside big cities with rural jobs looking for anaesthetists. Media were directed to Daryl Catt, chairman of RARS, and anaesthetists who, to date, had been placed by the service.

The story aimed to support one of the main RARS objectives, which is to raise awareness both in the community and the medical profession of the merits of rural practice as a career choice.

Performance Monitoring Story

The individual performance monitoring system being pioneered by Australian and New Zealand anaesthetists was promoted as a world first.

A pilot study of the system has created a unique partnership, bringing together the College, computer hardware and software companies, a medical indemnity organisation and a State reinsurer.

Small, hand-held computers are at the heart of the system, which has been developed by a team at Geelong Hospital, in Victoria, led by Professor Stephen Bolsin. The other members of the Geelong Hospital team are Dr Andrew Patrick, Dr Bernie Creati and Dr Paul Bent.

ANZCA is providing seeding funds for the pilot study, and UNITED Medical Protection is providing finance. Palm Sales Australia is providing the Palm IIIc hand-held computing devices, Sync International the software development and support, and the Victorian Managed Insurance Authority is providing advice and information.

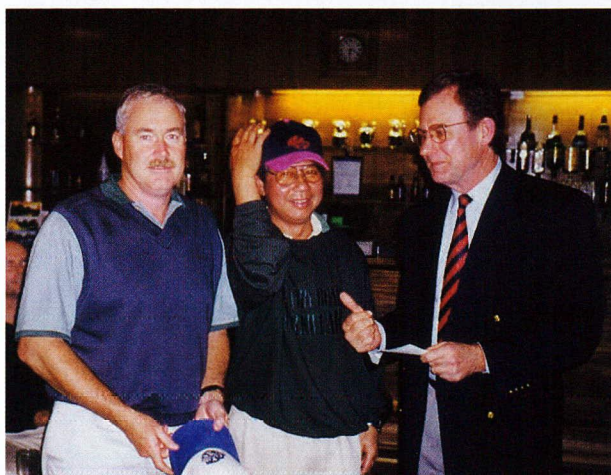
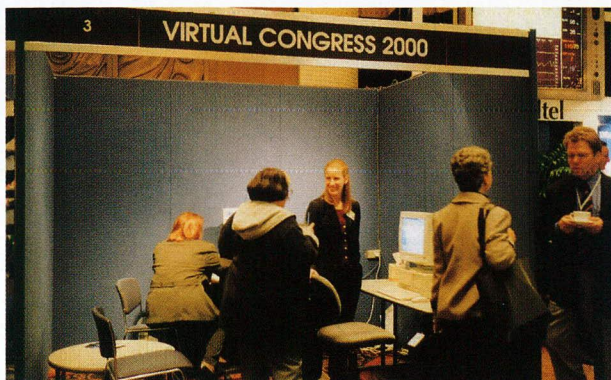
Then President of ANZCA, Dr Richard Walsh, said the monitoring system had the potential to greatly enhance efficiency in the training of specialist anaesthetists in the first instance, and later reduce hospital associated adverse incidents and therefore the overall cost of the health care system.

2000 Melbourne ASM

The ASM in Melbourne produced news stories over a wide range of subjects.

- Laparoscopic surgery and foetal well-being.
- 'Living wills' for the elderly.
- The widening use of public access defibrillators in the USA.
- The inaugural Barbara Walker Prize for Excellence in Pain Management.
- The case for using less blood in surgery, and developing alternatives.
- A case study that shows closing hospital beds costs more than it saves.
- New crisis teamwork education simulator program includes surgeons.
- Announcement of the new ANZCA President, Professor Teik Oh.

Print, radio and television outlets were serviced, with considerable success, both by the College media service and the Australian Associated Press National Medical Correspondent.



ASM Golf Day

Above left: Winner, Dr Larry McNicol, Victoria with Dr Michael Davies

Above right: Runner Up, Dr Rowan Hyde with Dr Vincent Chan, Hong Kong and Dr Michael Davies

Right: Dr Michael Lambros, Formal Project Prize winner



Left: Flurry of activity at the College desk

OURNE 2000



L to R: Assoc Prof Rowan Molnar (Deputy Convenor), Dr Kate Leslie (Scientific Convenor), Dr Philip Ragg (Convenor)



Mrs Eileen Holland, President, Dr Richard Walsh, Ms Jan Johnston, Prof Ross Holland



Dr Guy Ludbrook



President, Dr Richard Walsh, Mrs Ximena Sessler, Prof Daniel Sessler

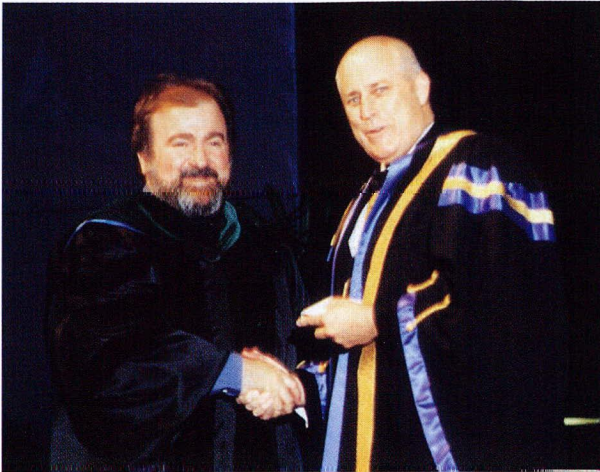


Dr Ian Mackay with Dr Patricia Mackay



Prof Michael Cousins, Mrs Michele Cousins, Mrs Marcia Phillips, Prof Garry D Phillips

FACULTY OF INTENSIVE CARE

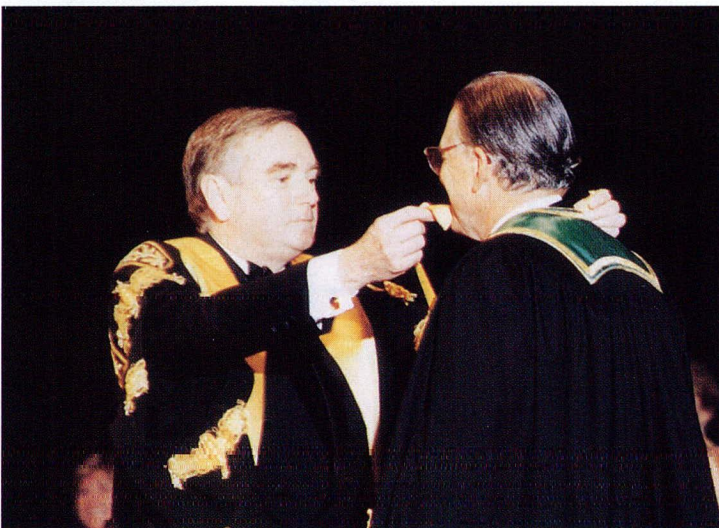


Professor Paul Pepe receives the Foundation Visitor's Medal



Foundation Visitor Professor Paul Pepe was entertaining and informative

FACULTY OF PAIN MEDICINE



Left: Mr Bruce H Barraclough, President RACS, presenting the Dean, Professor Michael J Cousins AM, with the Dean's Medal

Right: Faculty Fellows by Training and Examination Drs Leah Power, Martin Kennedy and Winnie Hong following their presentation at the College Ceremony



DO WE NEED RECERTIFICATION?

When most of us completed our specialist training, we recognised a feeling of significant achievement. We may have considered that continuing medical education in the form of attendance of Departmental meetings was important - but more for our trainees than for us. We may also have felt that CME would be difficult to fit into a busy private practice or rural work schedule. We probably enjoyed attending national or even international meetings with our colleagues - as much to meet old friends as to learn from experts in fields of interest. We had a realisation that it was necessary to 'keep up to date' and from one survey with which I was involved a number of years ago some three-quarters of anaesthetists took that responsibility seriously.

In recent years there has been increasing interest by our regulatory bodies and in some situations, our employers, to ensure that the process of CME is formalised. This has come about as a result of the process by which doctors (at a macro level) are no longer trusted to 'police' themselves in the way that was once the case. Events such as the National Women's Hospital (NZ) inquiry into the treatment of women with cervical cancer, the Chelmsford Hospital (NSW) inquiry into 'deep sleep' psychiatric treatment were amongst the more spectacular events that reduced public trust in their doctors. In more recent years there have been the court cases related to such matters as consent for treatment, the litigation against doctors when outcomes of treatment were not up to the patient's expectations as well as the studies that reveal a large number of adverse outcomes of treatment that were

considered to be preventable. These events have not been confined to Australia and New Zealand. As an example, the ramifications of the allegations of incompetent practice by paediatric cardiac surgeons in Bristol (UK) have been enormous for the medical community in that country.

The 'bottom line' seems to be that medical authorities are being told that steps to reduce the likelihood of adverse outcomes of treatment are overdue. These directions reflect political pressures. As well, doctors themselves are recognising that continued competency does require more than merely going to occasional professional meetings.

The ANZCA MOPS program has now been running since 1995. During 1999, it was upgraded to try and make it more 'user friendly' for anaesthetists in all types of practice - both public and private, urban and rural. Our MOPS program was not designed to check on the competency of participating anaesthetists. Even the practice review component is there as a quality assurance tool and is designed purely to assist anaesthetists with their work. Nevertheless active participation in MOPS programs is a component of professional maintenance and improvement in those countries (eg New Zealand, Great Britain and various provinces of Canada) which are adopting such requirements on a mandatory basis. MOPS programs are essentially working towards maintenance of an appropriate knowledge base. Of themselves they generally tell little about performance. The only link is that participants in MOPS programs are

generally competent practitioners. However, the converse is not necessarily true - that non-participants in MOPS programs are *ipse facto* less competent.

There need to be other components of re-certification programs. What those components should be is a matter for considerable debate. In some provinces of Canada, medical practitioners are surveyed by questionnaire and those who fit an 'as risk' profile (as I would at 65 years of age) may then be subject to a practice review. This appears to be a demanding and thorough program which costs all doctors a significant sum each year. Information can also be gained from sources such as prescribing profiles. In Australia the Health Insurance Commission has a great deal of data of this type and is now analysing it to determine those doctors with unusual prescribing profiles. In debate on this issue at a recent meeting between representatives of State Medical Boards (including the Medical Council of New Zealand) and Colleges, it was considered that a scheme of the magnitude of that in say Ottawa would probably not be acceptable to doctors in this part of the world. Nevertheless there was a feeling that there is a need to have some form of review of practice profiles and comparison with a defined standard within a few years. The old argument that it would be better for self regulation to apply rather than imposed regulation (by an external 'watchdog'). Would we want a medical standards ACCC?

So what performance measuring tools do we have?

The airline industry relies heavily on flight simulators to train and evaluate its pilots. Anaesthesia simulators are becoming available in many parts of Australia and it is likely that there will soon be a unit in every State as well as in New Zealand. While the analogy between airline pilots and anaesthetists is useful, it cannot be carried too far. Pilots are working with a complex piece of machinery and their work is prescribed in great detail. Anaesthetists are dealing with a frequently 'run down'

piece of machinery which is potentially more complex and which may not respond in well-defined ways.

Nevertheless simulators can help enormously with learning processes to deal with unfamiliar and rare events. They are also of considerable value in showing that when more than one problem arises at the same time, the difficulties of sorting out the problems are greatly increased. They are not at the stage where they could be used to allow for evaluation of competency in a way which would be clinically realistic and appropriate. At the present time they provide valuable learning experiences but could not yet be seen as a tool for 'signing off' on matters related to competency.

Credentialing is a process which – in some measure – looks at the performance of an individual doctor during his/her normal work. At present there are systems in some hospitals but there is no uniformity as to when and how the process should be carried out. Looking specifically at anaesthetists, there are some potential difficulties in a number of areas. Many of us work on our own and another anaesthetist may seldom see us delivering clinical anaesthesia. Surgeons have their own agendas and may not be a good judge of the quality of anaesthesia and patient care. Arguably the best observers of our work are trainees, anaesthesia assistants

and recovery staff. It should be noted that the General Medical Council in Great Britain will require input from hospital staff in general as part of their proposed revalidation process. ANZCA is hoping to develop guidelines for use by hospital credentialing committees which could reasonably be applied to anaesthetists.

What of age and performance in anaesthesia? Firstly, chronological age is not a clearcut determinant of performance levels. However, older subjects tend to slower response times in respect of both simple and complex problem solving. As against that, experience acquired over many years may greatly aid in dealing with unusual situations. Sleep patterns tend to change and recovery from sleep deprivation takes longer. Should senior members of our specialty be required to undertake night duties? It is of significance that the major airlines tend to retire their flight-deck crew at the age of about 55 years. As I noted above, there is some evidence from Canada of lower levels of performance by older practitioners. Age is a factor to be considered when evaluating performance.

Physical illness does not present major problems although the tendency of medical professionals to carry on working while unwell is widespread. Other work groups have higher rates of taking sickness leave. What of

performance standards when 'below par'? It is not an area in which there is much good evidence. A greater problem is found with long term illness particularly when states such as depression are considered. Significant depressive illness (which has been said to occur in 30 per cent of doctors at some time) is likely to reduce the ability to perform effectively. It is accepted that chemical dependence is inappropriate for the practice of medicine and ANZCA requires trainees and others to sign a declaration stating that they are not dependent. It is interesting to note that the evidence for markedly reduced performance during opioid dependency is not great until the condition is very severe. Nevertheless a statement on physical and psychological well-being could be a component of the credentialing process. Provided by another doctor (perhaps another anaesthetist should be excluded), such a process might help with better standards of healthcare for each of us!

These are matters which need to be thought about and which anaesthetists, as a professional group, should be considering. Comment from individual Fellows and trainees will be carefully considered.

JOHN M GIBBS

FACULTY OF INTENSIVE CARE DEAN'S MESSAGE

The election of a new Board of Faculty with a new Dean taking office provides an opportunity to review recent Faculty progress, to examine where it might be headed and to consider the challenges that lie ahead.

The process for accreditation of training units was radically overhauled in the interests of simplicity, fairness and reliability. It was with some trepidation that the move away from accredited training posts was undertaken although it appears to have occurred without detriment to trainees. Recent revision of documentation for unit inspections has completed the streamlining of this process.

The Fellowship examination also underwent extensive modification to improve its validity and reliability. The changes made are a credit to the efforts of the Chairman of the Examination, the Examination Committee and the Examiners. Early feedback from candidates confirms that the examination is now fairer and that the changes have been well received.

The Board has endeavoured to be outward looking and to pursue relationships with other bodies. Importantly, with the support of other Colleges, the Faculty has been admitted to Associate Membership of the Committee of Presidents of Medical Colleges. This was in recognition of the Faculty as the major body concerned with training and certification in intensive care and its role in standards setting.

The Board has also created a pathway for trainees and specialists in surgery and emergency medicine to pursue a specialisation in intensive care. This decision was taken to encourage continued development of intensive care medicine as a broad based discipline – our specialty will be enriched by the involvement of not only physicians and anaesthetists but also by these other disciplines.

The Faculty also provided major input to the first comprehensive study of the intensive care workforce through the Australian Medical Workforce Advisory Committee. The study provided an important base for planning with respect to the specialist



workforce. It also used modelling that will help to structure intensive care staffing in the future. It also served to highlight concerns that intensive care specialists have about their working conditions and the impact of this type of career on lifestyle.

The issue that has undoubtedly attracted most discussion over the last two years has been the progress towards a single body for training and certification in intensive care. Two surveys overwhelmingly confirmed that this is an important matter for intensive care specialists and that an independent College is the ultimate goal. For these reasons, the Board has strongly supported the formation of a Joint Faculty of Intensive Care Medicine with the Royal Australasian College of Physicians and at the time of writing this message, the signs are most encouraging. Should this proceed it would be the responsibility of the Board and its Fellows to ensure that it is truly a Joint Faculty. It will provide an organisation where all intensive care specialists can become involved in shaping the training program, contributing to the wellbeing of trainees and advancing the specialty.

For the Faculty to fulfil this expanded role it is essential that it be financially independent... in other words, pay its own way. To this end, the College Council and Board of Faculty have recently agreed to the introduction of a separate Faculty

subscription applying from the 2002 year. Details of this initiative are included elsewhere in the Bulletin.

Whilst these matters have progressed, the Board with the able assistance of its regional committees and our Executive Officer, has revised the Regulations and Administrative Instructions, developed guidelines for trainee selection and revised and expanded our policy documents. Considerable effort goes into the formulation of policy documents and it is gratifying to note that many become the benchmark not only for the Faculty but for other bodies.

Assuming that the Joint Faculty eventuates, we will then be in a position to undertake a much needed restructure of the training program. A number of deficiencies have been identified and preliminary work has suggested future directions. Past performance suggests that most view intensive care as a supra-specialty and it seems appropriate that we develop a modular training program that can be adapted to a broad range of medical disciplines.

There are two other major issues that are going to challenge us in the immediate future. The first will be to develop meaningful ways of ensuring that competence is maintained throughout

specialist life. External pressures are already demanding that this occur. Secondly, as an educational body, the Faculty needs to provide more for our trainees in direct educational guidance and support. Whilst we glow in the reflection of the quality of graduates from our programs, this probably relates as much to the attributes of trainees themselves and the sound environments in which they train and work as to the training program. The new technology age gives us an opportunity to provide much more in the educational arena for both trainees and intensive care specialists.

Finally, we are fortunate to be part of a highly professional organisation. Fellows have strongly indicated how they feel about the future of the Faculty. I would therefore encourage Fellows to become involved in the work of the College and its Faculties... it is a highly rewarding endeavour.

A.W. DUNCAN, DEAN

EXAMINATION – APRIL 2000 Adelaide



Court of Examiners



Successful Candidates



Presentation of certificate to RV Trubuhovich

FACULTY OF INTENSIVE CARE ANNUAL SCIENTIFIC MEETING, MELBOURNE, 2000

The Faculty's Program for this year's ASM, under the inspired leadership of its Intensive Care Program Organiser, Megan Robertson and with the close support of the Victorian Regional Committee of the Faculty, delivered a concentrated 5 half-days of quality CME opportunity. This was of course within the context of the whole conference program of the Regional Organising Committee, ably led by its Convenor Philip Ragg. A productive relationship with the Victorian Regional Committee of ANZICS and the Royal Melbourne Hospital enabled optimal utilisation of the 2 international speakers, Prof. Paul Pepe of Dallas and Prof. Paul Hebert of Ottawa. This was for the Faculty's ASM, and for ANZICS' one-day meeting at the Royal Melbourne Hospital on CPR - State of the Art on the day prior to the ASM.

Together with a framework of update on basic themes in intensive care - ventilatory advances, fluid and transfusion management, trauma and cardiac arrest - issues of research in intensive care were explored in depth, particularly that of collaborative research. Canadian, Australian, and American out-of-hospital experience were presented. The first Plenary Session had been devoted to Research in the new Millennium. Presentations on how-to-do-it (setting up a research department) the Canadian way were most valuable, while the lucid outline of the activities of the ANZICS Clinical Trials Group should have fired up any laggards.

A feature of this ASM of Refresher Courses on the Saturday morning before

the opening session had such a course for intensivists, which included, inter alia, updates on thromboembolism and acute liver failure.

As is customary at the ASM the annual General Business Meeting of the Faculty of Intensive Care was held. The opportunity was taken by attendees to question the Dean on matters of high interest: especially re ongoing discussions with the RACP concerning the formation of a single body for training and certification in intensive care medicine, and the matter of subscriptions.

The College Ceremony proved the usual splendid occasion. The address given by Emeritus Professor David Penington, AC on "*Illicit Drugs: Where do the answers lie?*", a subject of expertise for him, was forthright and thought provoking for coping with problems of drug addiction.

The success of the Faculty's excellent program cemented its place alongside those of our anaesthetic and pain medicine colleagues at the ASM. Attendance by non-intensivists at some sessions was heavy enough to produce a few overcrowded sessions and demonstrate the value of the intensive care program for them also.

All in all, for those attending this was a valuable and worthwhile conference. Congratulations Megan Robertson and team!

R.V. TRUBHOVICH
ASM OFFICER
COMMUNICATIONS OFFICER
BOARD OF FACULTY

ADMISSION TO FELLOWSHIP OF THE FACULTY OF INTENSIVE CARE, ANZCA

The following have completed all requirements for admission to Fellowship by examination and were admitted by the Board:

Ann Maureen Whitfield, Vic
Chinthamuneeji Meher Prasad, SA
Richard Paul Newman, SA

A SEPARATE ANNUAL SUBSCRIPTION FOR FELLOWS OF THE FACULTY OF INTENSIVE CARE, ANZCA

Background

When the Faculty of Intensive Care was formed out of the Section of Intensive Care in 1992, a decision was made not to introduce a separate subscription at that time. This situation contrasts with the Faculty of Pain Medicine which was formed de novo and where a separate subscription was struck from the time the Faculty was inaugurated. This situation now represents an anomaly within the College.

It is clear that the Faculty of Intensive Care is currently subsidised by ANZCA, although the true extent of that subsidy is impossible to determine.

Future of the Faculty

As a general principle, the Faculty should be self funding and indeed should be in a position to accumulate funds that would enable it to expand its activities in areas such as education, standards and research.

If the formation of an independent College of Intensive Care Medicine is ultimately to occur, it is essential that the Faculty reaches a point of financial viability and independence within ANZCA. In a recent survey (July 1998) the majority of Fellows (89%) indicated that they wished this to occur.

Currently the Faculty has no assets of its own and no claim on College funds. It is a just principle that the maintenance of each diploma (FANZCA, FFICANZCA) should carry a separate fee. These matters have been discussed by a Working Party of the College Council that met by teleconference in December 1999 and which supported the principles stated above.

In an endeavour to provide financial independence for the Faculty of Intensive Care, Council accepted the following recommendations of the joint

Working Party comprising College and Faculty representatives:

- That the College will create a separate accounting system within the College books to identify both incoming and outgoing financial activities relating to the Faculty of Intensive Care.
- That the budget for the 2002 Financial Year to be invoiced in December 2000 will include a subscription set by the Faculty of Intensive Care payable by Fellows of that Faculty.

The number of Fellows involved in practising both anaesthesia and intensive care was taken into account by the Working Party when making the appropriate recommendations:

1. Fellows who hold both the FANZCA and FFICANZCA and who spend the equivalent of two or more notional sessions per week in each specialty will be required to pay both a full College subscription and a full subscription to the Faculty of Intensive Care in order to maintain both Fellowships.
2. Fellows who hold both the FANZCA and FFICANZCA and who spend less than two notional sessions per week in one or other of the specialties will be required to pay a full subscription to the body representing the specialty of major clinical activity and 50% of a full subscription to the body representing the specialty of less clinical activity. This decision is in line with the College's current list of concessions.
3. For Fellows of FICANZCA and ANZCA who practise solely in intensive care and who wish to maintain their FANZCA diploma, the full Faculty subscription will be payable to the Faculty and 20% of the full College subscription will be

payable to the College. Similarly, for Fellows who hold FANZCA and FFICANZCA who practise solely in anaesthesia and who wish to maintain their FFICANZCA diploma, the full College subscription will be payable to the College and 20% of the full Faculty subscription will be payable to the Faculty.

The concessions described in points (2) and (3) above will be subject to review in the event the Faculty becomes fully independent from the College.

4. When one or other Fellowship is withdrawn due to non-payment of subscriptions, restoration of Fellowship could be undertaken at the discretion of the Council or Board by full payment of arrears plus a full subscription to the relevant body in accordance with the College Articles of Association. The subscription in subsequent years would be determined as in (2) and (3) above according to the Fellow's pattern of practice.
5. For holders of the FFICANZCA alone, the subscription will be payable to the Faculty of Intensive Care.
6. Council agreed in principle that (subject to financial responsibilities being established) any funds or assets accumulated by the Faculty after introduction of these subscriptions will be made available to the Faculty in the event of separation from the College.
7. Notwithstanding the above recommendations, Fellows are eligible to apply for other subscription exemptions and concessions available under College Regulation 7.1 – Remission and Exemptions. The exemptions and concessions will be applied to the total subscription payable. For holders of the FFICANZCA alone, the subscription will be payable to the Faculty of Intensive Care.

The amount of the Faculty subscription will be considered by the Board of Faculty at its meeting in June.

P.D. THOMAS
Treasurer

This proposal, by the NSW Medical Board, has been endorsed by the NSW Health Department and is now at the stage of being put before the NSW Parliament as an amendment to the Medical Practice Act.

Although this remains a proposal of the NSW Medical Board, it is noted that the Medical Boards of other States may adopt these guidelines in the future. The ongoing involvement of Faculty representatives is deemed essential. The NSW Medical Board has emphasised the importance of College involvement in relation to the availability of appropriately skilled specialists to serve on Assessment Teams and Performance Review Panels. Dorothy Breen will continue on as the Regional Committee's liaison with the Medical Board on this issue.

Standing Committee of College Chairmen

Theresa Jacques represents the Faculty on the Standing Committee of College Chairmen, which meets with the Director-General, and/or Deputy Directors-General of the NSW Health Department. It meets on a monthly basis.

It is a forum in which matters of concern can be voiced to the Health Department, as well as allowing the various colleges to have input to issues and circulars arising from the Health Department.

Attendance of Regional Committee members at Hospital Medical Appointment meetings

The members of the Regional Committee have been active in attending, when requested, hospital medical appointment committee meetings. Advice for hospitals seeking clarification on appropriate qualifications for intensivist positions has now been clarified. The document 'Procedures for advice to

hospitals regarding applicants for specialist intensive care positions' from JSAC-IC has been made available to all Regional Committee members who fulfil this function.

Admission to Fellowship by Examination

Christian Böhringer
Peter Harrigan
Antony Stewart
John Awad
Brad Smith
Cathal Nolan

Future activities

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.

Phil Byth has decided not to stand for election to the incoming Regional Committee. The Regional Committee members thank Phil for his untiring efforts in promoting intensive care, particularly in the years he served as Chair.

With 65 Fellows in the NSW/ACT region, the opportunity now exists to expand the size of the Regional Committee to 5 elected members, as well retaining the co-opted ACT, Younger Fellows and RACP Representatives. Newly elected members of the Regional Committee will be meeting in July to carry on the work of the Faculty in New South Wales.

*Prepared by
Eddie Stachowski
Honorary Secretary*

New Zealand

Office bearers and members

Chairman:	A/Prof Jack Havill
Vice Chairman:	Dr Ron Trubuhovich
Hon Secretary:	Dr Ross Freebairn
Hon Treasurer:	Dr Forbes Bennett
Education Officer:	Dr Forbes Bennett
Younger Fellow:	Dr Tony Williams
Representative for Board of Faculty:	Dr Ron Trubuhovich
Representative for Physicians – SAC-IC Chairman:	Dr Peter Roberts

We have also invited the Chairman of the Regional Committee of ANZICS to attend the meetings to facilitate liaison between the Faculty and ANZICS in NZ.

Dr Jim Judson resigned from the Committee in July.

Meetings held

29th March 1999 – Wellington	(5 present, 1 apology)
12th July 1999 – Wellington	(6 present, 1 apology)
22nd Nov 1999 – Wellington	(7 present – including ANZICS Chairman)
3rd April 2000 – Wellington	(7 present – including ANZICS Chairman)

Submissions

One of the regular activities of the National Committee is to respond to Governmental Agencies and other planners in the health field with submissions. These are usually a combination effort from several on the Committee. Apart from the opinions expressed, the process is important as we become recognised as an interested and constructive participant in change. Since the last report, the following submissions have been written:

- a) To the Health and Disability Commissioner on the Review of the Health and Disability Act 1994 and the Code of Rights for Consumers of Health and Disability Services. We combined with the NZ National Committee of ANZCA to make this submission. Submitted April 99.
- b) On the discussion paper “ Health and Hospital Services Review of RMO Training – the Employer’s Perspective”. This was a detailed discussion paper on workforce planning in NZ. It included discussion on a new career pathway for RMOs called “Career Medical Officers” (mini-specialists and MOSSs etc). Proper workforce planning, physician extenders, and management of initial RMO years were topics also included. The final paper has now been widely distributed. Submission made in February 99.
- c) A discussion paper prepared by the Ministry of Health on Part VI of the Medical Practitioner’s Act: Quality Assurance

Activities was circulated for comment. Generally this was sensible but there are still some anomalies especially in the execution of the process. Submission made May 99.

- d) Another Health Ministry document on “Proposed Changes to the Medical Practitioners Act 1995 to Better Protect Members of the Public” was also circulated for comment. It could increase some risks of “double jeopardy” for practitioners. Also it allows the possibility of a lot of shared information between Government agencies where the practitioner may or may not be guilty of malpractice. We responded accordingly, asking for safeguards. Submission made November 99.
- e) Medical Council – we have considerable communication with this group, and several mini-submissions have been written in answer to various discussion documents, including one on factors relating to registration of overseas specialists. The latest submission involves comments on a discussion paper on oversight, vocational registration groups and recertification. We were fairly frank about what we see as considerable confused thinking emerging on the concept of vocational groups as compared with the old speciality recognition, and the implications of this for oversight. Submission made January 2000.

VOCATIONAL REGISTRATION

Intensive Care Medicine was added to the list of recognised Branches of Medicine by Order in Council on 11th October 1999. That this has been achieved is largely due to the persistence of Ron Trubuhovich, who is now well known to all involved in the process!

We have now received a letter asking for the names of all those who have an intensive care qualification as recognised by the Colleges, and who have the appropriate training, experience, and competence. We have responded accordingly (also on behalf of physician intensivists with the appropriate qualification). Those people who have their FFICANZCA or FRACP (Int. Care), and have completed their training, will be automatically registered, on application to the MCNZ, without further corroboration needed. They will be sent an application form by the Medical Council to enable this. Thereafter, applications will need to be supported by three specialists and go through the standard referral channels which we have set up for consultation with the Medical Council. If applicants have a FFICANZCA or FRACP (Int. Care), the process will be fairly automatic. If they do not have those requirements, the Medical Council will refer the application for an opinion from the NZJSAC-IC (see below), which will recommend on standards of equivalence etc.

JOINT SPECIALIST ADVISORY COMMITTEE-INTENSIVE CARE MEDICINE

Because there are two colleges offering a qualification in intensive care medicine, the Faculty of Intensive Care, the

College of Physicians, and ANZICS have a joint committee which meets in Australia and supervises all trainees (except physicians in NZ), in both Colleges. It also recommends on equivalence in training of overseas specialists. In NZ the local physicians have a separate Specialist Advisory Committee-Intensive Care (SAC-IC) which supervises their own intensive care trainees, whereas the Faculty allows the Australasian JSAC-IC to supervise all Faculty trainees. Also, our Medical Council has different conditions pertaining to NZ. As a result of these complexities, we have formed a New Zealand Joint Specialist Advisory Committee-Intensive Care Medicine (NZJSAC-ICM). It has representation from the Faculty, the Physicians' SAC-IC, and ANZICS.

The main roles are:

- 1) Principally to advise the Medical Council of NZ (MCNZ) on enquiries from the MCNZ concerning the recognition of specialist status in intensive care medicine for Australasian and for overseas-trained doctors.
- 2) Also to advise the MCNZ or government bodies on any matters of intensive care medicine where a joint reply from both the Faculty and physician intensivists is requested or deemed appropriate.

This committee had its inaugural meeting on April 3rd 2000 when the terms of reference were refined and agreed to, and various matters of common interest discussed. The meetings will be held adjacent to the NZNC FIC Committee meetings.

OVERSIGHT

This issue has become confused, partly because the legislation has major problems in application which were not anticipated, and partly because of confusing messages from the MCNZ. One major issue is that the MCNZ at this stage does not recognise that vocational registration is the same as the old specialist recognition. It anticipates that much less training may qualify for registration in certain areas e.g. sports medicine. We have made critical comments about the difficulties this will cause.

The particular problem intensive care medicine is facing is that a lot of intensive care practice is carried out by anaesthetists and physicians who do not have a specific intensive care medicine qualification (probably there are more specialists without, than with, an intensive care qualification). In addition, anaesthesia in particular overlaps quite extensively with intensive care practice e.g. post cardiac surgery, simpler ventilatory techniques, invasive technology etc. In our correspondence with the MCNZ it has become evident that there is "confusion in the ranks of the MCNZ". Also, the ramifications of oversight have created considerable unease amongst anaesthetists practising intensive care as part of their job.

A working party composed of members from the NZNC, ANZCA, the NZNC, FIC, plus some representation from

ANZICS is in the process of defining criteria for exemption from oversight. Discussions have also been held with the MCNZ, and they are happy to accept the recommendations of the anaesthetists and intensivists, should agreement be reached. The essence of the agreement so far is to "grandfather" a group of anaesthetists, who have been practising intensive care, into "exemption from oversight" but that as time goes by it is expected that oversight will be required for all without their vocational registration in intensive care medicine. This process may take 5-10 years.

It is important to realise that oversight is not supervision, but is rather a system of audit, and as a result could be quite positive. However, there are still important issues of legal responsibility, financial obligations, and time restraints to be sorted.

EXAMINATIONS

NZ exam passes have included Craig McCalman (Waikato) FFICANZCA, and Wayne Wrathall (Middlemore) FFICANZCA in September 1999.

FORMAL PROJECTS

The NZNC, FIC favours continuing with formal projects for trainees in a similar way to the anaesthesia trainees.

EDUCATION

Forbes Bennett has kept a watch on trainees in NZ in his role as Education Officer. It is very difficult to keep track of trainees as they move between disciplines and countries frequently. As of November 99 there were between 15 and 20 trainees in the New Zealand system.

ACCREDITED TRAINING UNITS IN NZ

As of October 99:	3 units	– C24
	3 units	– C12
	2 units	– C6

WORKFORCE

As a NZ National Committee we are trying to be pro-active in looking at our workforce in Intensive Care Medicine in NZ. Hence, Tony Williams has circulated a questionnaire to everybody whom we know to be working in the discipline.

This will help in the future, when we have discussions with the Ministry and with training agencies. Some results are still to arrive, but we estimate that more than 120 doctors are involved in intensive care medical practice.

NZ ANAESTHESIA AND PERIOPERATIVE MEDICINE

Partly because there are a significant group of anaesthetists practising intensive care medicine who may not receive Faculty news, we have a separate section in the above publication. It is another means of keeping everybody up to date with intensive care medicine.

COUNCIL OF MEDICAL COLLEGES

The Faculty is not a member in its own right, but is represented by the Chairman of the NZ National Committee of ANZCA. We have been declined membership in the past because we were not a College, but were invited to reapply when we were vocationally registered. As soon as we get the initial Vocational Registration issues out of the way, we intend re-applying for membership. This body will probably become increasingly important over the years and it is important that we are able to have our share of influence at a national and political level.

NEW ZEALAND IS A SOVEREIGN COUNTRY

Increasingly, NZ intensivists and anaesthetists on our NZ National Committees are aware that we differ significantly from our corresponding Australian Regional Committees, in that we have demanding national responsibilities. This necessitates

a lot of response to various agencies which have the potential to affect our practice. Our laws differ considerably from Australia's, and what is an appropriate response there is not necessarily appropriate in New Zealand. At the same time, we value extremely highly the benefits and strength from being linked to a wider College body, and the strong leads in quality and education which have been provided by our Australian colleagues. The support NZ has received from them has been immense. Nevertheless, we do feel that increasing recognition within the College for our different status as a sovereign country is important, and both committees will be addressing this issue as time goes by.

JACK HAVILL
CHAIRMAN

Queensland

Office Bearers

Chair:	R Whiting
Secretary:	J Cockings
Regional Education Officer:	B Venkatesh
Physician / ANZICS representative:	D Fraenkel
Younger Fellow:	J Evans
Committee members:	C Anstey J Lipman
Regional Administrative Officer:	J Holland

Meetings 5 meetings & AGM

- 1 27th July 1999
- 2 28th September 1999
- 3 7th December 1999
- 4 22nd February 1999
- 5 30th May 2000

Attendances

R Whiting	4 of 4 (5th meeting yet to be held)
J Cockings	4 of 4
B Venkatesh	2 of 3
C Anstey	3 of 4
J Lipman	4 of 4
J Evans	3 of 4
D Fraenkel	3 of 4

EDUCATION

Trainees

There are currently 25 registered intensive care trainees in Queensland.

ITAs

All in-training assessments are up to date and indicate a good standard of trainees in Queensland for this year.

Supervisors of Training

<i>Cairns</i>	D Wenke
<i>Townsville</i>	G Gordon
<i>Nambour</i>	C Anstey
<i>Prince Charles</i>	D Mullany
<i>Royal Brisbane</i>	J Morgan
<i>Princess Alexandra</i>	C Joyce
<i>Greenslopes</i>	R Whiting
<i>Gold Coast</i>	R Quinn

Examinations

Dr Peter Kruger was the only trainee to take the Final Fellowship Examination during this year from Queensland. This he passed with his first attempt and our congratulations go to him.

Regional Educational Officers Report

This year saw the second Brisbane Course for Trainees. This was again timed to assist trainees with the oral component of the Spring examination. This course was attended this year by Drs. L Worthley and R Lee and we thank them for their help and support in producing another successful weekend course

for the examination candidates. We also thank all those others who provided their time to help.

The Brisbane wide rotational appointments continue to be successful and popular with both trainees and departments alike. This year has seen the inclusion of a six month general medical post and an anaesthetic component allocated to intensive care trainees. The Faculty continues its involvement in terms of advice in the selection of applicants and their training requirements.

Dr J Morgan has again been instrumental in organising an excellent series of tutorials for all Brisbane trainees on Wednesday afternoons. Once again, our thanks go to him for his tireless support.

Continuing Education

The local CME meeting was held in August, followed by the AGM. This meeting was again successful and well attended. Our thanks go to Dr Barnett for his help in the organisation and to Greenslopes Hospital for providing the venue.

Professional Affairs

The issue of consent for research in Queensland remains unclear. However, progress has been made with legislative changes expected soon.

J. COCKINGS
Honorary Secretary

South Australia

Members

Chairman:	M J Chapman
Honorary Secretary/Treasurer:	A Bersten
Board Member:	N Matthews
RACP Representative:	E Everest
Younger Fellow:	M Finnis
Regional Education Officer:	S Peake
	M O'Fathartaigh
Board Member:	P D Thomas
	Ms S Harrison

Annual Report

The following are the highlights of meetings held during the last year: 1st April 1999 – 31st March 2000. Dr Andrew Bersten was congratulated for his achievements as the Intensive Care Scientific Convenor for the ASM in Adelaide in May 1999.

The Intensive Care component of the Conference was excellent, and the subjects were topical, interesting and thought provoking. Prof Rick Albert's contribution as the Faculty's Foundation Visitor for 1999 was outstanding.

Dr Mark Finnis commenced on the Committee as a Younger Fellow representative and attended the Younger Fellows' Conference in Adelaide. Dr Finnis is a major contributor to the development of the Faculty's website, and welcomes feedback from Fellows. Dr Nicholas Edwards has been chosen as the South Australian representative for the Younger Fellows' Conference in Melbourne 2000.

Dr Neil Matthews stepped down as chair of the regional faculty after the committee decided that a non board member should

hold that position. Dr Matthews continues on the Committee as a Board representative. Dr Marianne Chapman has accepted the chair. Dr John Myburgh resigned from office of Regional Education Officer after enthusiastically filling that position for 7 years. Dr Sandra Peake (who was also recently nominated as Supervisor of Training at The Queen Elizabeth Hospital) has been appointed as the new Regional Education Officer. The Committee is grateful for the support from Drs Matthews and Myburgh.

The Royal Adelaide Hospital was assessed by the Faculty and found to be suitable to continue at its current level of training although several recommendations were made which are being addressed. An external review of Intensive Care Services was instigated by the South Australian Health Commission to advise on the needs of Intensive Care for the State in the future. Regional Faculty was represented at meetings with the Review Committee and we await the report of the review.

Active preparations are in place for the Faculty of Intensive Care Examination to be held in Adelaide 14/15th April 2000. This event is being organised by Dr Robert Young, Supervisor of Training from the Royal Adelaide Hospital, who is also an observer. We wish all candidates well. Preparations are also ongoing for the planned visit in May of the invited speaker Prof Paul Pepe as part of the ANZCA ASM in May.

Congratulations to Dr Andrew Bersten who was recently awarded the Young Tall Poppy of South Australia Award for scientific achievement from the Australian Institute of Political Science for his work to do with surfactant in ALI.

Victoria

Office Bearers

Chairman:	Dr Megan Robertson
Deputy Chairman and Regional Educational Officer:	Dr Graeme Duke
Honorary Secretary and Treasurer:	Dr John Green
Committee Members:	Dr Peter Morley Dr Craig French (co-opted)
RACP Representative:	Dr David Ernest
Board Members:	Dr Felicity Hawker Dr Jamie Cooper
Administrative Officer:	Ms Corinne Millane

Meetings

Regional Committee Meetings were held in May, August, December (by circulation) 1999 and February and March 2000. Meetings were well attended by regional committee members. Specifically:

Dr Megan Robertson	5/5
Dr Graeme Duke	5/5
Dr John Green	4/5
Dr Peter Morley	4/5
Dr Craig French (co-opted)	3/5
Dr David Ernest	5/5
Dr Felicity Hawker	1/5
Dr Jamie Cooper	1/5

Hospital Inspections

The VRC FIC involvement in the Faculty Inspection Teams for Accreditation of Intensive Care Units has continued in the past 12 months and six hospitals are scheduled for inspection in the current year. In addition, a local Inspection Team is expected to inspect the new facilities at Warringal Private Hospital in the near future.

Hospital Medical Appointment Boards

The VRC FIC has continued to participate in Hospital Appointment Boards and to provide recommendations regarding the specialist qualifications of applicants as requested by Victorian Hospitals. The VRC FIC believes that this is an important role for the Regional Faculty Committees in promotion and maintenance of professional standards. Whilst we strongly support the Procedure for Advice to Australian Hospitals regarding Applicants for Intensive Care Specialist Positions (Dec 1999) circulated by the JSAC-Intensive Care, the VRC FIC also believes that the Regional Committees should maintain a significant input into this area.

Educational Activities

1. A combined ANZICS/FICANZCA Educational Meeting on Trauma Management was held in July 1999, at The Royal Melbourne Hospital immediately prior to the Annual Registrars' Weekend at Melbourne University. This was the first new format Meeting after the VRC ANZICS split their

annual Meeting from ACCCN and as hoped, the successful Meeting attracted a strong medical attendance which had been lacking for several years. The format of a combined Victorian ANZICS/ VRC FICANZCA Meeting held immediately prior to the Annual Registrars' Weekend in July will continue in 2001.

2. The ANZCA ASM 2000 was recently held at the Crown Towers Complex in Melbourne, with the Intensive Care component of the Meeting running from May 5-8. The Meeting was extremely successful and as usual, the Intensive Care sessions were very well attended.
3. A Satellite Meeting entitled "CPR - State of the Art" was held on Friday May 4 2000, prior to the commencement of the Melbourne ASM 2000. Over 175 delegates, both medical and nursing from Victoria and interstate, attended the meeting which highlighted areas of consensus and controversy in this core area of Intensive Care practice. The proceeds from this Satellite Meeting funded the visit of Professor Paul Hebert from Ottawa, Canada, to attend the Melbourne ASM 2000 as a second invited international speaker participating in the Intensive Care program.

General Business

1. The VRC FICANZCA and the VRC ANZICS have continued to successfully combine to form a single joint body to represent the Victorian interests of Intensive Care. Executive Meetings have been held sequentially on the same day over the past 12 months and this has facilitated discussion and management of several important issues. The Chairmen, Drs Carlos Scheinkestel (Vic ANZICS) and Megan Robertson, have held informal talks with representatives of the Department of Health Services regularly during the year, improving communication between Intensivists and the Victorian Government.
2. The New Fellows Conference held in the coastal resort of Lorne prior to the Melbourne ASM (May 2000) was attended by Dr Craig French as the VRC FIC New Fellow. Dr John Green also attended as Deputy Convener and representative for the Faculty of Intensive Care.
3. The VRC FIC continues to have representation on a wide range of bodies with relevance to Intensive Care, including the Ministerial Committee on Critical Care, the State Trauma Taskforce, the ARCBS Victorian Blood Users Group and others.
4. Elected members of the VRC FIC for the next two years will be Megan Robertson, Graeme Duke, John Green and Craig French. Peter Morley will continue to be involved as a co-opted member.

Finally, the VRC FIC would like to thank Ms Corinne Millane for her expert assistance during the past year and also Ms Carol Cunningham-Browne and her assistants, Severine and Lindy for their continued support and excellent advice in all matters pertaining to the Faculty.

MEGAN ROBERTSON, GRAEME DUKE, JOHN GREEN, PETER MORLEY,
CRAIG FRENCH

Western Australia

Office Bearers and Members:

Chairman:	Dr Vernon van Heerden
Vice Chairman:	Dr John Weekes
Secretary:	Dr Frank Breheny
Regional Education Officer:	Dr Bernice Ng

Ex-officio Members:

Dean of the Faculty:	Dr Alan Duncan
Younger Fellow Representative:	Dr Mary Pinder
RACP Representative:	Dr Brad Power
Administrative Officer:	Ms Penny Anderson

Education

In general, there has been a shortage of Intensive Care trainees in Western Australia over the period 1999/2000. Those trainees present, have however, been of a high quality with very good results in the Final Examination. Dr Mark Hayden and Dr Simon Erickson were both successful in the Paediatric Intensive Care Final Examination. Dr Hayden won the GA (Don) Harrison Medal for 1999.

With the changes in the training and accreditation arrangements between the Faculty of Intensive Care and the Australasian College for Emergency Medicine, there has been an increased number of trainees from the Emergency Department rotating through Intensive Care departments in Perth. Several of these trainees have indicated an interest in joint accreditation (Emergency Medicine and Intensive Care).

The inaugural Care of the Critically-ill Surgical Patient (CCrISP) Course was held in Perth in 1999. Dr G Clarke (ex Dean of the Faculty) attended the course on the Faculty's behalf. In addition several of the local Intensive Care specialists were Faculty members for the course (Drs Thompson, Woods and van Heerden). This course was well received by surgical trainees and it is hoped the Faculty will have an ongoing input into this course in the future.

Continuing Education

A combined Annual General Meeting and Annual Scientific Meeting was held in 1999. At this meeting representatives of

all the teaching hospitals in Perth (Royal Perth Hospital, Sir Charles Gairdner Hospital, Fremantle Hospital and Princess Margaret Hospital) presented interesting clinical cases, followed by general discussion.

In May 2000 the Annual Scientific Meeting will be a conjoint meeting with ANZICS (W.A.) and will be held in York, WA. This meeting will focus on Trauma and ARDS. Dr Andrew Bersten will be the invited interstate speaker at this meeting.

Election of Office Bearers in 2000

In March 2000 nominations were called for positions on the WA Regional Committee of the Faculty of Intensive Care. As only sufficient nominations were received to fill the positions, no elections were to be held. Office bearers following the July AGM will therefore be: PV van Heerden, B. Ng, D. Simes and co-opted members will be A. Duncan (Board member) and B. Power (RACP representative).

Professional Affairs

The WA Regional Committee strongly endorses the endeavours of the Board of the Faculty in striving towards a common certification for both Anaesthesia and Internal Medicine background trainees in Intensive Care. In keeping with this, Dr Brad Power has been appointed as the RACP representative to the WA Regional Committee.

Acknowledgement

The WA Regional Committee acknowledges Dr Steve Edlin's excellent contribution as Regional Education Officer over the past few years. Dr Edlin has resigned from this position and Dr Bernice Ng has been appointed in his place. The WA Regional Committee was also pleased to nominate Dr Mary Pinder to the New Fellows Conference being undertaken as part of the ANZCA Meeting in Melbourne in May this year. Previous attendees at the New Fellows Conference have been Dr van Heerden and Dr Michael Corkeron, both of whom found this a valuable experience.

FACULTY OF PAIN MEDICINE

DEAN'S MESSAGE



Initial Board of Faculty

The Initial Board of Faculty has now completed its term and I wish to thank each and every member of this Board for the very harmonious and effective manner in which they have carried out their work. The Board has been comprised of membership from all five participating specialty bodies with different backgrounds and perspectives. It is a tribute to the individuals who have worked on this Board that they have been able to quickly form a team approach that is so characteristic of multidisciplinary pain medicine. The initial Board has set a standard which I hope will be emulated by successive Boards. I would particularly like to express my thanks to retiring Board Members Dr. Ben Marosszeky (AFRM) and Dr. Suellen Walker (ANZCA). Both of these individuals have made invaluable contributions to the initial Board and to the development of the specialty.

Elected Board

Following the recent election, two new individuals were elected to the Board, namely Dr. Penny Briscoe (ANZCA) and Dr. Bruce Kinloch (AFRM). I welcome both of these individuals to the Board and am confident that they will make a valuable contribution to its work. As noted elsewhere, Dr. Penny Briscoe has been elected Chairman, Examination Committee.

Dean's Medal

During the formal ceremony at the Annual Scientific Meeting in Melbourne, May 2000, the President of the Royal Australasian College of Surgeons, Mr. Bruce Barraclough, presented the Dean's medal on behalf of the RACS. I have written to Mr. Barraclough and the RACS expressing sincere thanks on behalf of the Faculty for this very generous donation. This 'badge of office' is a superb 5-sided gold medal, representing the five

specialties that make up the Faculty. It has a contemporary, yet dignified design and has been much admired by all who have seen it. It was crafted by the Victorian Silversmith, Mr Dan Flynn, whose work is much appreciated.

Barbara Walker Prize

At the ceremony during the ASM, Mr. Ron Walker AO, CBE presented the first Barbara Walker Prize for Excellence in Pain Management to Dr. Leah Power who was the top candidate in the first examination in November 1999.

Annual Scientific Meeting - Melbourne 2000

The Faculty Foundation Scientific Visitor, Dr. Daniel Carr from Tufts University and New England Medical Center Boston, was an outstanding success. The attendance at the Faculty scientific meetings was large and included not only members of the Faculty but also specialists in anaesthesia and intensive care attending the ASM.

Further Directions

There are some very important challenges that await the recently elected Board. Perhaps foremost among these is the creation of substantially more training positions in multidisciplinary pain centres for trainees from all of the five disciplines represented in the Faculty. Clearly there is a major manpower shortage in this new specialty and representations will be made by the Board to both Federal and State Governments. However, a good deal can be done at the local level and Fellows are encouraged to vigorously pursue the development of training positions within their own hospitals and health services.

A related and equally important issue is the appropriate recognition by Governments of the magnitude of the problem of chronic and cancer pain and the need for appropriate specialised Pain Management Centres, with adequate facilities and staffing. At the same time we must ensure that acute pain management continues to receive the attention that it deserves. I would particularly highlight emerging evidence that the severity of acute pain predicts the development of chronic pain, implying that improved treatment of acute pain may reduce the incidence of chronic pain.

I encourage all Fellows to foster close linkages in education, research and clinical care with respect to acute, chronic non-cancer and cancer pain.

MICHAEL J COUSINS AM

HIGHLIGHTS FROM INITIAL BOARD MEETING HELD ON MAY 5, 2000

Honours and Appointments

The Dean reported that Prof. Tess Cramond AO, OBE has been awarded Honorary Fellowship of the New Chapter of Palliative Medicine, RACP.

Education

Logbooks

The Board has agreed that the logbooks henceforth will not be an examination tool but rather will be an aid to training and to promote interaction between trainees and their supervisors. They will be reviewed by the Supervisor of Training with the trainee. Periodically the Hospital Accreditation Committee and Education Committee may wish to review a sample of a trainee's logbook.

Objectives of Training

Upon recommendation of the Education Committee, the Board has agreed that an "Objectives of Training" will be developed, in line with those currently available in anaesthesia and intensive care.

Curriculum

The Education Committee has recommended that this document should be renamed "Guide to Study". It is anticipated that the final draft of the new Guide to Study will be completed by 30th June, 2000.

Web Based Education

The Education Committee has begun discussions about this educational option.

Barbara Walker Prize for Excellence in Pain Management

The Board recommended that Leah Margaret Power FANZCA (WA) who gained the highest mark at the

examination on 26th November 1999 be awarded the Barbara Walker Prize for Excellence in Pain Management.

Pre-Examination Short Course

The Board agreed that, following the successful course held last year, this should be held again in the year 2000. Dr Suellen Walker will again organise the course with assistance from other members of the Board.

Hospital Accreditation

Review of Units

The HAC completed its review of the Westmead Hospital/New Children's Hospital/Sydney Pain Management Centre in April 2000. The Board has approved one training position each at Westmead Hospital and the New Children's Hospital, subject to a number of areas being addressed over the next eighteen months. The HAC will review for accreditation the following Centres: Auckland Hospital (May 23), Royal Brisbane Hospital (May 29) and Flinders Medical Centre (June 1).

Scientific Meeting – Melbourne 2000

The Board complimented Dr. T. Little for arranging an interesting scientific program for the Pain Medicine Sessions at the ASM on May 6 and 7.

Paediatric Pain Medicine Practitioners.

Discussions have been held with the New Children's Hospital Sydney and the Royal Children's Hospital Melbourne to establish a paediatric component of a training and education program for trainees, as part of a Pain Medicine training program attached to an adjacent

adult pain unit. As noted above, initial approval has been given for a joint training program between Westmead Hospital and the New Children's Hospital Sydney. It is hoped that a similar program can be developed in the near future in Melbourne.

Palliative Medicine

A joint working party, chaired by Dr. Paul Glare FRACP, has commenced work. The working party comprises representatives of the Faculty of Pain Medicine and Chapter of Palliative Medicine RACP. One of the major aims of the working party is to develop opportunities for rotation of trainees between the two training programs and potentially the development of a joint training program to permit individuals to train in both areas where desirable.

Chapter of Palliative Medicine

The Board noted the formation of the Chapter of Palliative Medicine within the RACP and plans to induct Foundation Fellows at the RACP meeting in Adelaide in May 2000.

HIGHLIGHTS FROM BOARD MEETING HELD ON MAY 7, 2000

This meeting represented the end of the term of office of the initial Board of Faculty. Following elections for appointment to the new Board, the following individuals were successful.

Mr R L Atkinson QLD, FRACS
Dr P A Briscoe SA, FANZCA
A/Professor M L Cohen
NSW, FRACP
Professor M J Cousins AM
NSW, FANZCA
Dr D Jones NZ, FANZCA
Dr C R Goucke WA, FANZCA
Dr B M Kinloch VIC, FAFRM
(RACP)
Dr T F Little VIC, FANZCA
Dr P E Macintyre SA, FANZCA
Dr G I Rice QLD, FRANZCP

Professor J M Gibbs
QLD, FANZCA
Co-opted Member Representing Council

The Dean thanked retiring Board Members Dr. Ben Marosszeky and Dr. Suellen Walker for the very valuable service that they had rendered to the initial Board and welcomed new Board Members Dr. Bruce Kinloch FAFRM (RACP) and Dr. Penny Briscoe FANZCA.

Appointment of New Chairman of Examination Committee

The Board elected Dr. Penny Briscoe as Chairman of the Examination Committee. Dr. Briscoe will replace Prof. Michael Cousins who chaired the Examination Committee during the development of the examination format and conduct of the first examination.

Election of Office Bearers

The following is the list of Office Bearers
Dean Professor M J Cousins AM
FANZCA
Vice Dean Dr C R Goucke FANZCA
Treasurer Mr R L Atkinson FRACS
Education Officer
A/Professor M L Cohen
FRACP
Chairman of Examination Committee
Dr P A Briscoe FANZCA

Chairman of Hospital Accreditation
Committee

Dr T F Little FANZCA

ASM Officer

Dr P E Macintyre FANZCA

Examination October 2000

Final Opportunity for Presentation to Examination without Further Training.

Upon resolution of the Board, the October 2000 examination will be the

last opportunity for individuals with specialist qualifications relevant to the field of Pain Medicine and appropriate past experience, to apply to the Censor for possible exemption from further training before presenting to the examination. From the year 2001 onwards, the only route to Fellowship of the Faculty will be by either meeting the full requirements for training and examination or by election.

ELECTED TO FELLOWSHIP

The following have been elected to Fellowship of the Faculty of Pain Medicine

Arun	AGGARWAL	NSW	FRACP, FAFRM (RACP)
Ghuri	AGGARWAL	NSW	FRACP
Guy	BASHFORD	NSW	FAFRM (RACP)
Allan	MacKILLOP	QLD	FANZCA
Timothy	PAVY	WA	FANZCA
Scott	SIMPSON	QLD	FANZCA
John	SPEIRS	NZ	FANZCA
Geoffrey	SPELDEWINDE	ACT	FAFRM (RACP)
Brett	TODHUNTER	NSW	FANZCA
Jane	TRINCA	VIC	FANZCA
Russell	VICKERS	NSW	Phd, MDSc, BDS
Adrian	WINSOR	SA	FAFRM (RACP)

HONORARY FELLOWSHIP

CITATION – DANIEL BARRY CARR



Mr President, I have the honour of presenting to you Daniel B Carr, M.D., who is the Saltonstall Professor of Pain Research in the Departments of Anesthesia and Medicine at New England Medical Center in Boston, Massachusetts.

A graduate of Columbia College and Columbia University, Dr Carr was trained in internal medicine at Columbia-Presbyterian Medical Center and later at the Massachusetts General Hospital, where he continued his training in internal medicine, endocrinology, and anesthesiology; subsequently he played a key role in

developing the Pain Center at that institution. He is a Diplomate of the American Boards of Internal Medicine and Anesthesiology and the American College of Pain Medicine, and holds the Certificate of Added Qualification in Pain Management from the American Board of Anesthesiology.

Dr Carr's clinical research activities include evaluation of the effectiveness and mechanisms of pain therapies, particularly opioid analgesia; and prevalence and mechanisms of postburn pain. He leads the US Cochrane Center for outcome research on pain. He has co-chaired the US Agency for Health Care Policy and Research Panels to prepare *Acute and Cancer Pain Management Guidelines* for the US Congress, as well as a joint US/France consensus guideline conference on pain in HIV/AIDS.

Dr Carr's preclinical research interests are: endogenous opioids;

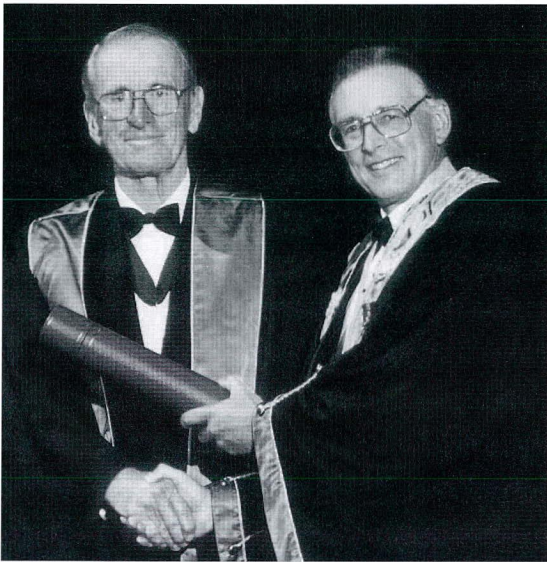
analgesic peptides and nociception. He is the Editor-in-Chief of the International Association for the Study of Pain's didactic publication for front-line clinicians (*Pain: Clinical Updates*) and has been active in the American Pain Society (APS). He serves on the Board of Directors of the APS, the American Academy of Pain Medicine, the International Association for the Study of Pain, and on the Legislative Task Force on Pain of the Commonwealth of Massachusetts.

He has published widely and is the recipient of many awards including the Bernard Schoenberg Memorial Award, American Institute of Life-Threatening Illness and Loss, New York and Citation, US Department of Health and Human Services for co-chairing the Acute and Cancer Pain Guidelines Panels.

Mr President, I have the great honour and privilege to present to you, **DANIEL BARRY CARR** for conferment of Honorary Fellowship of the Faculty of Pain Medicine.

MICHAEL J COUSINS

HONORARY FELLOWSHIP CITATION – BRIAN ERIC DWYER AM



Mr President, I have the honour of presenting to you Brian Dwyer AM.

Brian Dwyer is regarded as one of the pioneers of pain medicine worldwide. His interest in pain medicine began during his early years in the field of anaesthesia when he had an opportunity to work in the Oxford Department of Anaesthesia. Present at that time was Sir Robert Macintosh who not only led the way in the use of local anaesthesia but was one of the early clinicians to treat patients with chronic and cancer pain. As a result of this opportunity Brian Dwyer became extremely skilled in the use of subarachnoid and other neurolytic blocks. His four years of experience in Oxford gave him a very strong grounding in the fledgling field of pain medicine.

On his return to St Vincent's Hospital, Sydney in 1955, Dr Dwyer became the first full-time Director of a major hospital department of anaesthesia. This he moulded into an exceptional training facility. He immediately commenced his work in pain medicine, establishing the

first multidisciplinary pain clinic in Australia, in conjunction with neurosurgeon Dr Kevin Bleasel, and psychiatrist Dr John Woodford, in a format which persists to this day. Arising out of their experiences in this clinic, an article was published in the Medical Journal of Australia in 1965 (Medical Journal of Australia 1965;1:676). Dr Dwyer's commitment to the multidisciplinary assessment and treatment of pain was influenced by

his visits to the University of Washington in Seattle where he became well acquainted with the concepts developed by John J Bonica.

Dr Dwyer recognised early the importance of documenting outcomes of pain management interventions. His series of coeliac plexus block procedures was one of the first clear documentations of the efficacy and side effects of that procedure (Anaesthesia & Intensive Care 1973; 1: 315). He was also a pioneer in the use of neurolytic blocks for cancer of the head and neck (Anaesthesia & Intensive Care 1972; 1: 59). In addition to publications in the scientific literature, he was also the author of a major chapter on the use of all forms of neurolytic nerve block for the relief of chronic and cancer pain in two editions of a major text ("Neural Blockade in Clinical Anaesthesia and Management of Pain" ed Cousins and Bridenbaugh JB Lippincott 1980, 1988).

Brian Dwyer was a Founding Fellow of the Faculty of Anaesthetists and served as Dean from 1974 to 1976. During his term as Dean, he was largely

responsible for the establishment of the Diploma in Intensive Care. Within the Faculty, he was at times virtually the sole voice espousing the cause of pain medicine and urging its development in this country. He strongly fostered the Faculty's relationship with the Royal Australasian College of Surgeons and was elected to that College's Court of Honour in recognition of his distinguished Deanship. He was an integral influence in the development of the Australian Pain Society.

During his latter years at St Vincent's Hospital, Dr Dwyer became convinced of the need for specialist input to the management of terminally ill patients who had pain. He played a key role in the development of a consulting palliative care unit in 1982 which developed into the Sacred Heart Hospice on the St Vincent's Campus, where he served as the first Director of Palliative Care.

Brian Dwyer was recognised internationally by other pioneering individuals such as John Bonica in the United States and Sam Lipton and Mark Swerdlow in the United Kingdom as one of the key players in the pain medicine field during his era. In 1997 his contributions were recognised in this country by the Award of Membership of the Order of Australia.

Mr President, I have the great honour and privilege to present to you, **BRIAN ERIC DWYER** for conferment of Honorary Fellowship of the Faculty of Pain Medicine.

MILTON L COHEN

The Rural SIG co-ordinated a session during the recent ASM entitled 'Panel on Rural Anaesthesia Issues'.

The topics covered were:

1. Recruiting to Rural and Regional Areas. G Henderson, Ballarat.
2. MOPS implementation at a rural level. B Christie, Ballarat.
3. GP Anaesthetic Training. B Spain, Darwin.
4. Rural Anaesthetic Recruitment Service. D Catt, Alice Springs.

Efforts to provide proactive admission of rural students into medical schools and to increase the exposure of medical students and junior medical staff to rural practice is likely, in the longer term, to have positive benefits for all areas of rural practice. However the impact of a changing gender mix in medical schools and eventually newly qualified anaesthetists, as well as the expectations of lower workloads by all new medical graduates, is yet to be addressed in terms of metropolitan, let alone rural and regional practice.

Despite the changes in the most recent evolution of the MOPS program there are still many obstacles to implementing it effectively in rural practice. Distance, time and costs, both in attending meetings and in covering one's practice can all impede the process. However creative use of the internet, colleagues and local facilities can all contribute to CME. A challenge for the future is producing both a program and a climate

in which rural practitioners can't help but achieve successful maintenance of standards.

One obvious conclusion therefore, is that provision of anaesthesia by non-specialist providers in rural and regional Australia is a fact of life for the foreseeable future. This means that there must be mechanisms to provide support, assistance and training for those practitioners involved in its delivery. The Joint Consultative Committee on Anaesthesia, in which ANZCA participates, is the body responsible for the development of the 12 month Advanced Rural Skills Post in Anaesthesia within the Rural Training Scheme of the RACGP.

There are 25 hospitals across Australia involved in this scheme. One of the obvious problems involved is imparting adequate knowledge and practical skills within the 12-month period. Given this limitation one of the most important aspects of the training is the development of responsive lines of communication that can be utilised by the advanced rural trainees. Maintenance of skills and CME is obviously a major issue for these practitioners.

The Rural Anaesthetic Recruitment Service addresses a different issue:

advertising the availability and filling temporary and full-time positions for specialist anaesthetists in rural and regional areas. There has been some success matching 'recruits' with vacancies but a larger pool of recruits is needed. The project has so far been funded by the Rural Health Support, Education & Training Program, which is a division of the Commonwealth Department of Health and Family Services. The project will continue under the auspices of the ASA and ANZCA although exact funding arrangements have not been finalised. It provides a unique service to collect and collate those interested in rural practice with those looking for aspiring rural anaesthetists.

The session was well attended and the rural SIG would like to thank all the participants for their contributions.

MARK TUCK
RURAL REPRESENTATIVE
VICTORIAN REGIONAL COMMITTEE

Re-use of 'Single Use' Equipment for Invasive Procedures

The labelling of products as '**single use**' is an indication by the manufacturer that the product is either unable to be re-sterilised or its safe function may be compromised by the re-sterilisation process.

As sterilisation is required for apparatus that will be used for any invasive procedure (eg intravenous access, regional anaesthesia and invasive monitoring), such apparatus labelled '**single use**' must not be re-used. This includes all apparatus that is in continuity with the vascular system.



Sir Lou Edwards presenting Professor Tess Cramond with Honorary Fellowship of the Australasian Chapter of Palliative Medicine, Division of Adult Medicine, RACP, Honorary Doctor of Medicine, University of Queensland



L to R: Dr Leigh Coombs, Chairman WA Regional Committee, Dr Richard Walsh, President ANZCA, Dr Rod Westhorpe, Councillor and President ASA, at the opening of the CTEC Building at The University of Western Australia

ANZCA VIRTUAL CONGRESS 2000 REPORT

The Virtual Congress is a joint project of the College and Medeserv Pty Ltd. The goal is to create a web-based conference that would expand the educational value of the Annual Scientific Meeting. By registering for the ANZCA webgroup at www.anzca.edu.au you can use your password to visit the Virtual Congress website. The congress will remain online until November 2000.

The Virtual Congress team had a number of roles during the ASM2000.

VC2000 Booth at the ASM2000 Scientific Meeting

This booth was in the exhibitors' area, adjacent to the Internet Café. Karen Monette and Jennifer Ellis of the College performed a number of duties:

- assisting presenters in publishing their presentations using the online self-publishing tool;
- assisting delegates in registering online for the VC;
- answering questions of a general nature about the VC;

- directing technical problems to the Medeserv production team.

This was a very popular booth for both presenters and delegates. The greatest use was for instruction on how to navigate the VC website. Over the duration of the meeting, approximately 100 online registrations were performed, and many free papers were published.

VC Presentation Room at the ASM2000 Scientific Meeting

This area was near the Speakers Presentation Room (Speaker-ready room). The purpose was to collect presenters' slides and audiotapes for transcription and publication on the VC website. We were very impressed with the level of knowledge that the presenters had about what needed to be done. This was due to the forward planning of the team, co-ordinating mailouts with the ASM organising committee.

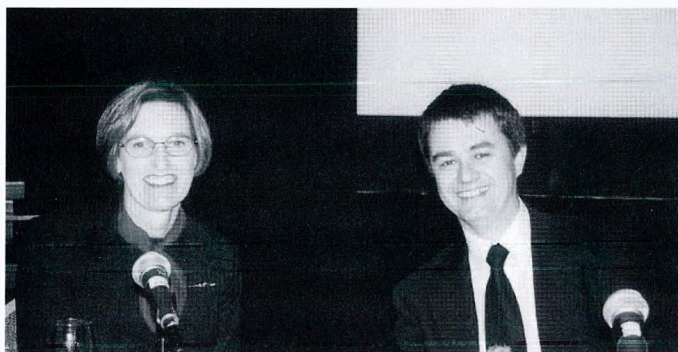
The VC2000 continues

Although the ASM2000 has closed its doors, the Virtual Congress is only starting to build in momentum! Two weeks after the ASM the presenters are still returning their transcripts for publication. As of 22 May we have 12 Multimedia Presentations (slides, text and, in some cases, audio). We also have about 20 Poster presentations that have been published by the presenters of free papers from the ASM2000. When all content is finally published there will be about 66 presentations to choose from. Delegates are also invited to contribute to the discussion forum for each presentation. There is also a Treasure Hunt. Prizes will be awarded in July.

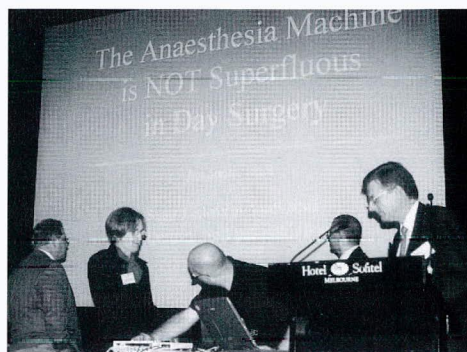
Come join us online by following the link from our College homepage: www.anzca.edu.au

JOE NOVELLA
VC2000 ORGANISING COMMITTEE

DAY CARE ANAESTHESIA: NOW AND INTO THE FUTURE



Keynote Speakers
Dr Glenda Rudkin and Dr Ian Smith



*Limbering up for the Debate:
"Is the anaesthetic machine superfluous?"*

This successful single day meeting was organised by the Day Care Anaesthesia Special Interest Group (DCA SIG) Executive and held at the Hotel Sofitel in Melbourne on Friday 5th May 2000, immediately preceding the Annual Scientific Meeting of ANZCA.

The meeting was organised to deal with both issues on the horizon for anaesthetists in Australia, as well as issues of everyday importance now. The meeting had two keynote speakers. Dr Ian Smith from Stoke-on Trent, UK was the DCA SIG International Visitor and Dr Glenda Rudkin from Adelaide, SA was the DCA SIG Australasian Visitor.

These speakers introduced issues such as intraoperative methods to improve recovery and office based surgery, which other speakers built upon. As well as presenting topics about to assume importance to us, a significant part of the meeting dealt with practical issues which allowed a re affirmation of current practice. Many of these topics were task oriented allowing a potential change in practice to be considered. The meeting concluded with a debate on "Whether the anaesthetic machine was superfluous". This debate humorously and informatively rounded this meeting.

The adjudicators (audience) voted that the anaesthetic machine is not superfluous yet! The organising committee would like to thank all speakers for their considerable presentations.

This meeting was attended by over 160 participants from Australia and overseas. The close proximity in time and place to the Annual Scientific Meeting of the College contributed to this good attendance. The Hotel Sofitel provided an excellent venue with tiered seating and excellent audiovisual equipment. The industry exhibition was well sited and catering was appropriate.

This meeting was significantly supported by industry. The organising committee would particularly like to acknowledge the significant support of the meeting's major sponsor, Abbott Australasia. The close proximity of this meeting to the ASM provided some confusion with potential industry sponsors, who understood that both meetings were the same.

I would like to specifically thank all the organising committee as well as Helen Morris and other staff from the ANZCA office in Melbourne.

DAVID KINCHINGTON
CHAIRMAN, DCA SIG



College Staff
Ms Helen Morris and Ms Juliette Mullumby

FELLOWS PROFILE

AMERICA'S CUP 2000

I have always had a very close association with boating. As a teenager in Auckland I lived by the beach so swimming and yachting were an active part of my growing up. After I returned from postgraduate training in the UK with a young family it was not long before boating became part of our lives. First in runabouts when all our four daughters learnt to water-ski and then into keelboats with family cruising and yacht racing (successfully). Next to fulfil a teenage dream I built a 10.6 metre keel yacht – a task that took me much longer than the three years I envisaged but gave me a huge sense of achievement. Unfortunately we only kept her for two years as my previous yacht racing crew all said they were too old to race (they are younger than I) and for our children and grandchildren to be part of the fun, something faster and more comfortable seemed the deal. We now have a 10.3 metre launch.

While building our keeler I kept up my interest in yachting by becoming involved in keel yacht race management. When New Zealand won the America's Cup in San Diego in 1995, I thought, what an opportunity to be involved in one of international sailing's most exciting regattas. And my future plans would enable me to give the time commitment. So in March of last year when the call went out for volunteers to be involved in the Louis Vuitton Cup Challenge and the America's Cup 2000 I was early in the queue.

In the middle of last year I was asked to attend at The America's Cup Challenge Association (NZ) office for an interview. Here I met Capt Vincent Cooke, US Navy (Ret.), the Regatta Operations Director. Vince was brief and to the point, he asked me to accept the position of Spectator Control Officer for the Louis Vuitton Cup under the guidance of Ralph Neiger (also Capt US Navy Ret.). What an opportunity and what a challenge!

And so began one of the most exciting and interesting five months of my life. There were about 200 volunteers and not all of us active retirees, and not just the boys – there were about 20 to 30 women. All age groups were represented, some

having taken time off work or business commitments to be part of a great team. The level of boating and race management experience varied but under the guidance of people such as Vince and Ralph with the expertise from previous regattas we soon learnt our various tasks.

Although we were part of two different task groups for the Louis Vuitton Cup regatta, those involved directly in the management of the yacht races and those involved in the control of the spectators and their vessels, we all met together as a team at the operations base at the Bucklands Beach Yacht Club. In this respect I was able to draw many parallels from previous experience in operative patient management by the surgical, nursing and anaesthetic team.

Each day started at 8 or 9 am with a briefing at the base including the joke of the day (censored jokes I heard in the OR were well received) and then out on the water, even if the weather and wind were unfavourable – too much or too little. Back to base between 4 and 7 pm for a drink and to recount all the challenges and incidents. In this way a strong camaraderie was built. By the end of the Louis Vuitton Cup we had controlled over 200 races.

My role as Spectator Control Officer was to ensure that the competing yachts had a 'level playing field'. The rule was 'No Wash and No Wind Shadow' on the Course. This had to be managed in such a way that the spectators still had every opportunity for the best view of the racing yachts. No mean task. But an excellent system had been developed at previous regattas and we had first rate co-operation from the spectators. Also I had a willing and able team of assistants who developed a professional approach to their roles.

The Louis Vuitton Round Robin races were conducted on two courses in the Hauraki Gulf, the Atlantic Course and the Pacific Course. I was the Spectator Control Officer for the Pacific Course. My team consisted of 10 six metre patrol

boats and four or five 9-11 metre launches. I ran Spectator Control from one of these launches operating at the starting/leeward mark/finish box area. As well as the launch crew, one or two radio operators and a recorder assisted me. Communication played a vital role in the management of the spectator fleet which initially was in the hundreds of craft, but for the Louis Vuitton Semi-finals and Finals and for the America's Cup Challenge numbered between one and 3,000! We used up to four UHF and up to three VHF radio channels, as well as cell phones plus direct communication. I used a laptop computer with a special program (Windlee 13) designed for America's Cup races to determine the position, the coordinates, the rounding marks and the dimensions of the course area. These depended on the wind direction, which on the Hauraki Gulf varies considerably especially at the time the Cups were run. Ever tried using a laptop on the bridge of a rolling launch? Believe me it takes concentration. As well as all this we needed to be aware of what was happening in the racing and be way ahead of all possibilities of course direction changes. In between times we did get to see those magnificent America's Cup yachts performing in racing mode at close range – what an awesome sight. They often passed within 10-20 metres of us.

All in all, I believe that with the training we received and with the kiwi attitude to do the best, our teams did a great job. We received many compliments not only from the competitors but also from overseas boaties and the media. As well the locals were very happy with how the events went and their opportunities to view the racing and their heroes.

The Louis Vuitton Cup semi-finals and the finals were staged on a single course. I then took on the role of Spectator Control Officer for the top end of the course, the Windward mark area under the direction of my mentor, Ralph who was very busily engaged with Spectator

Control at the Start box/Leeward mark/finish box area. Again I had the assistance of patrol boats, some launches and an excellent support crew. This position was very exciting as not only did we need to keep the spectator fleet well clear yet with good viewing but we were stationed near the rounding mark so had excellent views of some close yacht racing.

For the America's Cup Challenge races many of the volunteers for the Louis Vuitton Cup regatta assisted and were joined by others. The Cup Defenders, the Royal New Zealand Yacht Squadron, managed this series and their course management was slightly different. I again was in control of the spectator fleet at the Windward mark area and so although had an indispensable task to perform was close to the excitement once more.

Happily Team New Zealand were so much in control of the racing and always looking the winning team. As a consequence we did not see the level of exciting racing that we had during the Louis Vuitton regatta. From our vantage point looking down the course Team New Zealand were always pointing higher and standing more upright going upwind than Prada and right from the beginning 5 to 0 looked to be the result that it finally was.

There were many highlights, especially the opportunity to be involved in an event of such international standing in the yachting world. There were the new people with a similar spirit to work with and make new friendships. There was the challenge to do something new and different (never been done before in New Zealand). And then there was all the excitement of the racing and being close to the action and particularly to be there close by to congratulate the winners.

The Louis Vuitton Company, the sponsors of the Challenger's regatta and their Cup, were very professional to work with. As well they were very generous in their appreciation of the way the volunteers performed. We were all provided with an extensive range of boating gear, (this was also done for the America's Cup volunteers). Many volunteers in responsible positions were presented with gold Star Class Nobilia wristwatches. We were all invited to the Louis Vuitton Cup Party held in honour of the Challengers. This black tie evening was staged in the newly restored Civic Theatre, a magnificent venue and the evening matched the venue and the occasion. They also arranged an aerial photo of the entire group followed by a barbecue in park like

surroundings. We were invited to the skippers' press conferences held in the technologically modern Media Centre. And so on it went.

But it was the racing out on the water that provided all the action and excitement and all the volunteers had a great view of it all as they performed their essential tasks. Masts breaking, yachts bending in half, sails blown to shreds, especially eight green spinnakers, collisions, we saw it all. But it was the duelling between world class match racing yachtsmen and women that held our attention, right down to the wire for the Louis Vuitton Cup Final.

And to cap it all we were all there for the presentation of the Cups, part of the huge excited crowd but right up front where the action was. I was even sprayed by Moët Chandon – what a waste.

And so Team New Zealand won the America's Cup again. We will all again have the opportunity to be part of a highly successful team running an international event. Will I be there? You bet! I shall be first in the queue of volunteers.

CEDRIC HOSKINS

Module 30: Chronic pain management for anaesthetists

The prospect of having to edit a module on this subject filled me with dread. I have never practiced in this area and teaching on the subject was rudimentary when I did my FFARACS. When I started looking for potential authors of questions I realised just how few chronic pain practitioners there are in New Zealand. I am indebted to the 10 anaesthetists who supplied questions.

I also came to realise how much my personal anaesthesia practice impinged on the chronic pain field with the questions on tic douloureux and spinal cord stimulators (questions that were generally well done).

Questions with a 'false' answer predominated among the questions which caused problems. 'False' questions that are not too obviously false are harder to write than 'true' answers. (There were 79 'false' answers out of a total of 163 possible answers.)

Overall the mean score was 76 per cent, which is normal for HELP modules. One

pain practitioner told me he got 98 per cent and several of the answer sheets we marked obtained similar scores. I find this result satisfying as it suggests we produced a module of appropriate standard for anaesthetists, even if we did not extend the specialist pain practitioners.

Module 31: Anaesthesia and the Kidney

I was delighted when requests for questions produced 23 responses, the most I have had during my three years as editor of the HELP modules. Reading the questions made me aware I needed to revise basic renal physiology. That led to the thought that if I needed to do some revision, it might be a good idea to include renal physiology questions in the module. On the whole the basic science questions were not well done. Clinical questions were well done. The mean, of the sample of returns marked, was 76 per cent.

This was the last module I edited, as I have now finished my three year term as the Medical Director of CECANZ. I would like to take this opportunity to thank all those who helped me with the production of the modules. In particular

MAINTENANCE OF PROFESSIONAL STANDARDS

SCHEDULE QAA No. 1/2000

DECLARED QUALITY ASSURANCE ACTIVITY TO WHICH PART VC OF THE HEALTH INSURANCE ACT 1973 APPLIES

Item	Title of quality assurance activity	Description of quality assurance activity
2	Australian and New Zealand College of Anaesthetists (ANZCA) Maintenance of Professional Standards Program (MOPS)	The Activity is an assessment or evaluation of the quality of health services. The purpose of the Activity is to ensure the involvement of anaesthetists in a range of ongoing educational activities which maintain clinical standards in order to provide the highest quality of patient care. The services assessed are services in respect of which payments have been or may be made under Parts II or IV of the Act (ie Medicare Benefits or Health Program Grants) and under Division 3 of Part VII of the <i>National Health Act 1953</i> (ie payment for supply of pharmaceutical benefits). The persons managing the Activity are Professor Teik Ewe Oh, Medical Practitioner and Ms Joan Sheales, Registrar and Chief Executive Officer ANZCA. The persons are authorised to engage in the Activity by the Australian and New Zealand College of Anaesthetists (ANZCA) which is an association of health care professionals. The Activity is of a kind that has been engaged in Australia under a previous declaration, QAA No. 5/1994. The application of Part VC of the Act has encouraged and will continue to encourage full participation in the Activity by anaesthetists, which is necessary to make the Activity effective. The Activity is a national project involving anaesthetists in all States and Territories. Non-identifying information regarding participation and compliance under the MOPS program will be published as part of ANZCA's general reporting activities to its Fellows. Copies of this information will be provided to the Minister for Health and Aged Care.

MEDICAL EDUCATION IN THE DEVELOPING WORLD

A personal view with a focus on East Timor

Patricia Coyle, FANZCA, FRCA



*Back Row Right: Surgeon Martine Hennaux, Belgium;
Centre: Anaesthetist Patricia Coyle;
Front: OT staff and translator. Bancan Hospital, East Timor*

What follows in the matter of medical education in the developing world (third world) are impressions arising out of an experience of third world clinical work and teaching (formal and informal) beginning in 1981 and totalling about 10 years, eight of them with continuity in one region – East Africa, largely Uganda. The most recent Third World experience was three months working in an East Timor hospital since the independence referendum. Interest in third world medical education has continued in the form of varying degrees of involvement in distance education, currently, and for some time now, the World Anaesthesia/WFSA Education Project.

The East Timor experience has brought a realisation of some of the significant problems to be dealt with in the matter of health care and health care education by the administration of this new nation. Australia is East Timor's nearest first world neighbour, and I have the impression that, on the whole, we in Australia recognise that we have a special responsibility in East Timor's regard. In addition to our considerable military involvement (INTERFET and UNTAET

peacekeeping), Australians are associated with a variety of programs designed to improve some aspect of East Timor's present situation.

In the areas of health care, there exists a committee set up by the United Nations Transitional Administration East Timor (UNTAET) entitled Interim Health Authority. Some Australians are presently serving on this committee. Some important and often difficult decisions in the field of education must be made very soon, if not made already, and implementation got underway. Medical education is one of the very important areas.

It seems that 32 East Timorese have qualified in medicine; not all are in East Timor at present but it is possible that most will return there. The population is about 850,000 (though currently about 100,000 remain in West Timor); that is a doctor/population ratio of 4/100,000 – not the lowest in the third world but near to it. To match Indonesia's rate of 12/100,000 (WHO 1993) East Timor would require about 90 active medical practitioners. At the top of the range, Cuba has over 500/100,000 (WHO 1993).

There are no medical schools in East Timor. Students attended Universities in Indonesia, which, of course, until recently, included East Timor. While it seems that existing students, whose studies were interrupted by the recent crisis following the referendum, can return, and perhaps already have returned, to their universities, one wonders whether new (future) students will be able and/or willing to enrol in Indonesian universities. Certainly one hopes that this will be both possible and actual. Be that as it may, East Timor needs to assume responsibility to train, or make provision for the training of its own medical practitioners, in East Timor or in the region (Indonesia or elsewhere).

Training in East Timor would have the advantages of being thus less vulnerable to regional instability and other problems, culturally 'at home', probably cheaper, relevant content, less risk of 'brain drain' etc. Against training taking place in East Timor is the important fact that the numbers would probably be too low for economic viability (even with outside assistance); also staffing would pose difficulties, and for the foreseeable future would be largely 'outsiders'.

A number of possible strategies suggest themselves. The first and most obvious, as implied above, is that East Timorese students attend a 'foreign' medical school – but which university, which country? Logical possibilities would include a country in the region or a country with a significant past relationship with East Timor or a country with significant present and also future relationships; thus Portugal, Indonesia, the Philippines, Papua New Guinea, Australia, etc. Any consideration of location must include the language used and also cultural similarities, and for many this would include religious practices. Although Indonesia is largely Muslim whereas East Timor is chiefly Christian, in other regards it may well be the most suitable choice if friendly relations can be established. And as already noted, tertiary education has taken place there until very recently. At this point one needs to mention the language of tertiary education; obviously it has been, for those East Timorese

students in Indonesian universities, Indonesian. It is my opinion that at least for the present, it should continue to be Indonesian, while a gradual transition to English takes place.

Secondly, a 'college' or 'campus' of another university may be a suitable compromise, ie, the 'mother' university/medical school accepts a medical teaching institution in East Timor as an extension of itself. The student body may be entirely East Timorese, or, more appropriately I think, other students may elect or be directed to do part of their studies there.

Another possible interim strategy is for students to go 'abroad' for pre-clinical studies and a decreasing proportion of clinical studies, to the point where all clinical studies are done 'at home', then finally, the pre-clinical studies take place there too. This has been done successfully, eg Malawi (1987-1999). Now for a broader view of medical education in the developing world. As everywhere the divisions are undergraduate and graduate (or postgraduate) education; the latter includes general continuing education and specific specialty training.

My involvement in third world undergraduate medical education has been, of course, as an anaesthetist. In teaching medical students in Uganda for eight years my aim was not to instruct them about how to give an anaesthetic, but rather to lead the students to an understanding, or at least the beginning of such an understanding, of the work of an anaesthetist, of what anaesthesia is about, and the impact of anaesthesia and surgery on a patient. Thus I hoped to help ready these people for their entry into the world of medical practice. Their first clinical duties may well include preparation of an operation list and therefore the patients – an important task too often done very poorly. The teaching program consisted of 20 one-hour lectures and five small group tutorials of five to eight people; the latter included practical instruction in intubation, CPR, etc. This approach to undergraduate teaching was, and still is, I believe, appropriate to the prevailing circumstances.

Further instruction in anaesthesia should be offered to interns towards the end of their first or second year after graduation, depending on the stage at which a rural posting is possible. There the young doctors will likely be working with paramedical anaesthetists of whose work they should have at least a basic understanding.

Specific postgraduate training in anaesthesia takes a number of forms in the developing world.

Training of a limited number to staff specialist/consultant level, either at a national or regional centre is necessary to maintain a university/teaching department. A category I like to call the demi-semi-specialist is, ideally, more numerous (and, overall, more useful in the situations under consideration) than the preceding one. These people will hold a university diploma in anaesthesia, and work entirely, or almost entirely, in anaesthesia and related areas, in central hospitals, if necessary, but also, and more importantly, in district and other peripheral hospitals. The shorter training time will be more attractive to some people, and will, of course, produce clinical anaesthetists more rapidly than the three to four year MMed (Anaes), the most common postgraduate specialist anaesthetist qualification in the developing world. Some of these people will upgrade later to MMed.

There is a third category, though one without any formal recognition as yet, to the best of my knowledge. The medical practitioners who constitute this group are rural hospital medical officers who have done a short (eg 10 weeks) intensive course in anaesthesia at a central hospital, and then been followed-up during periodic visits to their places of work by specialist anaesthetists in addition to continuing distance learning. (A different version would involve a shorter intensive course plus a more intensive distance learning program as well as the visits.) This is an apparently popular and sought-after education option for MOs committed to rural hospital practice, who expect to be required to administer anaesthesia from time to time – perhaps quite frequently, perhaps less so. If and when and where

'specialist' GP/family medicine training is established, this style of anaesthesia training should be included.

Training of paramedical anaesthetists is an activity which must continue for the foreseeable future in many parts of the developing world. It is of course very important, but is not dealt with here.

East Timor and Us

What, if any, contribution should Australian anaesthetists make to anaesthesia in East Timor? It may be too early to say what is needed, but not too early, I think, to say this is, or should be, our responsibility. Why? We are neighbours, our military has already created a special link, started a special relationship. We need to give careful consideration to the form of our response when the time comes. It is essential that what we offer is appropriate to the needs, to the circumstances, to the time. East Timor is a third world country, a developing country and will remain so in the foreseeable future. Donations/aid in the form of education, drugs, equipment, etc must be appropriate. Not only is failure in this matter a waste of the donors' time and money, but very often a significant liability for the recipients. There have been so many references, over the years, to 'graveyards' of useless (for a variety of reasons) equipment in third world countries, to the dangers of unfamiliar equipment and 'new' drugs etc, that there is no need of any further mention here.

Australian and New Zealand anaesthetists have been involved in third world activities, especially education, for many years and in many places, and this involvement continues. It makes sense to draw on the accumulated experience and knowledge of such people, and others, in determining, with the relevant authorities in East Timor, at least in broad outline for the present, the nature of our support.

POLICY DOCUMENTS

PS39 (2000)

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS AND FACULTY OF INTENSIVE CARE

INTRAHOSPITAL TRANSPORT OF CRITICALLY ILL PATIENTS

1. INTRODUCTION

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

2. PROTOCOL

- 2.1 Relevant staff should formulate their hospital's protocol of intrahospital transport of critically ill patients. The protocol should be made widely known and available.
- 2.2 The transport itself must be justified. Whatever benefits of proposed interventions must outweigh the risks of moving the critically ill patient and those posed by the interventions themselves.

3. EQUIPMENT

- 3.1 Equipment must be dedicated to intrahospital transport.
- 3.2 The equipment should be durable, and trolley-linked devices must be able to enter lifts and pass through all doorways en route.
- 3.3 All equipment must be able to function in the specific intervention area (e.g. a magnetic resonance imaging room) and facilities for remote patient monitoring should be available where required. Gas, suction, and electrical supplies at the destination must be present and compatible.
- 3.4 No equipment should be placed on the patient; specially designed receptacles or transport trolleys are useful.
- 3.5 Basic monitoring of ECG, heart rate, blood pressure by invasive or an automated non-invasive monitor, and oxygen saturation by pulse oximetry must be available for all patients.
- 3.6 A defibrillator and a suctioning device must be available.
- 3.7 A portable ventilator with a disconnect alarm is recommended for ventilator-dependent patients.

Nonetheless, a manual resuscitator bag must always be available. Facilities to deliver PEEP and different modes of ventilation are necessary for some patients with pulmonary pathology.

- 3.8 Infusion pumps and monitoring of end-tidal CO₂ and minute volume are highly recommended.
- 3.9 Appropriate fully charged, spare battery packs for electrically driven devices must be available.
- 3.10 Equipment to secure the airway, and emergency drugs, analgesics, sedatives, and muscle relaxants must be available; these are best carried in a dedicated emergency box.
- 3.11 A procedure must be implemented to ensure that all intrahospital transport equipment is readily accessible and regularly checked.

4. STAFF

- 4.1 Key personnel for each transport event should be identified. The transport team should consist of a nurse, an orderly, and an appropriately trained doctor. Additional staff may be necessary for patients with haemodynamic instability.
- 4.2 Each team must be familiar with the equipment and be sufficiently experienced with securing airways, ventilation of the lungs, resuscitation, and other anticipated emergency procedures.

5. PRE-DEPARTURE PROCEDURES

- 5.1 The transport team must be freed from other duties.
- 5.2 The receiving person or staff at the destination must be notified, and the arrival time must be clearly understood.
- 5.3 All pieces of equipment must be checked, and notes and imaging films gathered. An example of a checklist is listed below. Individual responsibilities for checking equipment must be defined.
 - 5.3.1 The ECG and invasive pressure monitors (when used) function properly; alarm limits are set.
 - 5.3.2 The non-invasive blood pressure monitor functions properly; alarm limits are set.
 - 5.3.3 The pulse oximeter functions properly; alarm limits are set.

- 5.3.4 The capnometer functions properly; alarm limits are set.
- 5.3.5 The manual resuscitator bag functions properly.
- 5.3.6 The ventilator (if used) functions properly; respiratory variables are set.
- 5.3.7 The ventilator disconnect alarm (if a ventilator is used) functions properly.
- 5.3.8 The suction device functions properly.
- 5.3.9 Oxygen (\pm air) cylinders are full.
- 5.3.10 A spare oxygen cylinder is available.
- 5.3.11 Airway and intubation equipment are all available and working.
- 5.3.12 Emergency drugs, analgesics, sedatives, and muscle relaxants are all available.
- 5.3.13 Additional drugs are made available if indicated.
- 5.3.14 Spare IV fluids, inotropic solutions, or blood are available if needed.
- 5.3.15 Spare batteries are available for all battery-powered equipment.
- 5.3.16 Chest tube clamps (if an underwater chest drain is present) are available.
- 5.3.17 Patient notes, imaging films, and necessary forms (especially the informed consent form) are available.

6. PATIENT STATUS

- 6.1 Final preparations of the patient should be made before the actual move. Examples include giving appropriate doses of muscle relaxants or sedatives, replacing near-empty inotropic and other IV solutions with fresh bags, and emptying drainage bags.
- 6.2 The patient must be briefly assessed before transport begins, especially after being placed on monitoring equipment and the transport ventilator (if used). Transport preparations must not overshadow or neglect the patient's fundamental care. An example of a brief check on the patient is listed below.
 - 6.2.1 Airway is secured and patent.
 - 6.2.2 Ventilation is adequate; respiratory variables are appropriate.
 - 6.2.3 All equipment alarms are switched on.
 - 6.2.4 PEEP/CPAP (if set) and FIO_2 levels are correct.
 - 6.2.5 All drains (urinary, wound, or underwater seal) are functioning and secured.
 - 6.2.6 Underwater seal drain is not clamped.
 - 6.2.7 Venous access is adequate and patent.
 - 6.2.8 IV drips and infusion pumps are functioning properly.
 - 6.2.9 Patient is safely secured on trolley.
 - 6.2.10 Patient is haemodynamically stable.
 - 6.2.11 Vital signs are displayed on transport monitors and are clearly visible to transport staff.

7. IN-TRANSIT PROCEDURES

- 7.1 A best route should be planned. Lifts should be secured or reserved beforehand. Relatives and non-hospital staff

should be shepherded so as not to obstruct the patient trolley.

- 7.2 Adequate communication facilities during transit and at the destination must be available.
- 7.3 The status of the patient must be checked at intervals, especially if the journey takes considerable time. Any change in the patient's condition, unexpected event, or critical incident, must be acted upon immediately and so recorded.

8. ARRIVAL PROCEDURES

- 8.1 On arrival at the destination, the receiving monitoring, ventilation, gas, suction, and power facilities are checked if the patient is to be transferred from the transport facilities.
- 8.2 The patient must be briefly assessed when the new monitors, ventilators (if used), gas and power supplies are established.
- 8.3 If another team assumes responsibility of care, a complete hand over is given to the doctor in charge. The transport staff must remain with the patient until the receiving team is fully ready to take over care.

9. QUALITY ASSURANCE

The process of intrahospital transport of patients should be continually evaluated.

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'.

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AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

GUIDELINES ON THE DUTIES OF AN ANAESTHETIST

1. PREAMBLE

Fellows of the Australian and New Zealand College of Anaesthetists have the training and knowledge to provide high quality and safe patient care. The specific duties of an anaesthetist are outlined in this document. In hospitals with College approved training posts, specialist staff have additional educational duties which will ensure appropriate training for those occupying such posts. It is accepted that not all of these duties will be carried out by every anaesthetist.

2. CLINICAL DUTIES

- 2.1 Provision of anaesthesia services for patients having surgical, medical, obstetric or investigational procedures, including continuous monitoring during such procedures.
- 2.2 Pre-operative assessment and early post-operative care of patients.
- 2.3 Supervision of anaesthesia trainees and other staff as appropriate.
- 2.4 Supervision of Recovery Room patients.
- 2.5 Management of the anaesthesia component of the work of the Day Care Surgery Unit.
- 2.6 Organisation and clinical management of acute pain services and participation in a Pain Medicine Unit where appropriate.
- 2.7 Acute resuscitation services for medical, surgical and trauma emergencies, including retrieval services.
- 2.8 Assistance with the management of patients in the Intensive Care Unit.
- 2.9 Provision of clinic services for assessment and preparation of day-surgery patients, day-of-surgery-admission patients and other patients as necessary.
- 2.10 Supervision of clinical anaesthesia services in the role of the daily Duty Coordinator.
- 2.11 Supervision and/or management of cardiopulmonary bypass.
- 2.12 Clinical duties in the Hyperbaric Medicine Unit when appropriate.
- 2.13 Other clinical services as may be necessary and appropriate to the specialty.

3. OTHER PROFESSIONAL DUTIES

- 3.1 Administrative duties relating to the functioning of the department and the hospital.
- 3.2 Organisation of and participation in appropriate educational activities for:
 - 3.2.1 anaesthesia trainees
 - 3.2.2 intern and resident medical staff
 - 3.2.3 medical students
 - 3.2.4 trainee and postgraduate nurses
 - 3.2.5 anaesthesia nurses and/or technicians
 - 3.2.6 recovery room nurses
 - 3.2.7 operating room nurses
 - 3.2.8 other health professionals
 - 3.2.9 community groups in subjects such as "basic life support".
- 3.3 Participation in peer review and quality improvement activities to ensure and review the quality of patient care.
- 3.4 Participation in continuing medical education to maintain personal knowledge and skills as established in the College's Maintenance of Professional Standards Program.
- 3.5 Contribution to activities of professional associations, hospital committees, and other relevant state and national organisations.
- 3.6 Participation in research and reviews on matters relevant to anaesthesia, pain medicine, resuscitation and intensive care. These activities may include assistance to trainees with their Formal Project.
- 3.7 Participation in programs to safeguard personal wellbeing as well as the wellbeing of colleagues, trainees and related professionals.
- 3.8 Participation in activities to promote a positive image of the speciality to professional colleagues and to the public.

RELATED DOCUMENTS

- TE3 *Supervision of Clinical Experience for Trainees in Anaesthesia*
TE9 *Quality Assurance*
TE11 *Formal Project Guidelines*

- TE16 *Requirements for Multidisciplinary Pain Medicine Centres Offering Training in Pain Medicine*
- P4 *Guidelines for the Care of Patients Recovering from Anaesthesia*
- PS7 *The Pre-Anaesthesia Consultation*
- P9 *Sedation for Diagnostic and Surgical Procedures*
- PS10 *The Handover of Responsibility During an Anaesthetic*
- P15 *Guidelines for the Perioperative Care of Patients Selected for Day Care Surgery*
- P16 *The Standards of Practice of a Specialist Anaesthetist*
- P20 *Responsibilities of the Anaesthetist in the Postoperative Period*
- P26 *Guidelines on Providing Information About the Services of an Anaesthetist*

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AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

A.C.N. 055 042 852

POLICY DOCUMENTS

E = Educational P = Professional T = Technical EX = Examinations
PS = Professional Standards TE = Training and Examinations PM = Pain Medicine

- E1 (1996) Guidelines for Hospitals seeking College Approval of Posts for the First Four Years of Vocational Training in Anaesthesia *Bulletin Nov 96, pg 64*
- TE3 (1999) Supervision of Clinical Experience for Trainees in Anaesthesia *Bulletin Nov 99, pg 67*
- TE4 (1997) Duties of Regional Education Officers in Anaesthesia *Bulletin Nov 97, pg 88*
- TE5 (1997) Supervisors of Training in Anaesthesia *Bulletin Nov 97, pg 89*
- TE6 (1995) Guidelines on the Duties of an Anaesthetist *Bulletin July 2000, pg 86*
- TE7 (1999) Secretarial and Support Services to Departments of Anaesthesia *Bulletin Nov 99, pg 69*
- TE9 (1999) Quality Assurance *Bulletin June 99, pg 94*
- TE11 (1999) Formal Project Guidelines *Bulletin Mar 99, pg 70*
- E13 (1996) Guidelines for the Provisional Fellowship Year *Bulletin Nov 96, pg 66*
- E14 (1994) Guidelines for the In-Training Assessment of Trainees in Anaesthesia *Bulletin Aug 94, pg 62*
- TE16 (1998) Requirements for Multidisciplinary Pain Centres Offering Training in Pain Medicine *Bulletin Nov 1998, pg 83*
- TE17 (1999) Advisors of Candidates for Anaesthesia Training *Bulletin Nov 99, pg*
- EX1 (1996) Examination Candidates Suffering from Illness, Accident or Disability *Bulletin Nov 96, pg 70*
- T1 (1995) Recommended Minimum Facilities for Safe Anaesthetic Practice in Operating Suites *Bulletin Nov 95, pg 52*
- T3 (1995) Recommended Minimum Facilities for Safe Anaesthetic Practice in Organ Imaging Facilities *Bulletin Nov 95, pg 56*
- T5 (1995) Recommended Minimum Facilities for Safe Anaesthetic Practice in Dental Surgeries *Bulletin Nov 95, pg 65*
- T6 (1995) Recommended Minimum Facilities for Safe Anaesthetic Practice in Delivery Suites *Bulletin Nov 95, pg 61*
- P1 (1997) Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia *Bulletin May 97, pg 81*
- P2 (1996) Privileges in Anaesthesia *Bulletin Nov 96, pg 72*
- PS3 (1998) Major Regional Anaesthesia and Analgesia *Bulletin Nov 98, pg 85*
- P4 (1995) Guidelines for the Care of Patients Recovering from Anaesthesia *Bulletin Aug 95, pg 64*
- P6 (1996) Minimum Requirements for the Anaesthesia Record *Bulletin Mar 96, pg 48*
- PS7 (1998) The Pre-Anaesthesia Consultation *Bulletin Mar 98, pg 73*
- PS8 (1998) The Assistant for the Anaesthetist *Bulletin Mar 98, pg 75*
- P9 (1996) Sedation for Diagnostic and Surgical Procedures *Bulletin Nov 96, pg 73*
- PS10 (1999) Handover of Responsibility During an Anaesthetic *Bulletin Nov 99, pg 62*
- P11 (1991) Management of Cardiopulmonary Bypass *Bulletin May 91, pg 43*
- PS12 (1996) Statement on Smoking as Related to the Perioperative Period *Bulletin Nov 97, pg 78*
- PS14 (1998) Guidelines for the Conduct of Major Regional Analgesia in Obstetrics *Bulletin Nov 98, pg 81*
- P15 (1995) Guidelines for the Perioperative Care of Patients Selected for Day Care Surgery *Bulletin Aug 95, pg 62*
- P16 (1994) The Standards of Practice of a Specialist Anaesthetist *Bulletin Nov 94, pg 45*
- PS17 (1997) Endoscopy of the Airways *Bulletin Nov 97, pg 80*
- P18 (1995) Monitoring During Anaesthesia *Bulletin Nov 95, pg 68*
- P19 (1995) Monitored Care by an Anaesthetist *Bulletin Nov 95, pg 60*
- P20 (1996) Responsibilities of the Anaesthetist in the Post-Operative Period *Bulletin Mar 96, pg 52*
- P21 (1996) Sedation for Dental Procedures *Bulletin Mar 97, pg 56*
- P22 (1996) Statement on Patients' Rights and Responsibilities *Bulletin Mar 96, pg 53*
- P24 (1997) Sedation for Endoscopy *Bulletin May 97, pg 78*
- PS26 (1999) Guidelines on Providing Information about the services of an Anaesthetist *Bulletin Nov 99, pg 63*
- P27 (1994) Standards of Practice for Major Extracorporeal Perfusion *Bulletin Nov 94, pg 46*
- P28 (1995) Policy on Infection Control in Anaesthesia *Bulletin Mar 95, pg 38*
- PS29 (1997) Anaesthesia Care of Children in Healthcare Facilities without Dedicated Paediatric Facilities *Bulletin Nov 97, pg 82*
- PS31 (1997) Protocol for Checking the Anaesthetic Machine *Bulletin Nov 97, pg 84*
- PS33 (1999) Recommended Minimum Facilities for Safe Anaesthetic Practice for Electro-Convulsive Therapy (ECT) *Bulletin Nov 99, pg 64*
- PS36 (1997) Sedation for Regional Anaesthesia for Ophthalmic Surgery *Bulletin Nov 97, pg 93*
- PS37 (1998) Regional Anaesthesia and Allied Health Practitioners *Bulletin Mar 98, pg 79*
- PS38 (1999) Statement Relating to the Relief of Pain and Suffering and End of Life Decisions *Bulletin June 1999, pg 93*
- PM1 (1999) Guidelines for Trainees and Departments seeking College Approval of Posts for Training in Pain Medicine *Bulletin Mar 99, pg 73*
- PS39 (2000) Intrahospital Transport of Critically Ill Patients *Bulletin July 2000, pg 84*
- PS40 (2000) Guidelines for the Relationship Between Fellows and the Healthcare Industry *Bulletin Mar 2000, pg 55*