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 management'

Inside...

Anaesthetists care

and the way we care for you is getting better

Volume 8 Number 2 June 1999

PRINT POST APPROVED – PP 381691 100040

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EDITORIAL

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

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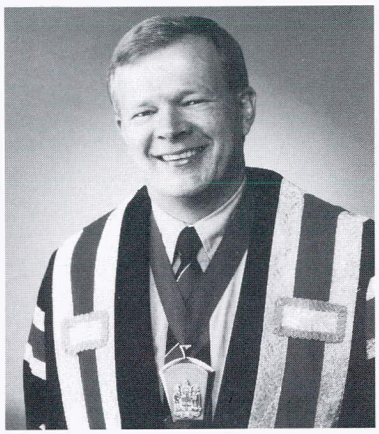
PRESIDENT'S MESSAGE



As President of the College since June last year, I have attended meetings of the Committee of Presidents of Medical Colleges (CPMC) and have served on its Executive Committee for the past six months. Our College provided the Secretariat of the CPMC up until recently (when the Committee funded its own staff, who are still based at our College headquarters). The CPMC has proven to be a highly successful conduit for communication between all Colleges and with all relevant bodies involved with training, education and standards / quality of care. Such organisations include the Australian Medical Council, the New Zealand Medical Council, Australian and New Zealand medical schools, the Australian Medical Workforce Advisory Committee, the Medical Training Review Panel, the NHMRC, various sections of the Commonwealth Department of Health, the AMA, and many others. I believe that the new workings and infra-structure of the CPMC have brought post-graduate medical specialist and vocational training (as represented by the Colleges) into a new era of rational development, consistency and transparency in the interests of constantly improving quality of medical care of the Australian and New Zealand communities. The CPMC has enabled the Colleges to respond constructively, efficiently and with greater ease to proposed reforms from government and other bodies.

The prime focus of the College has always been on training, education and standards. This will never change. New developments in these areas, prompted by improved communication and cooperation with other Colleges, will see or are seeing ANZCA developing programs to train clinician educators, supervisor and mentor training, management seminars for Department clinical administrators, and courses on interviewing techniques for selection of trainees and those seeking higher positions. Guidelines are being constructed on the difficult topics of competence and, more importantly, incompetence assessment, particularly as the state Medical Boards are inviting College guidance. Finally, the Australian Medical Council is likely to take over the functions of the now defunct National Specialist Qualification Advisory Committee (NSQAC), which has implications regarding the difficult area of overseas trained specialists assessment by Colleges and the possibility of accreditation of the processes (not content) of training of specialists by Australian and New Zealand Colleges. A similar system of accreditation of university medical schools in Australia and New Zealand has successfully and very benignly been in place for over a decade.

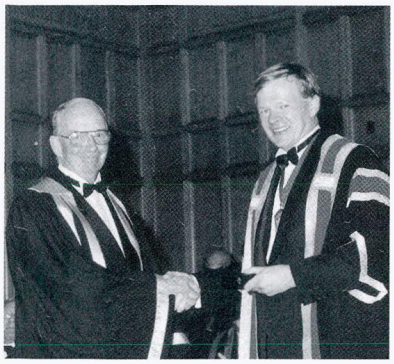
All the above outlines but some of the essential and perhaps less exciting activities of the College and its Council over recent times. Myriads of workshops, meetings and seminars have been attended, and many submissions, responses and presentations have occurred on behalf of ANZCA. A few key representatives of the College make enormous efforts on these issues in the interests of Trainees, Fellows and our professions generally. I state all this because I sometimes feel that many do not always appreciate the value of their College subscription, the work done by their College and the absolute need for our professions to be actively involved in matters as they arise. I can only respond with the above words, the fact that the College provides a great many other services, and that Councillors and Regional Committee members are elected in open ballots giving all Fellows the opportunity to have an ultimate say in future directions.

There are many other issues which I would like to personally address in this message but most have been noted in other pages of this publication. I urge you to carefully read them and keep yourself informed and interested in College affairs. I welcome comments and constructive (even destructive!) criticism on College issues by writing to me.

I finally congratulate the Organising Committee of the recent 1999 Annual Scientific Committee in Adelaide on the brilliant success of that conference. I particularly welcome the involvement of the new Faculty of Pain Medicine of our College. There is no doubt that through the cooperative efforts of ANZCA, ASA, NZSA, ANZICS and other organisations, we in Australia and New Zealand provide an enviable record of the greatest continuing education meetings for our various specialties.

Richard Walsh

RICHARD WALSH
President



Australian and New Zealand College of Anaesthetists Medal

Citation – William Rayner Fuller

"The Australian and New Zealand College of Anaesthetists Medal is awarded at the discretion of the Council of the College in recognition of major contributions to the status of Anaesthesia, Intensive Care or related specialties."

Mr President I have the honour to present to you Dr William Rayner Fuller for the award of the Australian and New Zealand College of Anaesthetists' Medal.

Bill is a native of Adelaide and commenced his medical training in 1947. He graduated in 1952 and after residency jobs at the Royal Adelaide Hospital and the Adelaide Children's Hospital, he embarked on a career in general practice.

During this time he married Jocelyn Ewart and also followed an active sporting career. He represented the State in Baseball and won the Capps Medal in 1951 for the best player of that season. He also played district cricket being, by his own admission, one of the best chuckers of his time.

He combined full-time general practice with a major anaesthetic commitment, an extremely demanding combination. Fortunately for the specialty he decided to follow a career purely in anaesthesia. He commenced formal anaesthetic training and passed his specialist examination in 1968. He then broadened his experience by packing Jo and their three children off to England where he worked as a Senior Registrar in Anaesthetics in the Hammersmith Hospital between 1969 and 1971.

He returned to Adelaide where, in 1972, he established the Intensive Care Unit in the Queen Elizabeth Hospital. Ironically, his work commitment had not really changed from those earlier days with his being the sole specialist in the Unit. By dint of his usual enthusiasm and energy he was able to develop, over the next ten years, a modern well-staffed unit, while still spending a day every week in Anaesthesia.

He returned to full-time anaesthesia in 1982, becoming Senior Director of Anaesthesia in the Queen Elizabeth Hospital. Under his leadership, the Department was successful professionally and socially, and excellent education was provided not only in Anaesthesia, but also in wine appreciation.

Bill was actively involved in College activities, serving on the Regional Committee for 15 years from 1974 to 1989, chairing the Committee from 1977 to 1980. In addition, he was an Office Bearer for the Australian and New Zealand Intensive Care Society in South Australia between 1978 and 1981, and Regional Education Officer in Intensive Care from 1979 to 1982. Bill has maintained an extensive commitment to rural anaesthesia in South Australia, acting as a resource person particularly to those GP anaesthetists in the more remote areas of the State. He has continued this commitment despite leaving full-time anaesthesia, and remains the representative of the Regional Committee on the Clinical Privileges Advisory Committee of the Far Western Region.

Bill would be long remembered in South Australia for these achievements alone, but a further achievement must be emphasised. He served as Chairman of the Anaesthetic Mortality Sub-Committee in South Australia from 1987 to 1998. He also served nationally on the Anaesthetic Mortality Working Parties of initially the NHMRC, and subsequently ANZCA. These were volatile times for Mortality Committees in this State, with continually fluctuating circumstances and major obstacles presented by the Governments and bureaucracies of that time. At all times, Bill showed dogged persistence combined with cool decorum to bring us ultimately to a situation which is precisely what had been sought. It speaks volumes for the trust the Anaesthetic community has for him that, even at those times when the Committee was in abeyance, and confidentiality could not be guaranteed, anaesthetists continued to provide him with mortality information. Without Bill, anaesthetic mortality review in this State would have collapsed totally. It is Bill Fuller we have to thank for the current Perioperative Mortality Committee with its significant surgical input, together with the recently published five year report.

Such is his popularity and standing with all of these achievements that for his retirement dinner in 1995, the Bradman Room at the Adelaide Oval was filled. All of us in this State owe a debt to "Uncle Bill".

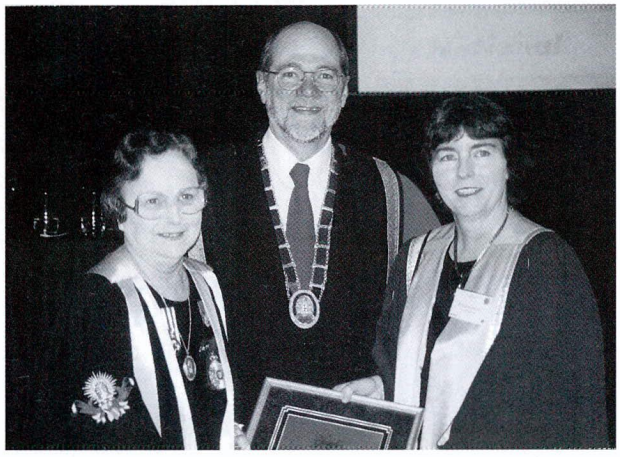
Mr President, I have the honour to present to you **WILLIAM RAYNER FULLER** for the award of the Australian and New Zealand College of Anaesthetists Medal.

ALAN RAINBIRD
RICHARD WILLIS

WOMAN IN MEDICINE, 1999

PROFESSOR EMERITUS TESS CRAMOND

by EDDIE DEAN
College Communication Consultant



1999 "Woman in Medicine" Award – left to right: Professor Emeritus Tess Cramond, Dr David Brand, AMA President and Dr Eileen Burkett, Chair, AMA Women and Medicine Committee.

The Australian Medical Association's Woman in Medicine Award for 1999 has been presented to Emeritus Professor Tess Cramond, AO, OBE, at a ceremony in Canberra.

The Woman in Medicine Award is given to an AMA member who has made a major contribution to the medical profession in fields such as commitment to quality patient care, medical research, initiation and involvement in public health projects, and improving availability and accessibility of medical education and medical training for women.

It is only the second year the AMA award has been made. The inaugural recipient of the Woman in Medicine Award was Professor Priscilla Kincaid-Smith.

The citation with the 1999 award said:

> "Professor Cramond, from Brisbane, is known throughout Australia and overseas for her role in anaesthesia, pain medicine and resuscitation, and as Foundation Professor of Anaesthetics and Senior Anaesthetist at the Kenneth G Jamieson Neurosurgical Unit at the Royal Brisbane Hospital.
>
> Her significant contributions have been in medical education, particularly of undergraduates and anaesthetists-in-training, and in pain research.
>
> She has been actively involved in community education in resuscitation through Surf Life Saving Australia, which has made her an Honorary Life Member of Red Cross, the State Electricity Commission and other organisations for almost 40 years. Her role in the Australian Resuscitation Council, of which she is Honorary Consultant, has been long-standing and pivotal. With the rank of Colonel she served as Consultant to the Army Office.
>
> In 1967 she established the Multidisciplinary Pain Centre at the Royal Brisbane Hospital and she is still its Director. The Inaugural Chairman of the Palliative Care Association of Queensland, she has encouraged the development of palliative care services.
>
> Tess Cramond is a Fellow of the Australian and New Zealand College of Anaesthetists and a Past Dean of the Faculty of Anaesthetists, RACS, a Fellow of the Faculty of Pain Medicine, a Fellow of the Royal College of Anaesthetists, and an Honorary Fellow of the Irish Faculty and a Member and former Honorary Federal Secretary of the Australian Society of Anaesthetists.
>
> She is a Fellow of the AMA and a Past President of the Queensland Branch."

Professor Cramond's many interests and achievements outside anaesthesia are typified by her commitment to the teaching of resuscitation techniques in the community.

Her long commitment to Surf Life Saving Australia included the "grass roots" teaching of resuscitation to lifesavers in the Club House, as well as the development of policy and the publication of training manuals.

As she did in so many other areas of her work, she "enthused" others, including many anaesthetists, to become similarly involved at the local lifesaving clubs and the Surf Medical Advisory Committees.

In 1960, Tess Cramond and another anaesthetist, the late Roger Bennett, demonstrated on four volunteer lifesavers, who were anaesthetised and paralysed, that it was possible to keep them alive with "mouth-to-mouth" resuscitation.

Doctors, nurses, first aiders as well as lifesavers were instructed in expired air resuscitation and the use of the Ambu bag.

The successful demonstration proved not only the efficacy of expired air resuscitation but also the feasibility of teaching it in the community – and surely the faith the lifesaving fraternity had in Roger Bennett and Tess Cramond.

The Australian Resuscitation Council (ARC) was formally established by the Royal Australasian College of Surgeons (and its then Faculty of Anaesthetists) in 1976. Its principal role is to ensure that the highest standards and most effective techniques of resuscitation are adopted and practised by all relevant specialists and government and community organisations in Australia.

Tess Cramond, who was among those at a Sydney Opera House meeting that decided to form the Council, became its first Deputy Chairman. The record shows that her commitment and dedication were significant factors in ensuring the Council's on-going development. For 12 years, she travelled regularly between her hometown of Brisbane and Melbourne, where the Council (and the RACS) has its headquarters. She was accompanied by her secretary, Maree Campbell, who assisted in the Council work.

A legendary suitcase ("later two suitcases", Maree Campbell says) was the Council for many years, as papers and records travelled back and forth with Tess Cramond and Maree Campbell. Today, the ARC – in the formation of which Australia was ahead of Britain and Europe – has international standing.

According to the book "Portraits in Australian Health" (John Best, publishers MacLennan and Petty, Sydney, 1988) there are interesting historical elements to Tess Cramond's involvement in anaesthesia and resuscitation.

Training in anaesthetic flows naturally enough through to an interest in resuscitation in the community and an efficient ambulance service. But there is a more direct historical connection. Her grandfather and her uncle were involved in the foundation of the Ambulance Service at Pialba, a small Queensland town about 250 km north of Brisbane and were Honorary Ambulance Bearers. "There the first two-wheeled stretchers or Ashford litters were man-powered through the streets."

Another interesting coincidence lies in the fact that Tess Cramond appears to have first focused on anaesthesia as her possible career choice in medicine in Launceston, northern Tasmania, where during a student elective she attained proficiency in venepuncture and lumbar puncture, skills which were to be invaluable in her first rotation as an intern – anaesthetics. It was in Launceston of course, on 7 June 1847, that Dr William Russ Pugh administered what is acknowledged as Australia's first anaesthetic for a surgical procedure.

A graduate of the University of Queensland, Tess Cramond's career has seen her practise in the United Kingdom, the USA and New Guinea. Today she continues what has always been a special commitment to her home state of Queensland, where she maintains an active involvement in a wide range of community organisations outside her busy professional commitment.

In 1988, Tess Cramond received one of many awards over the years, the then Faculty of Anaesthetists' Robert Orton Medal, awarded for distinguished services to anaesthesia. The citation referred to her "apparently inexhaustible energies".

The Faculty of Anaesthetists, Royal College of Surgeons (now the Royal College of Anaesthetists) similarly honoured her with its Faculty Medal in 1983 – the only Australian to receive it.

She has been the recipient of Distinguished Service Award of Australian Red Cross and the Institute of Ambulance Officers Australia elected her to Honorary Membership.

ANZCA President, Dr Richard Walsh, warmly welcomed the AMA's choice of Professor Cramond for its Woman in Medicine Award, 1999.

"The Award is a fitting tribute to her long and tireless contribution to the high quality and standards of anaesthetic services in Australia," Dr Walsh said. "She has achieved respect nationally and internationally for her contributions to anaesthesia and pain medicine, and extended her professional expertise into the wider community by her active involvement in resuscitation teaching. Her work has helped make our streets and beaches that much safer. Tess Cramond's commitment to improving anaesthesia, resuscitation and pain medicine services has long been recognised by her peers, and the AMA's Woman in Medicine Award is further acknowledgement of her significant contribution to her specialty and far beyond," Dr Walsh said.

Examination Prize Winners

The **Renton Prize** for the period ending 30th June 1999 was awarded to

Dr Tyron Robert Crofts (Vic.)

The **Cecil Gray Prize** for the period ending 30th June 1999 was awarded to

Dr Anthony Neville Coorey (Qld)

Dr Coorey was also awarded the Renton Prize at the April 1996 Primary Examination

Rural Anaesthetic Recruitment Service

The Rural Anaesthetic Recruitment Service (RARS) is a collaborative venture between the College and the Australian Society of Anaesthetists. The spirit of co-operation of the two primary professional bodies of Anaesthesia in Australia has occurred to solve some of the unmet needs of rural practitioners and subsequently rural citizens.

For some time the ASA's Locum List has been unable to meet the needs of rural practitioners.

Some 32% of Australians live in rural areas serviced by only 14% of the anaesthetic community. The national press has many stories of medical staffing shortages – principally GPs, but significant specialist parallels exist. The Federal Government and many groups including the Committee of Presidents of Medical Colleges are keen to explore solutions to this staffing difficulty.

RARS was established to assist rural areas to fill vacancies, not only long term positions, but also the full spectrum to locum tenens. RARS has been established with the assistance of a Federal Government grant to the College from the Rural Health Support Education and Training (RHSET) program.

RARS will act to facilitate contact between "Anaesthetists looking for jobs" and "Jobs looking for Anaesthetists". RARS is aimed at not only specialists, but also JCCA registered GP Anaesthetists.

RARS will be a broker between all parties while keeping each group informed about the market situation so realistic working conditions can be arranged. To this end information gathered will be passed between all parties, but the final negotiations will be conducted directly between the Anaesthetist and the potential Employer.

RARS will also be involved to promote Rural Practice as a career choice aimed at all levels of training. RARS also intends to determine rural workforce needs as well as attempting to determine other needs of rural practitioners.

The RARS will need to be in frequent communication with all parties to maintain an up to date database. The preferred contact medium is email as it is quick, cheap and rapidly spreading: rars@anzca.edu.au.

If you are interested in a rural career ranging from long term, intermediate or locum tenens, please respond to our expression of interest.

DARYL CATT
Chairman
Rural Anaesthetic Recruitment Service

New Chair in Anaesthesia

Western Australia finally established an Inaugural Chair in Anaesthesia, some years behind the other mainland States. The Chair is in the Department of Pharmacology, University of Western Australia, and is based at Royal Perth Hospital. Perth anaesthetists headed by Dr Aileen Donaghy were instrumental in establishing the Chair, and the University has appointed Professor Teik Oh. Professor Oh graduated from the University of Queensland, and after training in Australia and UK, was appointed Director of Intensive Care at The Canberra Hospital, ACT, and then at Sir Charles Gairdner Hospital in 1976. In 1988, he took up the Chair of Anaesthesia and Intensive Care in Hong Kong, where he also served as Sub-Dean Medical Education and Dean of Medicine, Nursing and Pharmacy. He is a Fellow of ANZCA and the Faculty of Intensive Care, the Royal College of Anaesthetists, and the Colleges of Physicians. Professor Oh became a College Councillor in 1995 and is the current Vice President and QA/MOPS Officer. He is married to Lala and they have a daughter Kazia studying Law, and a son Stefan in Year 12.

LAW REPORT

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

CORONIAL REFORM

In the last issue of the Bulletin, provisions of the Coroner's Act 1985 were reviewed. It noted that, in most other States and Territories (including New Zealand), the Coroner has an ability to find that a doctor has contributed to death, but is under no obligation to do so - particularly where simple negligence, or an adverse event or outcome, is involved. However, in Victoria, there is an obligation for the Coronial to make such findings, and a Coroner must name a doctor who may have contributed to the death of a person (even though there may be no negligence,or other serious fault or blame).

The consequences of such a finding are, of course, enormous. The reputation, standing and future prospects of the doctor would be affected. The stress on the doctor and his or her family would also be substantial.

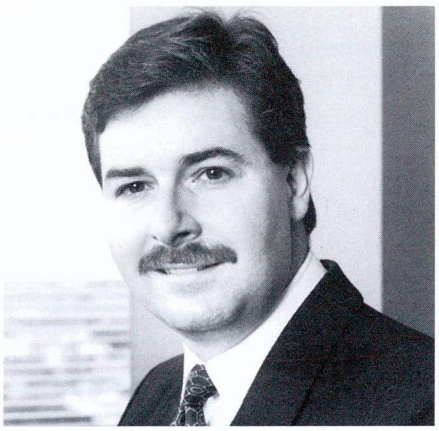
There has been reasonable debate of these provisions and the Victorian Government has recently introduced amending legislation, the Coroner's (Amendment) Bill 1999, which abolishes the mandatory obligation of the Coroner to name any contributor to the cause of death.

The removal of this obligation does not mean that a Coroner can avoid stating whether a person contributes to the death of another. The Coroner must still make findings as to how the death occurred and the cause of death.

However, the Coroner will have some greater freedom in framing the findings to reflect the circumstances of any particular case. It is to be hoped that this will lead to fairer reporting of the findings from an inquest, a more appropriate accounting of the facts and a more corrective coronial system.

Other reforms contained in the proposed legislation include providing the Coroner with power towards costs against individuals or legal practitioners whose conduct delays an inquest. The Victorian Coroner will also have the ability to declare findings of an inquest void in particular circumstances.

This is welcome reform that addresses a very important issue for doctors and others participating (whether willingly or unwillingly) in coronial proceedings. It minimises the harm to doctors' reputations, which might have unfairly followed.I am grateful to Victor Harcourt, one of my partners at Russell Kennedy Solicitors, a health law litigation expert, for the following contribution:-



DOCTORS DUTY TO A THIRD PARTY – MEDICAL REPORTS AND EXAMINATIONS

A doctor may be engaged by a third party (not the patient) to conduct an examination and provide a medical report in respect of a person outside the traditional doctor/patient relationship in a number of different settings and for a variety of reasons. These include for pre-employment examinations, life insurance medicals and for social security purposes.

The duty of care the doctor may owe to the examinee for the contents of the report, and by implication the examination and assessment, is a contentious issue. There are at least two aspects of the relationship calling for the exercise of professional skill and care:-

1 A doctor owes to the examinee a duty of confidentiality in relation to any confidential information disclosed or ascertained in the course of the examination (subject to the implied or express consent to disclosure to the third party for the purposes for which the examination was undertaken).

2 A doctor also owes a duty to the examinee not to cause injury during the course of the examination.

Beyond this there is considerable uncertainty as to whether a doctor may owe to an examinee a duty to inform him or her of the existence of any significant medical conditions found during

the examination. On the current state of the law there does not appear to be any positive obligation imposed upon the doctor to disclose to the examinee any information about the latter's health, even of a significant nature, in the absence of what may be "an assumption of responsibility" by the doctor to provide such disclosure.

The debate has, however, re-surfaced in the light of two recent cases in England. In the first case of *Baker v Kay [1997] IRLR 219*, the Court found that a doctor conducting a pre-employment medical examination for a prospective employer for the purposes of considering the job application, owed a duty to the examinee to take reasonable care in carrying out the assessment and preparing the report.

The plaintiff, Mr Baker, was a television sales executive who received an offer to take up a senior appointment from a major company, just three weeks after commencing a new position with another company. The offer was subject to a satisfactory medical report from Dr Kaye, an independent doctor retained by the company as a medical adviser. Not anticipating any adverse findings, Mr Baker resigned from his position prior to meeting with Dr Kaye. Dr Kaye performed the medical examination, including blood tests which suggested alcohol-related abnormalities. After ascertaining from the company the nature of the position being offered to Mr Baker, and being aware of the company's low tolerance for employees whose alcohol intake could reflect unfavourably on it, Dr Kaye arranged to see Mr Baker again.

At the second consultation Dr Kay informed Mr Baker of the test results and asked a number of questions concerning Mr Baker's drinking habits. Mr Baker was guarded in his responses and defensive. Dr Kaye took a second blood test and assessed the results as confirming the first results. Dr Kaye advised Mr Baker's treating doctor of the results and informed the company that he could not recommend Mr Baker for a stressful position that required regular travel and business related entertaining as in his opinion Mr Baker was likely to drink excessively.

After receiving Dr Kaye's report the company withdrew the offer of employment. Mr Baker also undertook further blood tests over a period of 4 weeks which disclosed improvements in the results. Mr Baker commenced proceedings against Dr Kaye for the negligent mis-statement of Dr Kaye.

The Court did not find that Dr Kaye had acted negligently as the evidence suggested "that a substantial body of reasonable medical opinion would have arrived at the same conclusion when interpreting the results". **BUT** the Court did find that in the circumstances of this case, Dr Kaye owed Mr Baker a duty to take reasonable care in carrying out the medical assessment, and in making his judgment.

The Court identified three key features of the relationship which indicated sufficient proximity to give rise to a duty to take care:-

- Dr Kaye was aware of the consequences of his report;
- Mr Baker provided confidential information to Dr Kaye, which was not to be disclosed to the company; and
- Dr Kaye regarded himself as under a duty to inform Mr Baker to seek medical advice if the assessment revealed any indication of a medical condition for which he required medical treatment or advice.

The Court also held that it was fair, just and reasonable to impose the duty, there being no conflict between Dr Kay's duty to the company or to Mr Baker.

This case has, however, been disapproved by the English Court of Appeal in *Kapfunde v Abbey National plc [1998] IRLR 583*. In this case, Mrs Kapfunde was temporarily employed by Abbey National plc and applied for a permanent position. She disclosed in a medical questionnaire submitted with the application that she suffered from sickle cell anaemia. The questionnaire was given by the company to a doctor retained by it, Dr Daniel, who assessed Mrs Kapfunde as not suitable for employment as she was likely to have a higher than average level of absence from work.

Accordingly, the company rejected the application and Mrs Kapfunde commenced the proceedings for the negligent assessment. At first, the claim was dismissed on the basis inter alia there was no sufficient proximity between the parties and it would not be fair, just or reasonable to impose such a duty, nor was there any breach of such a duty if it existed.

The Court of Appeal agreed, finding that Dr Daniel did not owe a duty of care to Mrs Kapfunde as claimed in the circumstances of this case. Lord Justice Kennedy noted at the outset three factors significant to distinguish this from other cases. They were, firstly, that there was no doctor/patient relationship; secondly, the employer did not owe a duty to exercise skill and care in the processing of job applications; and thirdly, the claim was only for economic loss.

Two of the judges made a clear statement of disapproval of the decision in *Baker v Kaye*. Lord Justice Millett observed that in his opinion:-

> "The critical facts are that the applicant is required by the prospective employer or insurer to submit himself to medical examination by a doctor who is instructed by the employer or insurer to advise it and not the applicant. The advice is given to the employer or insurer and not to the applicant, who is a patient only in the sense that he is the subject of the examination and advice. The doctor is taken to assume responsibility for his advice, but only to the employer or insurer who commissioned it and not to the "patient" who is the subject of the advice."

Both of these cases contain strong views concerning the obligations owed by a doctor to an examinee that he or she may

be required to examine. They are peculiar to their facts, both cases relating to claims for economic loss, a category of claim that often meets judicial reluctance. As perhaps a sign of the continuing uncertainty as to whether a doctor may owe a duty to an examinee where the failure to inform of a medical condition may lead to physical injury is the admission of the defendant in *R v Croydon Health Authority [1998] 40 BMLR 40.*

The Authority admitted that a doctor employed by it owed a duty to exercise all reasonable care and skill in the interpretation of the pre-employment X-ray to an examinee and to inform her of a significant medical condition found on examination. The medical examination was conducted in support of an application for employment with the Authority. The failure to inform caused, so it was found, personal injury to the plaintiff.

There is scope for a creative plaintiff to argue that a doctor, in all the circumstances, owed a duty to warn of any significant medical conditions that were found during the examination, event if that person was never a patient and the doctor was retained by a third party. The argument becomes stronger where a doctor has taken steps that a Court may infer as "an assumption of responsibility" in respect of the examinee.

We have seen a definite move to widen the liability of doctors to examinees in America, and a possible crack in England. In Australia, the legal landscape may prove even more accepting of a claim against the doctor by a non-patient than in England. It may therefore be prudent for a doctor conducting third party medical examinations to **require the examinee to sign a disclaimer of responsibility** to minimise the risk of litigation.

Disciplinary Action by Committees - The Need for "Natural Justice"

Michael Gorton – Honorary College Solicitor
Partner, Russell Kennedy, Solicitors

If someone had made allegations against you, how would you wish the College to deal with you in any proposed disciplinary proceedings?

When you were a trainee, or potential trainee, would you have expected the College to deal with you fairly in selecting you for training or considering your removal from the training program?

Obviously, decisions made by the College and its committees have dramatic and significant affect on the lives of individuals. Decisions made by the College affect the future and livelihood of individuals.

It is for these reasons, that the professions generally are seeing an increase in the threat of litigation against their decisions on matters of training and discipline.

Just as the Olympics have seen an increase in resort to legal action - whether it is drug-testing results or selection for particular events - so too, professionals are prepared to resort to legal measures where their career and livelihood are under threat.

There are a number of circumstances in which the activities of officers and committees of the College may be the subject of legal review. These include:-

1 The selection of trainees.
2 The removal of trainees from a training program.
3 Discipline of Fellows in general.

Each of these procedures have particular bodies or committees to deal with them, and operate under different rules and regulations. For example, the selection of trainees is usually conducted by the Specialty Board, in accordance with the guidelines and criteria stipulated by the College in its handbook to trainees. The discipline of Fellows generally, is dealt with pursuant to the Articles of Association of the College and any regulations made by the College Council.

Any decision of the College, or an officer or committee of the College is also subject to review by the Appeals Committee, which has been established by the College pursuant to its regulations.

Each of these committees and bodies is, to some extent, subject to legal rules and principles, including the possible application of the rules of "natural justice".

It is not unusual, when an individual has had a decision made contrary to their interests, to have their lawyer scream that the decision was a "denial of natural justice". In many cases, the mere utterance of the words are intended to strike fear and terror into the hearts of the committee or body making the decision. In fact, there should be nothing mysterious about the rules governing "natural justice", since they accord with common sense and fairness. In addition, they do not always apply.

For example, the rules of "natural justice" are extremely limited in relation to the selection of trainees, where a committee is

selecting a number of trainees in a competitive selection process. The rules of "natural justice" are more likely to apply where some allegation is made against a particular individual, where some harm or disciplinary action is likely to be taken against an individual, or where some rights of a particular individual are affected.

The general principles underlining "natural justice" are as follows:-

Appropriate Notice

It would seem fair to most people that, where the rights of an individual are affected, the individual should have notice of any hearing and have the opportunity to put their views. This right is one of the fundamental principles underlining "natural justice".

Appropriate notice should be given to the individual, setting out in general terms the nature of the hearing or meeting, the substance of any particular allegations being made against the individual, and the evidence or factual material upon which the committee or body proposes to rely.

The notice should be given to the individual in sufficient time to enable the individual to consider the material and prepare submissions.

Obviously, the more damaging or important the allegations, or the more severe the likely punishment or consequences, then the more detail will be required of the allegations.

If the individual does not believe that he or she has had ample opportunity to prepare for a hearing, it may be important to adjourn the meeting for a period of time to permit the party to properly prepare their case.

In cases where trainees are being selected competitively, there may still be "allegations", or at least adverse material relevant to a candidate, upon which the relevant board or selection committee may base their judgment. It would be fair for the candidate to have any adverse material put to them, so that they could adequately respond and give any explanation that may be available.

Relevance

No matter what the particular activity of the board or committee, only material relevant to the actual decision required should be considered by the board or committee.

It will come as no surprise to some to hear of times past, where boards or committees, when selecting trainees, took into account a range of factors that many today would regard as completely irrelevant to the decision of whether to admit a trainee to a training program. Certainly, in more recent times, legislation ensures that circumstances such as race, religion, gender and a range of other grounds can form no part of a decision regarding trainees, or in relation to any disciplinary action.

Whilst not covered by legislation, presumably we would also consider the chosen football team supported by candidates to be an irrelevant factor, as much as whether their hobbies included opera or macrame!!!

The simple principle is that the selection committee or the disciplinary committee should confine their considerations to material relevant to the decision at hand. They should not permit consideration of irrelevant material, and where irrelevant material is presented, it should be made clear that it is not being considered or relied upon in any way.

Bias

A selection committee or disciplinary committee must be free of bias. That is, the membership of the committee should not include any person previously having taken part in any substantive decision affecting the individual, and should not have any relationship with the individual (whether family or otherwise), which would preclude them dealing with the matter with an open mind.

Again, common sense would dictate that the relevant committee should operate impartially and without prejudice, and most importantly, to be seen to be so.

Pre-judgment

Similar to the question of bias, is the question of whether the committee, or any member of the committee, has previously made a decision about the individual, which would suggest that they have already pre-judged the issue. For example, a committee member who has carried out an investigation of an individual and may have prepared an investigative report and given a recommendation to the committee, could then not sit as a committee member to determine the committee's view of the matter.

This does not mean that the committee cannot delegate particular tasks of the committee to a smaller number, or to particular individuals. However, a committee member cannot have been part of a former process where some judgment was already made regarding the suitability or otherwise of a candidate, or whether disciplinary proceedings were warranted or not.

Procedure

Most of the procedures of these boards and committees remain relatively informal.

However, members of such committees should make themselves aware of any particular requirements, either under the College's rules or regulations, or the principles of "natural justice" generally, so that any necessary requirements can be observed.

There is nothing wrong with informality, so long as any required procedures have been adequately taken into account.

For example, it would be important for each board or committee to determine upon what criteria a decision is to be made before proceeding to deal with the matter.

Additionally, in relation to disciplinary procedures, it might be considered that the individual against whom allegations are made, should be permitted professional legal representation. In most of the disciplinary procedures in which the College is involved regarding disciplinary actions, the individual has been permitted to have legal representation present to advise, but not to act as an advocate. The rules establishing the College Appeals Committee permit legal representation at the discretion of the Committee itself.

Obviously, the more important the outcome of the proceedings, the more formality may be required. For example, disciplinary proceedings which may remove Fellowship from an individual, or proceedings akin to a hearing by a medical board, where a licence to practice may be removed, will require a greater degree of formality and structure.

Rules of Evidence

The College's committees are not bound by formal legal rules of evidence, unlike courts. They are entitled to hear material from any source, and determine themselves what weight to place on the material.

Obviously, committees should avoid placing any or too much weight on information from anonymous parties, or information which is second or third hand. Similarly, opinions should be regarded merely as such, unless the person forming the opinion is entirely qualified to have their opinion respected.

Again, without formal rules, evidence to be considered must nonetheless be relevant to the issue at hand, as previously noted.

Defamation

Normally, in relation to disciplinary proceedings particularly, the parties directly involved will not be subject to the ordinary laws relating to defamation. It is said that the protection of "privilege" against defamation applies to these proceedings. This would also extend to material prepared prior to and for the committee's deliberations, such as statements of witnesses and report providers.

However, statements made by individuals which go beyond what is strictly necessary for the proceedings, may lose protection from defamation, particularly if it is mischievous or malicious.

Thus, whilst there is some protection against defamation involved in these proceedings, participants should still deal only with relevant matters and not stray into character assassination or clearly irrelevant material.

Appeals

Because the College has its own appeal process, any decision of a selection committee or disciplinary committee may be subject to review by the Appeal Committee.

There are specific grounds upon which appeals can be made.

An appeal must be made within six months of being notified of the relevant decision against which the appeal is lodged. The appeal can only be made on one or more of the following grounds.

- *New material not available or considered when the original decision was made.*
- *An error in law or in process.*

The Appeals Committee consists of College Fellows (not involved in the specialty to which the appeal relates), as well as distinguished non-Fellows.

The College Secretary and the Honorary College Solicitor assist the Appeals Committee with its hearings and processes.

The Appeals Committee can consider all relevant information which it thinks fit, and may invite any person to appear before it to provide information. The person lodging the appeal has the right to appear before the Committee and make submissions, but is not entitled to be legally represented, unless the Appeals Committee consents. Normally, the Appeals Committee permits legal representation to advise, but not to act as an advocate.

The Appeals Committee has a broad power to review a decision of a Committee or College Officer. The Appeals Committee may confirm the decision, revoke the decision, refer the decision to a relevant board or committee for reconsideration, or replace the decision with its own, as it thinks fit.

Once the College's appeal process is exhausted, of course, individuals have their ordinary rights at law to seek review before the courts.

DEATHS

Council noted with regret the death of the following Fellows:

Dr George M. Davidson, NSW – FFARACS 1953, FANZCA 1952
Dr George D Robinson, Vic – FFARACS 1956, FANZCA 1992

HONOURS AND APPOINTMENTS

Congratulations were extended to the following Fellows:

Professor T E Oh, WA – Inaugural Chair of Anaesthesia, University of Western Australia
Professor Tess Cramond AO OBE, Qld – 1999 AMA Woman in Medicine Award
Dr Stephen Gatt OAM, NSW – Member of the Royal Australasian College of Medical Administrators
Dr Roderick McRae, Vic – Appointed to the AMA Executive as Chairman of Council
Dr Phil Harrington, Qld – Chairman, State Branch, AMA Queensland
Associate Professor John Overton, NSW – OAM (Medal of the Order of Australia)

Presenters at the CME Meeting held at Freycinet Lodge, Tasmania

Drs Roman Kluger, Vic., Colin Royce, Vic., Margaret Walker (Chairman of Regional Committee), Richard Walsh (College President), Luke Calligan, Tasmania and Richard Waldron (Convenor of the Meeting)

PRIMARY EXAMINATION COURT APRIL, 1999

Front L to R: Drs Paul Myles, Ted McArdle, Rob Henning, Neville Gibbs (Acting Chairman), Miss Karen Monette, Administrative Assist. (Examinations) and Miss Cherie Wilkinson, Administrative Officer (Assessments and Examinations)

Back L to R: Drs Malcolm Futter, Jim Love, Terry Loughnan, Alan McKenzie

HIGHLIGHTS OF JUNE 1999 COUNCIL MEETING

WELCOME

The President welcomed Mr Bruce Barraclough, President of the Royal Australasian College of Surgeons, who attended the Friday sessions of the Council Meeting. Historically, in addition to RACS representatives, the President of that College attended and reported to the meetings of the Board of Faculty of Anaesthetists. This provided an opportunity for the Board to have discussions of mutual interest to both organisations with the President. Mr Barraclough's attendance at the Council meeting was the first such attendance by a RACS President since the establishment of the College. Council was most grateful for this opportunity and expressed great interest in discussions on various matters with Mr Barraclough.

In line with Council policy for Regional Committee Chairmen to attend Council meetings on a rotational basis, Dr Leigh Coombs, Chairman of the Western Australian Regional Committee, was also welcomed to the meeting.

EDUCATION

Australasian Association of Simulator Centres

Council resolved that the Australasian Association of Simulator Centres be invited to consider the formation of a Special Interest Group under the Generic SIG Constitution of the Anaesthesia Continuing Education Coordinating Committee (ACECC). It was considered that such Special Interest Group would provide a cohesive group of people in various areas to advise on participation and highlight the benefits of involvement for anaesthetists and trainees in Skills Laboratories.

Directory of Training

Following communication with approved hospitals, a database highlighting areas of interest in particular hospitals has been distributed to all departments and trainees and will be published on the College website to enable Provisional Fellows to identify hospitals where they may wish to obtain experience in particular sub-specialties.

Clinical Practice Guidelines – Pilot Study

Following the establishment of the NHMRC "Guidelines on Acute Pain Management", the Education Committee has recommended that the College establish a pilot study to consider Clinical Practice Guidelines on Preoperative Management. The pilot study will be coordinated by Professor Oh and will include two representatives nominated by each Regional Committee and the New Zealand National Committee. Invitations have been forwarded to the Regional Committees and the New Zealand National Committee seeking nomination of representatives to this pilot study. It is envisaged that this study will be a long term project examining all implications of budget, time and facilities involved in such production and finally presenting a general Position Paper.

Publication – "Anaesthesia – A Rewarding and Challenging Career"

The publication "Anaesthesia – A Rewarding and Challenging Career" for undergraduates has been reviewed and reprinted. Stocks have been forwarded to the various Regions for distribution at undergraduate workshops. Copies are available from the College Headquarters upon request and on the College Website.

EXAMINATIONS

Examination Dates for 2000

Examination dates for the year 2000 have been approved. In view of the timing of the Olympic Games, the oral section of the Final Examination will be held in Sydney from 14-16 April and in Melbourne from 25-27 August, 2000.

CONTINUING EDUCATION AND QUALITY ASSURANCE

Annual Scientific Meetings
Council resolved to grant retired Fellows complimentary basic registration for the Annual Scientific Meetings which includes attendance at all Scientific Sessions. Retired Fellows will be most welcome at all social functions, however, they will be required to fund such attendance.

ASM 2000 – Melbourne
Dr Ian Rechtman was appointed Councillor to this Meeting

INTERNAL AFFAIRS

Rural Health Support, Education and Training (RHSET) Program Grant
The College has received a RHSET Grant for $120,000 to establish a Rural Anaesthetic Recruitment Service. This initiative is in collaboration with the Australian Society of Anaesthetists. An Administrative Officer will be appointed shortly to develop and administer the project.

Change of Date of June 2000 Council Meeting
As the 12th World Congress of Anaesthesiology will be held in Montreal from 3-9 June 2000, the Council Meeting will be brought forward to the 10, 11 and 12 May, immediately following the Annual Scientific Meeting in Melbourne.

New Zealand Structural Review
In view of the particular nature of New Zealand as a different country involved in national matters and following the deliberations of the Working Party to consider the restructuring of the New Zealand Committee within the College, Council resolved that the New Zealand Regional Committee be renamed the New Zealand National Committee. A separate Council Agenda item will be established entitled "New Zealand National Matters" which will give an opportunity for matters of importance pertaining to New Zealand only to be considered by Council.
The Working Party is continuing to deliberate on administration and responsibility for other areas of College business within New Zealand.

Census of Fellows for Regional Committee and New Zealand National Commitee Elections
Council resolved to amend Regulation 3.17 to provide that the census relating to the number of Fellows within a Region shall be taken as at the stated closing date for the receipt of nominations for election to the Regional Committee or New Zealand National Committee.

Tribute to the late Dr Gwen Wilson
Council resolved that an occasional national lecture on anaesthetic history be established to commemorate the late Dr Gwen Wilson.

PROFESSIONAL

College Policy Documents and their Applicability to Non Teaching Hospitals
Council resolved that all College documents numbered with the "PS" prefix should be regarded as guidelines applicable to non-training public or private institutions as well as College approved training hospitals.

College Policy Documents
Council reviewed and approved the following documents which are published elsewhere in this Bulletin.
PS38 (1999) Statement relating the relief of pain and suffering and end of life decisions
TE9 (1999) Quality Assurance

INFORMATION TECHNOLOGY COMMITTEE

Special Interest Groups
Council agreed that the reports and activities of the Special Interest Groups should be published in the public domain of the College Website.

CPMC IT Committee Appointee
Dr Mike Martyn was appointed to the CPMC IT Committee. This enables ANZCA the opportunity to have input into the development and of sharing resource information, technologies and initiatives with other Colleges.

OBITUARIES

DR GEORGE DAVID ROBINSON

Victoria – FFARACS 1956, FANZCA1992

George Robinson (Robi) was born on 26 January 1921 and died on 12 March 1999. He was born in Perth and went to Wesley College in Perth. Following a year of science at the University of Perth where there was no medical school, he came to Melbourne in 1938 and completed a five-year course in medicine, graduating in 1943. He returned to the Royal Perth Hospital as an RMO for a year and then went into private general practice for four years. Following this, he went to the United Kingdom to undertake the Physicians' Course, which, fortunately for our specialty, he never completed. He then went to Germany for a six-month period as a general practitioner examining migrants destined for Australia.

George was married in London on 8 October 1949 to Elinor. After working for a period of time as a medical officer at the West Middlesex Hospital, working as a ship's doctor he returned to Australia at the end of 1950. He went into general practice in Dandenong and then in West Preston. During this period of work he was discovered to have tuberculosis and spent two years in the Heatherton Sanatorium, as well as undergoing a thoracoplasty.

Upon recovery, George worked in the tuberculosis ward at Heatherton Sanatorium where Bob Gray, who had given his anaesthetic for the thoracoplasty, encouraged him to become an anaesthetic registrar. He worked initially at the Alfred Hospital as a registrar, and then his obvious talents were noted by Kevin McCaul and he went to the Royal Women's Hospital as a full-time registrar.

Following his success in the first final examination held by the Faculty of Anaesthetists in 1956 George became Deputy Director to Kevin McCaul at Royal Women's. In 1959 he was an original partner and founder of the Victorian Anaesthetic Group. He then followed Pat Mackay as Director of the then Footscray and District Hospital, now the Western Hospital. He was there as Director for 25 years. He was a keen supporter of the College, and under his guidance, Footscray and District Hospital became the first peripheral hospital in Melbourne to be approved for College training.

George served on a number of committees, including the Victorian Regional Committee for a short period of time and the Mortality and Morbidity Committee for many years, including a period of time as deputy editor of the report. Amongst other services that George Robi gave to the community was a period as a thoracic anaesthetist to a team of thoracic surgeons in Papua New Guinea, and then also in Vietnam with one of the civilian teams.

George had a great love of music and the theatre, and his beloved Melbourne Football Club. He was also an extraordinary sportsman. He played league football for Perth and for an interstate West Australian side. In cricket he captained an Australian eleven that played Wally Hammond's cricket side in 1947-48, and was vice-captain of the West Australian side that won the Sheffield Shield of the 1947-48 season. Other sporting talents included hockey, which he played until well in excess of 60 years of age, squash, golf and tennis, and trekking in Nepal.

George was widely loved around Melbourne for all of his achievements. He was never known to raise his voice, with the possible exception of on the sporting field. He always seemed to find out if someone was unwell, and called in regularly to pay visits to friends, family and members of the medical profession who were unwell and/or hospitalised. There were over 400 people at the memorial service at St Hilary's Church, Kew, conducted in the week following his death.

I can only speak with sadness of his last four or five years of life, during which he suffered increasingly from Parkinson's Disease. However, as was typical of the man, he never once complained about this problem and was wonderfully supported by Elinor during this period of time.

I especially mourn the passing of my friend and mentor who gave me so much good advice over many years, even as recently as last year. I am certain he learned this ability of mentorship from Kevin McCaul who indeed had been George Robi's own friend and mentor for many years.

IAN RECHTMAN

Dr. Trevor John Watkins

New South Wales – FFARACS 1977, FANZCA 1992

John Watkins entered anaesthetic practice in Dubbo in 1987 and rapidly became an invaluable and highly respected member of both the medical and the wider community. In his every endeavour he contributed wholeheartedly and made his mark.

He was educated at Prince Alfred College in Kent Town, South Australia where his association with the scouting movement, adventure and physical fitness began. A Queen's Scout, he was also a Leadership member of the Scout Association of Australia and a member of the Lord Baden Powell Society. John loved the outdoors and participated in a wide range of physical pursuits. In his final year at Prince Alfred College he rowed on the Torrens in the Head of the River.

For most of his life John was an active member of the Methodist Church. He met Heather Macdonald, a fellow chorister, whom he married in 1968. He was a Life Member of the Old Collegians Association and a trustee of the Prince Alfred College Foundation.

Initially studying Agricultural Science, John graduated in Medicine from the University of Adelaide in 1970. He worked in Adelaide and at Masterton, New Zealand, and was awarded his Fellowship of the Faculty of Anaesthetists, Royal Australasian College of Surgeons in 1976, and in 1992 became a Fellow of the Australian and New Zealand College of Anaesthetists. He joined the Associates in Anaesthesia in North Adelaide and worked in both city and country hospitals. From 1982 - 1987 he was a member of the South Australian Regional Committee of the Faculty of Anaesthetists, and in 1984 was Treasurer for S.A. of the Australian Society of Anaesthetists.

In response to an advertisement the Watkins family moved to Dubbo in Central Western NSW in 1987, where John practised in partnership with Drs. Michael Logan and David Schuster. He was the most honest, conscientious and obliging partner a man could hope for. He worked hard, but found time also for others through Rotary, where his duties and responsibilities were protean. In 1997 John was made a Paul Harris Fellow for service to youth exchange and the advancement of understanding and friendly relations among peoples of the World.

To meet this quiet man would provide little clue to the diversity of his interests and abilities. He read widely, loved music and gardening, wines, kites and model trains, and the sea. Especially the sea and ships.
John Watkins died peacefully and courageously in Dubbo on 30 July 1998, having had a hemicolectomy two years earlier. He is survived by his devoted wife Heather and three sons, for whom he could always find time.

DAVID SCHUSTER

PRIMARY FELLOWSHIP EXAMINATION

MARCH/APRIL 1999

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

The Viva Examination was held at the Australian Institute of Management in Melbourne.

One hundred and fourteen (114) candidates presented and seventy-four (74) were approved.

S B Baker	SA	Ku Shu Wing	HKG	G G Pattullo	NSW
A L Barry	NSW	Kwok Fung Kwai	HKG	D J Probert	QLD
S K Begg	ACT	Kwok On Ki	HKG	F M Re	NSW
P K Bhabha	NZ	I C Lack	VIC	C J Reid	VIC
K Boddu	NZ	Li Ching Fan Carina	HKG	K A Ryan	NZ
T W Boesel	NSW	C D Liessmann	QLD	C W Scarff	VIC
J D Boessenkool	NZ	J M L Liew	NSW	N J Scurrah	VIC
M P Brodie	QLD	P Liston	NSW	T J Studholme	NZ
N W Brown	NSW	Liu Kwok Kuen	HKG	S Sturland	NZ
J E Chaffer	NSW	S M Lord	NSW	Suen Sai Tsz	HKG
D L S Chan	HKG	Y W A Lui	HKG	A S I Tanious	QLD
Chan Kin Wai	HKG	K K Lundqvist	QLD	M R Thompson	WA
C P Chau	HKG	T W Maddock	NZ	G L Van Essen	VIC
M F Chen	VIC	S E Malcolmson	NZ	M G F Van Gulik	NZ
Cheung Wing Wai, Rochelle	HKG	A J Mark	NZ	S Velandy Koottayi	ACT
J C Coldrey	SA	C A McCutcheon	VIC	V L Walsh	SA
P J Craft	QLD	C A McInerney	NSW	D J C Ware	VIC
T R Crofts	VIC	M S McManus	QLD	J Wells	WA
F J Davidson	NSW	P M Mezzavia	VIC	G Wijerathne	NZ
D J Fahlbusch	SA	T L Morris	NSW	L K Winston	QLD
D C Gardiner	QLD	S P W Neff	NZ	G T C Wong	NSW
C B Gourlay	TAS	Ng Ka-Lai	HKG	Yeong Suet Ming	S'PORE
D F Innes	NSW	S A Nicolson	NZ	B Yim	VIC
A V Jaumees	QLD	T J Nixon	SA	Yuen Man Kwong	HKG
R A Jones	VIC	R M M Orme	VIC		

Final Fellowship Examination

April/May 1999

The written section was conducted in all capital cities in Australia, Newcastle, Auckland, Dunedin, Wellington, Hong Kong, Kuala Lumpur and Singapore.

The Viva Examination in anaesthesia and medicine was held at the Australian Institute of Management and the Alfred Hospital, Melbourne.

One hundred and four (104) candidates presented in Melbourne and eighty-four (84) were approved.

The successful candiates were:

E V Agius	NSW	P J Clunies-Ross	VIC	R L Gillies	VIC
S G Apana	NSW	C M Cole	WA	P T J Girdlestone	VIC
E J Bennett	QLD	J P Cooper	VIC	S C Goetz	WA
F M Bennett	NSW	A N Coorey	QLD	A Grossi	VIC
C N Bradfield	NZ	P A Corby	VIC	A J Haughton	NZ
V J Browning	NSW	D A Cowie	VIC	P G Herreen	SA
N D Burgess	NSW	C M Ducat	NZ	D K Hong	NSW
J M Calder	SA	M K Duncan	QLD	J J Hunt-Smith	VIC
D Campbell	NZ	K Eastern	QLD	A R Imison	WA
G Caponas	NSW	D R Emerick	QLD	C R M James	VIC
D J Castanelli	VIC	M P Fanshawe	QLD	F J Johnson	VIC
S D P Chandrasekara	VIC	S J Ferguson	NSW	S J Jones	VIC
G W M Chang	NSW	S Y Fong	WA	S K Kafle	SA
G A Christie-Taylor	SA	P W Found	NSW	A M Kattula	VIC
D J Keavy	NSW	M Moyle	NSW	F H Stapelberg	NZ
H Kocent	VIC	E J Murphy	NSW	R G Steele	VIC
Y Kontrobarsky	VIC	C L Murray	NSW	J Stellios	NSW
J F Lambert	NSW	Ng Man Wai, Vivian	HKG	V Swainsbury	VIC
R A Lang	SA	C E Nightingale	VIC	Tan Soo Guan	S'PRE
Lee Pik-Lin, Monica	HKG	D J Olive	VIC	E M Taylor	NZ
S I Lim	WA	B R Paix	SA	N J Theaker	NSW
T J Mann	WA	N V Pal	NSW	T Theodorou	NSW
A J McDonald	NSW	S G Pearce	NZ	M G Veltman	WA
C S McFarlan	NZ	A B Poon	VIC	Y E Wagner	NZ
D R McIlroy	VIC	A C Schneider	VIC	D E Washbourne	QLD
I M Miles	NSW	J Shen	HKG	W R Watson	VIC
T Mohler	VIC	P Sinclair	NSW	P J C Weidmann	WA
A R L Molnar	VIC	I W Smith	QLD	S J Worboys	VIC

COMPETENCE – DISCUSSION DOCUMENT ONLY

The majority of our colleagues are recognised as "good anaesthetists". We often make judgements on the competence of those with whom we work on a regular basis. Yet the formal assessment of that competence is seen as presenting considerable difficulties - for numbers of very valid reasons. This is at a time when such assessments are likely to be required with increasing frequency for anaesthetists at all career stages. When requested formally, it is commoner that assessment is seeking to determine whether the doctor is incompetent - and thus unsafe to work with patients.

At the Maintenance of Standards Workshop in October 1997, Council decided that the ANZCA MOPS Program was not designed to evaluate the clinical or professional competence of those participating in the program. At the same time, it was noted that while the assessment techniques used by ANZCA for its trainees place significant emphasis on knowledge, there is only limited ability to evaluate their skills and professional attitudes. Conversely, patients are increasingly demanding service based substantially on skills and professional attitudes. This last requirement demands a doctor with an empathetic attitude and good communication skills. When there is a perceived failure of one of these, there are frequently demands for the assessment of the competence of the doctor involved from medical licensing authorities or as a part of legal process..

The current Medical Practitioners Act in New Zealand (which became law in 1996) gave the Medical Council of New Zealand (MCNZ) the power to undertake competence reviews and also spells out the significant powers of the Council in respect of undertaking and acting on those reviews. The Council commissioned a review of the subject which has been written by Professor Bob Large under the title "Maintaining Doctors' Competence". This was a wide ranging examination of the limited information available in the medical literature together with an analysis of the perceptions of a number of senior NZ doctors. More recently, there has been a formal approach to ANZCA by MCNZ asking that the College advise and assist with competence assessments should this be required. It seems likely that such a move would be in response to a complaint about performance with an answer being required in a relatively short time frame. It is therefore necessary to have developed a contingency plan to deal with a potentially professional, personal and legal minefield.

In August 1998, the New South Wales Medical Board issued a draft document ***Performance Assessment*** which set out a possible pro-forma for the assessment of doctors with Colleges being involved at the assessment stage and again at the stage of re-training if this is the recommendation of the Performance Review Panel. It was noted in discussion that other Medical Boards were aware of the New South Wales initiative and that Medical Boards may be aiming for a common national process.

At a recent meeting convened by the Australian Medical Council (AMC) to discuss matters related to the assessment of overseas trained specialists, it was clearly stated that the Colleges will be required to assist with competence assessments or else to accept that such assessments will be performed by others.

Evaluation of competence is on the agenda of teaching and regulatory bodies in many parts of the world. Formal re-certification at specified intervals after training is in place in many States of the USA and New Zealand. Most of these programs require evidence of continuing CME rather than any evaluation of competence. Specific practice evaluation has been attempted in Canada and a few other countries but is hard to maintain because of the resources required. A number of bodies require that a doctor produce evidence that she/he is credentialed to work in the hospitals or institutions where he/she practices. This process of credentialing might be considered as an *ad hoc* form of competence determination.

A dictionary definition of "Competence" is "the condition of being capable". The American Board of Internal Medicine has identified six elements of clinical competence as: clinical judgement, medical knowledge, clinical skills, humanistic qualities, communications skills and continuing scholarship. It can be seen that some of these elements form part of a MOPS program. Thus a MOPS participant is more likely to have those elements of competence than a non-participator. However, it could not be inferred that a non-participator is incompetent.

In his paper, "Maintaining Doctors Competence", commisioned for MCNZ, Dr Large draws attention to the importance of humanistic qualities and communication skills and notes that they are frequently overlooked because of the difficulties in measuring them. They are amongst the qualities which patients require in their doctors. Large also notes the distinction between impairment and competence but stresses that competence is not without its personal cost in respect of continuing physical and emotional availability to sick people.

There have been various attempts to formalise the assessment of competence with peer ratings being increasingly used as a method of assessing a doctor's competence. Self-assessments and video playbacks of doctor-patient interactions may be valuable in providing accurate feedback.

Undergraduate medical education is moving towards competency based assessment to some degree following on the development of this type of approach in schools. Problem based learning is in part a performance based approach to education. It is easier to build decision making skills and their use into these structured learning experiences. It is interesting that such learning exercises are only now becoming a part of continuing medical education at postgraduate level and have yet to play a significant role in graduate education in anaesthesia or intensive care. Although the ANZCA *Objectives of Training in Anaesthesia* are written in competency terms, assessment of that competence is still largely knowledge based with only a minor part currently played by the In-Training Assessment process recently introduced by the College. With this rather conservative approach to graduate education, it is not surprising that competence assessment for existing practitioners presents a significant challenge.

There are enormous difficulties with practical clinical competence assessment. It is easy to generalise about performance from isolated observations. We simply do not know how large the observed sample(s) must be to make them representative of all competence determining behaviours. There is considerable subjectivity in most observations of performance. Yet performance of a clinical task to an appropriate and safe standard is probably the most important determinant of an anaesthetist's competence. Subjectivity can be reduced by the use of a prospectively developed "check list" which allows scoring on each of a number of domains of performance. Nevertheless, such techniques have major limitations in that they may fail to take account of variations from the normal pattern as the result of the use of the complex skills expressed as clinical reasoning.

The literature related to detailed competency assessment in anaesthesia is very sparse. In a recent BJA editorial JD Greaves comments on the inherent difficulties of such a process and stresses that currently reliable techniques are not available. His final comment is worth quoting: *Until the time that research* (into proper assessment techniques) *is done, measurements made in the work place should not be used either to monitor the progress of trainees or to make decisions in relation to their careers.* Surely the same is also true of other medical practitioners in whom we may be asked to make judgements of competency with far reaching consequences.

A potentially useful tool which has appeared in recent years is the anaesthesia simulator. It maybe that it will eventually have a place in competency assessment but it is doubtful that its development has yet reached that point. This is a tool which must be prospectively evaluated for learning purposes before it becomes relevant to assessment of competence.

How then should ANZCA proceed if asked to assist with a competency assessment. I believe that the College must become involved because it is the best source of knowledge about anaesthesia and anaesthetists. If the College is not a part of the process then it is likely that others, less well qualified, will participate.

The group set up to undertake the task should include two anaesthetists, one of whom has detailed knowledge of any relevant area of sub-specialty practice. There should be a non-anaesthetist member - perhaps a lawyer, perhaps a medical colleague such as a psychiatrist or a psychologist.

Matters related to the legal indemnity of those involved must be prospectively established in writing. The boundaries of the process to be used must be established in advance as well as details of the procedures to be used. All parties must know of these in advance. It must be stressed that this is a clinical and not a judicial enquiry. Any legal consequences can only occur after a report has been considered by the relevant initiating authority. The anaesthetist can have a support person but if this is a lawyer then that person cannot respond on behalf of the anaesthetist.

Elements of an assessment might include:

- a detailed review of participation in educational programs (such as MOPS) during the past five years.
- a review of twenty anaesthesia records randomly selected from the last 50 anaesthetics given by the anaesthetist followed by face to face discussions as to content and management of the cases. On occasions a review of work during the conduct of anaesthesia may be helpful but this should not be mandatory.
- discussion with the anaesthetist as to the details of the complaint and how it has come about
- discussion with staff (both medical and nursing) who have been recently associated with the anaesthetist during his/her professional duties. Such interviews must be conducted in a structured manner with emphasis on the need for facts rather than opinions.
- discussion with an agent of the complainant(s) in the presence of the anaesthetist and his/her representative.

At the conclusion of the investigations, a preliminary interview with the anaesthetist should identify any major areas of concern. There should be a mentor available for ongoing contact with the anaesthetist from the time that the process is initiated. This person should have no formal involvement with the conduct of the investigation.

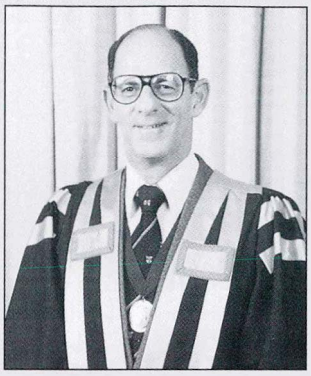
A copy of the formal report should be sent to the anaesthetist at the same time that it is sent to the authority who initiated the review. Further actions (if any) are then set out by the initiating authority.

I emphasise that this is a personal rather than an official account. Nothing stated here is current College policy. This account has been written in the hope that Fellows will give input as to their views and that we can move towards fair and appropriate processes for evaluating competence.

A list of references is available from the author.

JOHN M GIBBS

DOUGLAS JOSEPH PROFESSOR OF ANAESTHESIA



The Council of the Australian and New Zealand College of Anaesthetists invites applications for the Douglas Joseph Professorship of Anaesthesia.

This award was established by the Board of the Faculty of Anaesthetists following a most generous bequest from the late Douglas Joseph to endow a Fellowship or grant in aid for research in human anaesthesia.

Applications are invited from Fellows making an outstanding contribution to the advancement of the specialty to pursue scholarship and research in human anaesthesia in Australia and/or New Zealand.

Each application shall be accompanied by a full curriculum vitae, and a detailed proposal for scholarship and research in human anaesthesia. The proposal should be limited to three A4 pages with an additional page containing the proposed budget. The names of three referees to whom reference may be made should also be included.

The Fellowship of $65,000 has a tenure of approximately one year but variations may be made at the discretion of the Council. The appointee will deliver the Australasian Visitor's Lecture at the appropriate Annual Scientific Meeting. During the time of the appointment, the appointee will hold the courtesy title of "Douglas *Joseph Professor of Anaesthesia*".

The closing date for applications is the 28th February 2000 and must be forwarded to:

The Chief Executive Officer
Australian and New Zealand College of Anaesthetists
630 St Kilda Road
Melbourne Vic 3004

RE-ENTRY TO WORK:

A PROGRAM OF REHABILITATION FOR EX-SUBSTANCE ABUSING ANAESTHETISTS

This workshop was one of several conducted in Adelaide in May at the ANZCA Annual Scientific Meeting. It was presented by Drs John Paull and Jack Warhaft.

"DOCTORS IN RECOVERY"
DR JACK WARHAFT

Substance abuse is disproportionately high in anaesthetists compared with other doctors. In the USA, anaesthetists are 3% of all doctors, but 14% of doctors in treatment centres for drug and alcohol abuse.

It has been estimated that 15 % of doctors abuse alcohol or other drugs at some stage in their lives, and that, at any given time, between 1-2% of doctors are addicted and need treatment.

Dr Warhaft emphasised that the decision to join a Doctors in Recovery program was a life or death matter, as the risk of accidental or deliberate fatal overdose was very high in addicts.

"Recovery" involves detoxification, rehabilitation and a re-entry program. Detoxification is usually as an inpatient; there are two or three establishments in Australia which are suitable for recovering doctors.

Regular attendance at Narcotics or Alcoholics Anonymous Meetings, as well as a "Doctors in Recovery Group" is essential.

Other components include continued counselling; this must be given by a person skilled in addiction work, usually from the local Drug & Alcohol Foundation.

There must be a personal primary care physician, since continuing medical and perhaps psychiatric care may be necessary. The monitoring doctor(s) must be familiar with addiction issues and with treating doctors as patients – addicted doctors are very devious in eluding detection of relapse. Self treatment is absolutely prohibited.

Australian Doctors in Recovery also offers family support, an extremely necessary and valuable component of the recovery process.

A successful Re-Entry to work program is dependent on the success of detoxification and rehabilitation, as well as the existence of a suitable program at a hospital where there are supportive colleagues, theatre staff and administrators.

RE-ENTRY TO WORK PROGRAM
BOX HILL HOSPITAL, MELBOURNE
DR JOHN PAULL

The program was started by Dr Paull, when, after a stressful personal experience, he perceived a need by distressed colleagues who were recovering from substance abuse: gainful employment in an environment which encouraged retrieval of skills, knowledge and self-confidence.

He decided to start a program at Box Hill Hospital, Melbourne, for anaesthetists recovering from substance abuse. The program he has devised meets the rehabilitation requirements of the Medical Practitioners' Board of Victoria for ex-substance abusers. Acceptance into the **Re-entry Program** starts with a personal application by a recovering anaesthetist, followed by assessment of the recovery process so far, and several interviews with senior members of the department.

A **contract** is then developed, and an application for appropriate registration is made to the Medical Board.

Included in the contract is an undertaking to completely abstain from mood altering chemicals. Regular attendance at Narcotics Anonymous, Doctors in Recovery Meetings, and counselling sessions is mandatory.

Participation in department, College and ASA CME meetings is obligatory, and an individual educational program is developed. The recovering anaesthetist's state is fully disclosed to the department.

Urine testing requirements set out by the Medical Board have to be complied with. The recovering practitioner has to accept that non-compliance will be reported to the Board. The urine testing program is essential, but has to be supervised, which is demeaning for both the recovering and supervising anaesthetist. Occasional positive urine tests unleash a frenzy of activity. So far there have been no substantiated positive tests – a careful history of food intake is necessary as some foods have given false positive results.

Progress is formally reviewed at regular meetings of the recovering anaesthetist and those personnel involved.

Dr Paull commented that a relapse by one of the recovering anaesthetists would be a major setback for the program; there would be several "I told you so's" and a few "You can't trust an

addict". A contingency plan for this event has been developed, which includes staff counselling by experts.

The program has been very worthwhile, with several doctors returning to productive work who would not otherwise have done so. Other staff in the department and in theatres have been supportive; they now have a far greater understanding of the potential for substance abuse, and insight into the problems of recovering doctors.

Resources

1 **Australian Doctors in Recovery (ADR)**
which meets regularly in Melbourne and Sydney; individual contacts elsewhere.

Telephone numbers: 0418 546 654 or 0412 405 751

2 **International Doctors in Alcoholics Anonymous (IDAA)**
USA. Meets annually.
Contact: C Richard McKinley MD, PO Box 199, Augusta, MO 63332 USA

Diana C Strange Khursandi

LETTERS TO THE EDITOR

The recent Australian and New Zealand College of Anaesthetists policy document [1] relating to anaesthesia of children outside of non paediatric dedicated healthcare facilities is long overdue. Hatch [2] raised his concern over paediatric anaesthesia as long ago as 1984. However, the document is cautious in that it only advises on criteria to be considered in the **development of individual hospital policies.** There are no quantifying guidelines as to what constitutes ongoing experience.

In contrast to the usual age classification of neonate, infant and child, Lunn [3] referred to the classification used by the UK Report of a Confidential Enquiry into Perioperative Deaths. The Report [4] stressed that surgeons and anaesthetists should not undertake occasional paediatric practice. Lunn [3], using this classification, suggested that ongoing experience could be maintained if the anaesthetist were to anaesthetise one infant under 6 months of age per month, one child under 3 years of age per week and one child under 10 years of age per day.

An editorial in *Anaesthesia* [5] questioned the wisdom of anaesthetising children outside specialist hospitals in the absence of sufficient ongoing experience and appropriate infrastructure. In Australian practice, it may be unworkable, to refer all age groups to paediatric centres especially from country areas. However, it would be more expedient to transfer infants under six months, both public and private, and, particularly, cases of intussusception and pyloric stenosis.

Atwell and Spargo [6] reported that "in Australia and the USA paediatric surgery is only undertaken by paediatric surgeons at all ages and the standard of care is very high" while another [7] mentioned that "in Australia and Canada sick infants are transferred safely hundreds of miles." In reality, in country areas, it is the general surgeon working in the non specialist hospital who may operate on the infant, and it may not be a specialist anaesthetist, *and certainly not a paediatric specialist anaesthetist,* who anaesthetises.

It is conceivable that some surgeons and anaesthetists are coerced to deliver a minimal surgical service for infants and refusal could be ridiculed and even perceived as weakness [7]. With particular reference to informed consent, I wonder if parents in country areas are made fully aware of alternative venues for their children's perioperative management.

Atwell and Spargo [6] stated that when neonatal surgery was concentrated into a single unit in Liverpool, UK, the mortality fell within five years and they postulated that a similar concentration for children under 3 years of age should result in an improvement in mortality and morbidity.

The British Association of Paediatric Surgeons has suggested that transfer of children *under 5* should be the eventual aim in the United Kingdom [6].

I would have welcomed a College policy which quantified ongoing experience, both anaesthetic and surgical, in line with Lunn's recommendations and solid advice to transfer all infants under 6 months to a specialist centre. Perhaps it could have even included advice that children, under the age of 3, should be transferred if local ongoing experience is sporadic and suitable paediatric infrastructure is wanting.

T.G. COUPLAND

References

[11 *Australian and New Zealand College of Anaesthetists Policy Document PS-29* (1997). Anaesthesia Care of Children in Healthcare Facilities without Dedicated Paediatric Facilities.

[2] Editorial. *Anaesthesia,* 1984, 39, 405-406

[3] Lunn. Implications of the National Confidential Enquiry into Perioperative Deaths for Paediatric Anaesthesia. *Paediatric Anaesthesia,* 1992, 2, 69-72

[4] Campling, Devlin, Lunn. The Report of the National Confidential Enquiry into Perioperative Deaths. London: NCEPOD, 1989.

[51 Editorial. *Anaesthesia,* 1997, 52, 513-516

[6] Atwell, Spargo. The provision of safe surgery for children. *Archives of Disease in Childhood,* 1992,66,408-411

[7] NCEPOD and Perioperative Deaths of Children. *Lancet,* 1990, 335, 1498-1500

Response

We thank Dr Coupland for raising his concerns about the wording of the College's *Policy Document PS29* ***Anaesthesia Care of Children in Healthcare Facilities without dedicated Paediatric Facilities (1997).*** There was considerable consultation with Regional Committees and with paediatric anaesthetists from many parts of Australia and New Zealand before the consensus document as published was

agreed upon. As with any consensus, compromises were necessary and it is on some of these areas that Dr Coupland comments.

It was considered impossible to draw up firm statements that would meet all the needs of the widely varied hospitals in Australia and New Zealand which undertake paediatric surgical procedures. The strategy of suggesting that hospitals develop their own policies having regard to local factors was therefore adopted.We preferred not to suggest the actual amount of "hands on" experience which an individual might require to maintain competence as this can vary considerably from person to person.There could be difficulties when an anaesthetist considers that she/he requires more experience than that mandated by a College document. Within such a framework, we accept completely that smaller children presenting for emergency surgery in particular should, as a policy, be transferred to a paediatric centre. This is stated in para 2.1 of *PS29*.

Dr Coupland refers to two papers which mention Australian practices. We note that they were dated in 1990 and 1992 and question whether they accurately reflect current realities. Certainly the care of critically ill patients during transportation has developed greatly in recent years. This factor must be taken into account by any hospital in developing its own policies. Dr Coupland's main criticism of *PS29* appears to be that it is not sufficiently supportive of transfer policies. We consider that the document does not strongly support transfers in the circumstances of the final paragraph of his letter. If there is specific evidence that such transfers are not occurring and that individual patients (and anaesthetists) are being jeopardised, we would ask that the College is informed so that the existing *Policy Document* can be strengthened.

John M Gibbs
Rod Westhorpe
ANZCA Councillors

Committee of Presidents of Medical Colleges — 1999

Back Row L to R: *Dr David Brand AMA: Prof Garry Phillips Chair Workforce and Restructuring Sub Committee: Dr Michael Jelly RACMA: Prof Hugh Dickson AFRM: Dr Robin Mortimer Chair Education Sub Committee: Dr Bill Land ACD: Prof Charles Watson AFPHM: Prof Derek Frewin Chairman CDAMS.*

Middle Row L to R: *Mrs Joan Sheales Secretary: Dr Jill Sewell Div of Paediatrics RACP: Prof Ian Fraser RANZCOG: Dr Jonathan Phillips President-elect RANZCP: Prof Kerry Goulston Chairman CPMEC: Dr Jack Hamer RCPA: Dr Ann Long AFOM: Dr Bill Gillies RACO: Prof John Earwaker RANZCR: Mrs Jill Horton Administrative Officer.*

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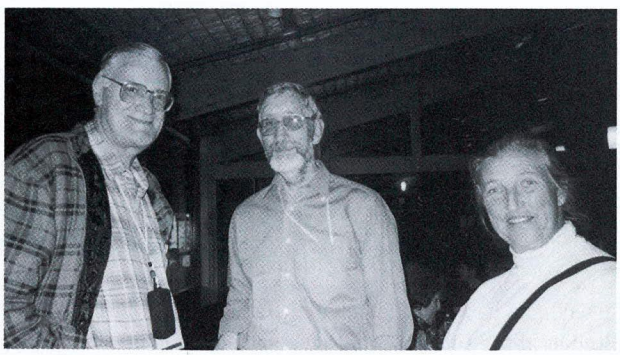
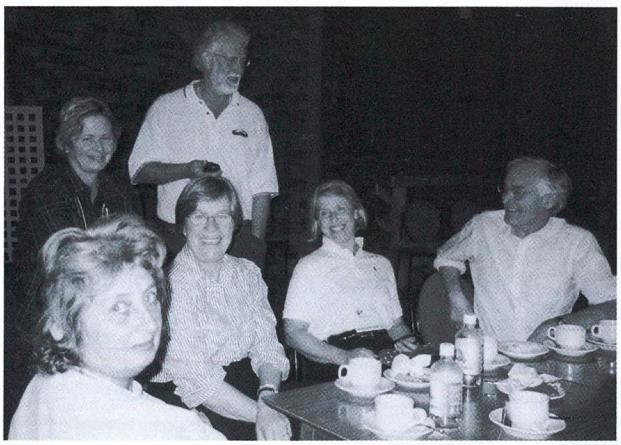
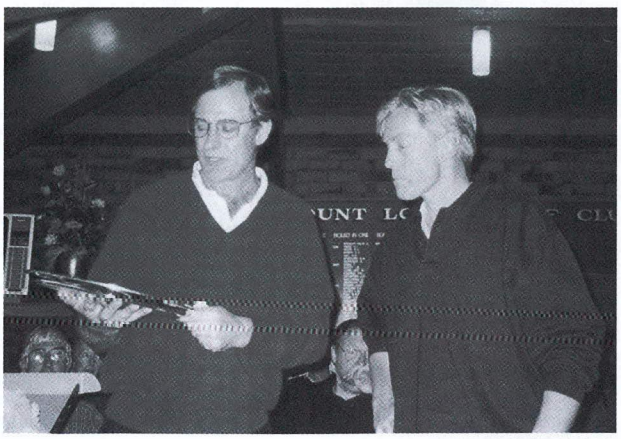
ASM Adelaide – Sports Afternoon

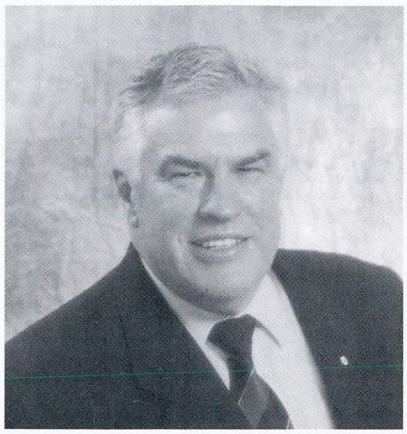
Above and below:
Walkers relax at Mount Lofty Golf Club following the walk.







Dr Michael Davies presenting Dr Frank Whitton (Vic) with the ANZCA Golf Trophy.



FELLOW'S PROFILE

MERVYN COBOCROFT OAM RFD

Merv graduated from Queensland University in 1967 and obtained his FFARACS in 1975 after completing his training in and around Brisbane. Up to this time most newly qualified anaesthetists gravitated to the UK for an almost obligatory final "polishing". When a London appointment fell through at the last minute, Merv had no option to seek employment elsewhere. Having just been the second anaesthetic registrar at Ipswich General Hospital, he was offered a partnership with Peter Morris, a VMO at IGH Merv readily accepted. To go directly from registrarship to private practice was then extraordinarily revolutionary and caused considerable comment.

Ipswich in those days was heavily reliant on GP anaesthetists. Because the available work for two specialists was patchy, Peter and Merv agreed to consolidate the work for one while the other would seek opportunities elsewhere. Peter decided to go overseas regularly while Merv would work for the military. Many of Merv's family had served with the RAAF during the Second World War and his uncles had continued well after the war ended. In 1962, Merv joined the now defunct University of Queensland Squadron as a cadet under officer, graduating in 1964 as a Pilot Officer in the Medical Flight. During this time, he received extensive training in aviation medicine at RAAF Point Cook and elsewhere, an interest he continues to this day. Ipswich is the location of RAAF Amberley, the airforce's largest base and home to its F-111's Merv re-enlisted in Number 23 "City of Brisbane" Squadron as an active reserve medical officer, eventually being promoted to the Senior Medical Officer position as a Squadron Leader.

His RAAF career has taken him all over Australia and South-East Asia, particularly on many secondments as a specialist anaesthetist to No.4 RAAF Hospital, Butterworth, Malaysia. During his career Merv has done some fairly unusual things *for* an anaesthetist. he has been through the sound barrier twice in fast jets and hurtled up-side-down at 500 feet over the Liverpool Plains of New South Wales. He has been fired up a tall steel tower in a training ejection seat and been winched in and out of helicopters over all sorts of terrains including the ocean. He has been on numerous aeromedical evacuations including those associated with the devastating Charleville floods of the early 1990s. But he did draw the line at an "invitation" parachute jump when relief manning the Parachute School, RAAF Willliamtown. The chief instructor had only just drowned doing a "routine" water jump and another instructor had a nasty compound leg fracture when blown off-course during a shopping centre opening! Tempting fate is not one of Merv's attributes although he was strapped to the open ramp of a C130 Hercules at 14000 feet while watching departing troops and has the photographs to prove it.

Merv's service with the RAAF Reserve came to an abrupt halt when a massive restructure of the Defence Force downgraded his position. He then switched to the Army and has served as an anaesthetist with 2 Field Hospital and as a Regimental Medical Officer with the Queensland University Regiment. He has just completed two tours of duty with the tri-service surgical team with the Peace Monitoring Group in Bougainville for which he was awarded the Australian Service Medal.

Merv's many other interests include Rotary where he raised over $50,000 for the Rotary Health Research Fund; St John Ambulance where he was Queensland's chief medical officer; and the University of Queensland's Medical School's Hirschfeld Museum of Medical History. He was secretary of the College Queensland Regional Committee from 1992 to 1995. He is currently documenting historic anaesthetic equipment in Queensland for the Australian Society of Anaesthetists. He has written numerous articles on medical history, numismatics, ornithology and even anaesthetics. He is presently compiling a catalogue of Australian medical medals with Professor John Pearn. If this was not enough, he has just completed a Graduate Diploma of Islamic Studies at the University of New England. Dealing mainly with the impact of Islam on South-East Asian politics, it. is a subject he became greatly interested in while serving in Malaysia.

Merv was awarded the Order of Australia Medal in the New Year's Honours List in 1992 for community service and is a member of the Venerable Order of St John of Jerusalem He also holds the Reserve Force Decoration and the National Medal. Following the tragic death of his first wife from cancer, Merv left private practice and now works as a full time staff anaesthetist and sometime director at Queen Elizabeth II Jubilee Hospital, Brisbane and has since remarried. He has two "permanent university student" children from his previous marriage.

REPORT FROM THE PRESIDENT

TO FELLOWS OF THE AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

AS AT THE 11 MAY 1999

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

GENERAL COLLEGE MATTERS

Maintenance of Professional Standards Program

After widespread consultation with all Fellows and Regional Committees, the Council has instituted a revised MOPS Program in Anaesthesia as from 1 January 1999. The Program, which is voluntary, will be available in manual and electronic form and encompasses greater flexibility for valid compliance.

Faculty of Pain Medicine, ANZCA

As announced in College communications, the Faculty of Pain Medicine of this College was established in early 1999 in collaboration with the Colleges of Surgeons, Physicians and Psychiatrists, and the Faculty of Rehabilitation Medicine of the RACP. A Diploma of Fellowship will be available by examination, with initial Fellowship established through Foundation Fellows, Honorary Fellows and Elected Fellows. Regulations for operation of the Faculty and its Board have been adopted. The inaugural Dean of the Faculty is Professor Michael Cousins.

College Headquarters Extension

The Council has resolved to proceed with a major extension to the College headquarters, "Ulimaroa", in St Kilda Road, Melbourne. This facility is long overdue and will enable the College to more efficiently conduct its business and expand with the professions it represents over many decades to come. The cost will be up to $7 million, an affordable amount which has been acquired by the College for this purpose over many years. The building is expected to be completed by mid-2000.

Faculty of Intensive Care

The Dean of the Faculty, Dr Alan Duncan, has reported extensively on issues and developments confronting the Faculty in the College Bulletin. The specialty of Intensive Care is a well-established entity and vital to the College, as all anaesthetists and others depend on a close clinical association with the specialty. The Faculty has held its own Business Meeting at this ASM at which a full report was delivered.

Rural Anaesthesia

The College continues its close association with the Royal Australian College of General Practitioners in training of general practitioner anaesthetists in rural areas through the Joint Consultative Committee in Anaesthesia (JCCA). This has been a particularly successful venture for our College. The Rural Special Interest Group, through its Chairman, Dr Daryl Catt, has brought special concerns of rural anaesthetists in Australia and New Zealand to the attention of the College Council. The College has been most concerned about the imbalance of anaesthesia services in city and rural locations, and there have been indications that the College may receive a considerable government grant to assist the recent establishment of a Rural Anaesthesia Recruitment Service within the College. The role of the Service, which includes collaboration with the Australian Society of Anaesthetists (ASA), will be to encourage placement of specialist anaesthetists in rural areas and fill vacancies as they occur, along with providing locum services.

Public Relations and Communications

The Communications Committee, under Dr Mike Martyn, has continued in its many ventures to increase positive public exposure for our specialties. The ASA, NZSA and the College collaborate in these exercises with cross-representation on respective committees. July 7 sees National Anaesthesia Day with a theme of Perioperative Medicine, a theme which is challenging both for getting the message across to the public and for many anaesthetists. The Committee has again planned a comprehensive promotional package for 7th July 1999.

Annual ANZCA Prize in Anaesthesia

The ANZCA initiative of donating a small prize to medical students has been received with great enthusiasm by Universities in Australia and New Zealand. In each Medical School, an annual prize will be awarded to the student with best marks in anaesthesia and related subjects.

EDUCATION AND TRAINING

In-Training Assessment

This initiative of the College was introduced several years ago to improve assessment beyond the examination system. A major review of the process will be undertaken in the near future,

including widespread consultation, with respect to its increasing applicability to final granting of College Fellowship and therefore recognition of speciality status.

Objectives of Training

Formal documentation, already well defined, will be reviewed over the next 12 months and published by the College following the extensive revision of this document.

Directory of Training

The College has, upon the suggestion of the Education Special Interest Group, established a published register of Provisional Year Posts for those seeking a special interest in their fifth and final year of ANZCA training. This is an information data base and is included on the College Website for those involved.

Logbooks in Training

The maintenance of logbooks by College trainees is a controversial issue, some maintaining that their assessment is invalid or impractical, and others suggesting ensurance of overall training including that of subspecialties. A formal trial of logbooks will be conducted in Queensland and the results will be further considered by the College Education Committee.

Undergraduate Teaching of Anaesthesia

The College has recommended to Australian and New Zealand Medical Schools that a core curriculum and an elective curriculum in anaesthesia and related disciplines, including Intensive Care and Pain Medicine, be adopted for all undergraduate medical education.

Selection of Trainees

This is a major discussion issue in Australia following publication of a special investigation into procedures and workforce procedures on selection of trainees. The College has therefore developed well-defined policies on selection principles, selection criteria and selection procedures as recommended guidelines. Further definition of the College role in this process will need widespread consultation.

AWARDS, HONOURS AND APPOINTMENTS

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

Dr John E (Fred) Gilligan (SA) was awarded Officer of the Order of Australia (AO) in the Australia Day Honours List.
Professor Michael A Denborough (ACT) and Dr Michael Hodgson (Tas) were awarded Members of the Order of Australia (AM) in the Australia Day Honours List. Dr Hodgson was also elected Vice-President of the Australian Society of Anaesthetists.
Professor Tess Cramond AO, OBE (Qld) was the recipient of the 1999 AMA Woman in Medicine Award.
Dr Stephen Gatt, OAM (NSW) was invested as a Member of the Order of St John.
Dr Richard Walsh (NSW) was elected to Fellowship of the Academy of Medicine, Singapore and was appointed Deputy Treasurer of the World Federation of Societies of Anaesthesiologists.
Professor T E Oh (WA) was appointed Inaugural Chair in Anaesthesia at the University of Western Australia.
Dr Rod Westhorpe (Vic) was elected President of the Australian Society of Anaesthetists.
Dr Chris Bolton (Vic) won a bronze medal in the Commonwealth Championships for fencing.

ANZCA MEDAL

The ANZCA Medal was awarded to Dr Bill Fuller (SA) for his contribution to anaesthesia in South Australia. It was my great pleasure to present the medal to Dr Fuller during the College Ceremony at this ASM.

DEATH OF FELLOWS

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

Dr George M Davidson, AM, NSW – FFARACS 1953, FANZCA 1992
Dr Kevin McCaul, MBE, Vic – FFARACS 1954, FANZCA 1992
Dr George D Robinson, Vic – FFARACS 1956, FANZCA 1992
Dr Colin A Shanks, USA – FFARACS 1969, FANZCA 1993
Dr T John Watkins, NSW – FFARACS 1977, FANZCA 1992
Dr Gwen C M Wilson, MD, NSW – FFARACS 1956, FANZCA 1992
Dr W Derek Wylie, UK – Honorary FFARACS 1984, Honorary FANZCA 1993

RESEARCH

John Boyd Craig Award for 1999

No application was received for the 1999 Dr John Boyd Craig Award.

Research Grants for 1999

A total of 19 applications were received for funding amounting to $686,543, with $250,000 available for allocation. All applications were perused by the Research Committee according to NHMRC guidelines and reviewed by two to three external Reviewers with recognised expertise in the area of the project.

ANNUAL SCIENTIFIC MEETING

The 1999 Annual Scientific Meeting is being held at the Adelaide Convention Centre from the 8th to the 12th May. The Foundation Visitors to this Meeting are Professor David Rowbotham from England and Professor Peter Moore from the United States. The Ellis Gillespie Lecture was delivered by Professor Rowbotham, and Professor Moore delivered the fifth Mary Burnell Lecture. Dr Richard Morris (NSW) is to deliver the Australasian Visitor's Lecture.

A full report of the 1999 Annual Scientific Meeting, including the award of the Gilbert Brown Prize and Formal Project Prize, are published in this Bulletin.

POLICY DOCUMENTS

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

- PS3 – *Major Regional Anaesthesia and Analgesia*
- PS14 – *Guidelines for the Conduct of Major Regional Analgesia in Obstetrics*
- PS37 – *Regional Anaesthesia and Allied Health Practitioners*
- TE11 –*Formal Project Guidelines*
- TE16 – *Requirements for Multidisciplinary Pain Medicine Centres Offering Training in Pain Medicine* (previously numbered P25)

College Policy Document TE15 was reviewed by the Faculty of Pain Medicine in February 1999, and following final approval by the Faculty, is to be promulgated as PM1 – *Guidelines for Trainees and Departments Seeking College Approval of Posts for Training in Pain Medicine.*

COLLEGE COUNCIL MEMBERSHIP

In accordance with the provisions of the Articles of Association, nominations were called for two vacancies on Council. Only two nominations were received, those from the Councillors eligible for re-election, namely Associate Professor Greg Knoblanche (NSW) and Dr Mike Martyn (Tas). No election was therefore necessary. I congratulate Professor Knoblanche and Dr Martyn upon their re-election to Council.

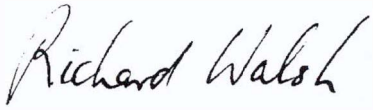
COLLEGE ADMINISTRATION

A number of College staff changes have occurred during the past twelve months. At the end of July 1998, Ms Jan Graham joined the staff to assist Mrs Lorna Berwick in the New Zealand Office. Mrs Denise Schultz was appointed Administrative Assistant to the Queensland Regional Committee Office on a part-time basis. In Melbourne, Miss Nikki Breheny has been appointed Administrative Assistant (CME) to assist Ms Helen Morris in the CME Department. Miss Severine Monnet has been appointed Administrative Assistant to the Faculty of Intensive Care and Ms Corinne Millane appointed Administrative Officer to the Victorian Regional Committee. Ms Margaret Benjamin was appointed Executive Officer to the Faculty of Pain Medicine and Executive Officer of the Anaesthesia, Intensive Care and Pain Medicine Foundation. Miss Juliette Mullumby was recently appointed Administrative Assistant within the College to undertake general administrative duties.

DIRECTOR OF PROFESSIONAL AFFAIRS

The appointment of Professor Garry Phillips as Director of Professional Affairs was ratified by Council in February. This is a part-time position to assist the President, Deans of the Faculties, the Council and various College Committees in response to correspondence, reports from internal and external bodies, and in the preparation of relevant submissions for consideration by the College Council.

I would like to express my sincere thanks to Members of Council, Regional Committees and the great many other College Committees for all the work they have done for the College in the past year. I cannot over-emphasise that these bodies could not function however without the great effort put in by the College staff at Ulimaroa and in the Regions. The support of the Honorary College Solicitor, Michael Gorton, and the College Public Relations Consultant, Eddie Dean, are also acknowledged.



RICHARD G WALSH
President

REGIONAL COMMITTEES
ANNUAL REPORTS 1998 – 1999

QUEENSLAND

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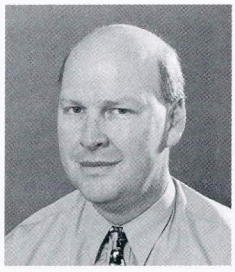
Dr Peter Moran

Committee Members:
Dr Gerard Handley
Dr Anton Loewenthal
Dr Malcolm McSorley
Dr Di Khursandi (Councillor)



Dr Robert Whiting

Dr Geoffrey Gordon

Representatives on External Committees:

Dr 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

Dr Jennifer Parslow
Chair, Queensland Health Theatre Utilisation Steering Committee
State Health Department Committee Elective Surgery Project
Ministerial Task Force on Elective Surgery

Dr Peter Moran
Editorial Committee Representative "Australasian Anaesthesia"
Postgraduate Diploma in Anaesthetic Nursing, Queensland University of Technology
ANZCA/RACS Building Committee

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

Dr Mark Gibbs
Queensland Committee to Investigate Perioperative Deaths

Dr Geoffrey Gordon
Emergency Services Specialist Advisory Panel

Dr Di Khursandi
Post-graduate Medical Education Committee, University of Queensland

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

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

Dr Paul Mead
Australian Resuscitation Council

Dr Ken McLeod
Queensland Council for Rural Medicine, Rural Specialists Steering Group

Dr Norris Green
RACS Queensland Trauma Committee

Total No. of Regional Committee Meetings for the Year: April 1998 to March 1999 = 9
Attendance:

Dr Bob Whiting	9	Dr Jennifer Parslow	8	Dr Geoff Gordon	7
Dr Ken McLeod	3	Dr Peter Moran	7	Dr Kerry Brandis	8
Dr Mark Gibbs	7	Dr Di Khursandi	9	Dr Gerard Handley	7

Queensland (continued)

Ex-officio Members:
Professor John Gibbs (Councillor)
Dr Bob Whiting (Faculty of Intensive Care Representative)
Dr Alison Holloway (ASA Representative)

Younger Fellows Representatives:
Dr Gerard Handley
Dr Anton Loewenthal

Course Organisers:
Primary Short Course
Dr Kerry Brandis
Primary Long Course
Dr Liz Boge
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

Administrative Officer:
Mrs Joyce Holland

Administrative Assistant:
Mrs Denise Schultz

Dr Anton Loewenthal 7
Prof John Gibbs 2
Dr Malcolm McSorley 4
Dr Alison Holloway 5

FINANCIAL REPORT

The accounts of the QRC (Business account, Course 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 modest surplus.

Major purchases this financial year included a digital projection system, laptop computer and a portable sound system.

These have been put to frequent use by Fellows and 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 1999 is 77. The trainees are organised into two rotational training schemes known as the Northside Scheme (38 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-specialty 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. The number of Cardiothoracic rotations is sufficient for the number of trainees. Involvement in Acute Pain services is widely available but opportunities for experience in Chronic Pain are 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 24. This number includes several trainees in accredited Pain Medicine positions and in accredited Intensive Care positions.

Registrar Training Courses

Three types of courses are available for registrars:

- Hospital Departmental meeting programs
- Long Courses
- Short Courses

The hospital-based programs are organised mostly by the Supervisors of Training in the individual hospitals for the continuing education of their own staff. Separate tutorial programs in Anatomy and in Equipment are organised at the Princess Alexandra Hospital by Dr Kersi Taraparawalla. All interested registrars are invited to attend.

All the Long and Short Courses are planned and administered by the College under the general direction of the Regional Education Officer. A pleasing aspect of these courses is the high level of enthusiasm of specialists involved as lecturers. Thank you.

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 Liz Boge.

Queensland (continued)

The Long Part 2 Course commences this year as 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 during the last 2 weeks of May annually. This course is organised by Dr Kerry Brandis. Due to the huge demand from local, interstate and overseas registrars, the course for 1999 will have concurrent sessions utilising both the upstairs and downstairs 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 first course was held in March 1999 and a second one week course will be held in July. In view of the essentially tutorial nature of this program, 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.

Because of the growth of demand for registrar training courses, a need for improved facilities has been recognised. The College Building in Spring Hill is currently being refurbished to provide two separate lecture rooms, a smaller meeting room and an office area for dealing with training matters. Because of this redevelopment, several lectures and the initial Part 2 course have had to be held in off-site locations and this has reinforced the great advantage of having the College venue at an excellent central location with parking, kitchen and educational facilities.

Other Training Matters:

The Queensland Regional Committee has been tasked by the College Council with the trial of a log book for trainees in 1999/2000. This matter is being progressed by a Sub-committee of the QRC.

Continuing Education:

The 22nd Annual CME meeting was held on the 31st October 1998 at the Royal Pines Resort. Major themes of the meeting included Trauma Anaesthesia and Hot topics in Anaesthesia. 148 delegates attended the meeting which was well supported by the trade with 25 companies exhibiting. The Convenor was Dr Gerard Handley.

The 2nd Combined ANZCA-ASA Annual Registrars' Meeting was held at the Royal Pines Resort, Gold Coast on the 1st November 1998. Dr Ian Cameron 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. The College would be poorer but for her enthusiastic involvement.

Robert Whiting, *Chairman*

VICTORIA

Office Bearers:

Chairman:
Dr Mark Buckland

Deputy Chairman:
Dr Kate Leslie

Honorary Secretary:
Dr Rowan Molnar

Honorary Treasurer:
Dr Mark Fajgman

Education Officer:
Dr Elizabeth Ashwood

Formal Project Officer:
Dr Brendan Flanagan

CME Officer:
Dr Peter McCall

Paramedical Personnel:
Dr Philip Ragg

VMPF:
Dr Steve Chester

Safety Officer:
Dr Graham Cannon

Road Trauma/Electronic Media/Web Page:
Dr Joseph Novella

Rural Representative:
Dr Mark Tuck

Councillors:
Dr Ian Rechtman
Dr Rod Westhorpe

Dr Mark Buckland

Dr Rowan Molnar

Total No. of Regional Committee Meetings for Year: 1998 = 11
1999 = 3

Attendance of Elected Members

Dr Buckland	10	Dr Leslie	13	Dr Molnar	11	Dr Fajgman	13
Dr Ashwood	12	Dr Flanagan	7	Dr McCall	7	Dr Ragg	12
Dr Chester	6	Dr Cannon	8	Dr Novella	8	Dr Tuck	3

INTRODUCTION

The last twelve months has been an active time for the Regional Committee. There has been some change in office bearers, and a number of new faces have joined us. The President of the College attended our November meeting and the VRC Chairman will attend a Council meeting this year. The relationship with the Victorian ASA remains helped by the enthusiasm of their Co-opted Representative Dr Mark Sandford, who now moves on to be the Victorian Chairman.

Not surprisingly, the education of Trainees and of Fellows continues as a major focus of the Committee. The number and quality of CME meetings is being maintained and they enjoy an ongoing popularity. The courses run by the VRC for both primary and fellowship candidates are also very popular and oversubscribed, requiring restriction of places to those candidates sitting for the next set of exams. Dr Kate Leslie and Dr Phil Ragg continue to do an excellent job in organising these; their energy and continued generous support from the Region's Fellows has made these an ongoing success. Alternative venues for the courses have been organised when the College renovations commence.

The planning and organisation for the 2000 ASM continues under the able leadership of Dr Philip Ragg, who, after his term as VRC Chairman, has taken on yet another managerial task.

The Committee and its members continue to be active in a range of other activities including inspections of hospitals, accreditation of training posts, involvement in the appointment process at both public and private hospitals throughout the State, review of College Policy Documents and representation on a wide range of committees.

CONSULTATIVE COUNCIL ON ANAESTHETIC MORTALITY

The Council met on nine occasions during 1998 and considered 68 deaths and 75 cases of significant morbidity. About 30 cases from 1998 remain to be finalised. During 1998 Dr Richard Connock resigned due to an interstate move. His long and valuable contribution to the operations of the Council is fully acknowledged. The new appointment nominated by the Victorian section of the ASA is Dr Alex Babarczy. Other new appointments during the year were forensic pathologists Professor Stephen Cordner and Associate Professor David Ransom.

During the year the Minister commissioned the Surgical Consultative Council and our Council nominated the Deputy Chairman, Dr Tony Weaver, as the anaesthetic representative on this Council.

The National Working Party on Anaesthetic Mortality, consisting of the Chairmen of State Committees and Chaired by the President of the College met in Melbourne on several occasions and produced the National Report for the years 1991-93, edited by Dr Brian Horan. This was well received by anaesthetists and certainly in Victoria got reasonable press coverage. Currently work is in progress for a report on the next triennium.

In Victoria an Information Bulletin was issued to all anaesthetists outlining recent issues of concern, particularly in relation to morbidity.

The Victorian report of the Consultative Council for the years 1993-96 is currently in preparation and expected to be published mid-year.

Victoria (continued)

Co-options:
RACS:
Mr P D Danne

Consultative Council on Anaesthetic Mortality and Morbidity:
Dr Patricia Mackay

Australian Society of Anaesthetists:
Dr Mark Sandford

Faculty of Intensive Care:
Dr Megan Robertson

Younger Fellows Representative:
Dr Colin Iatrou

Administrative Officer:
Ms Corinne Millane

The Council has also made submissions to the Victorian Government regarding changes to the Health Act as it relates to Consultative Councils, to the Attorney General's Department in an effort to secure uniform Coronial legislation. Submissions were also made to the National Health Information Group regarding adequate coding of anaesthetic procedures, both at a national and state level.

The Consultative Council acknowledges the considerable assistance provided by the Victorian Regional Committee and also by the College Librarian, Miss Shanti Nadaraja.

EDUCATION

The only issue of note regarding educational activities over the last year was that the Committee has changed the date of the Annual Scientific Registrars Meeting to the same weekend as the Annual CME Meeting in an effort to increase attendance.

FINANCE

The three VRC business accounts remain in order. The last ASA/ANZCA CME meeting in October 1998 ran at a loss, a legacy of the poor strength of the dollar against the pound. The need to move the various courses "off campus" during the College building expansion means the running costs will go up; the Committee has agreed to fund these increases from available funds rather than pass them on to trainees via a fee increase.

CONTINUING EDUCATION

The past year has seen further increase and development of CME activity for anaesthetists and trainees in Victoria. Major hospitals have sponsored excellent meetings. (St Vincent's, Geelong, Mercy, RWH, RMH and the Alfred).

College sponsored activities included:

May 98	*Management of Road Trauma* Dr Marcus Kennedy Mr Phillip Hogan Mr Michael Gorton
July 98	*Registrars' Scientific Meeting*
September 98	*Update on Obstetric Analgesia* Dr Rowan Gebert
October 98	*Complications of Regional Blockade* Prof. Tony Wildsmith
December 98	*Interplast: The China Experience* Dr Brendan Butler Mr Keith Mutimer

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

The Combined ANZCA/ASA meeting was held on 16th October 1998 on "Pain Medicine and the Anaesthetist". The International Guest was Professor Tony Wildsmith. The meeting covered wide range aspects of acute and chronic pain management. All local contributors should be thanked and congratulated again for this excellent educational event. Dr Mark Sandford, ASA Education Officer, should be thanked for his tireless effort organising this meeting and the many visits throughout Melbourne and Victoria for Professor Tony Wildsmith.

The next Combined ANZCA/ASA meeting will be held on 14th August 1999. It will be presented in conjunction with the Australian Red Cross Blood Service: Victoria. The topic

Victoria (continued)

will be "Transfusion Medicine: An Update". Areas to be covered include physiology of transfusion and coagulation, drugs and disease affecting coagulation, current transfusion recommendations and relevant clinical scenarios.

A local register of meetings is maintained. Anyone with details of planned meetings wishing inclusion on this list should contact the VRC Administrative Officer on (03) 9510 6441.

VICTORIAN MEDICAL POSTGRADUATE FOUNDATION INC.

The VMPF has continued to provide courses for the Australian Medical Council examinations and for prevocational postgraduate medical training. Therapeutics Guidelines Ltd have assumed the responsibilities of the Therapeutics Guidelines Committee and a palliative care course is being established. The Computer Matching Services is conducted by the VMPF for residents, interns and nurses.

As a new initiative, the VMPF will be conducting a career advice day for medical students and recent graduates at the Royal Children's Hospital in July. VRC Younger Fellow Dr Colin Iatrou along with Dr Mark Tuck and Dr Philip Ragg will represent the College.

ROAD TRAUMA

Apart from the recent release of its findings to the press, the Victorian Road Trauma Committee has been quiet, with no calls for attendance at meetings.

ELECTRONIC MEDIA AND WEB PAGE

Electronic communication amongst Committee Members is being actively promoted, as well as use of the College web site. A Victorian Regional Committee web page has been established. The address is www.vic.anzca.edu.au. In the near future, the page will have photos of Committee Members, Co-opted Members, and Ex-Officio Members, including contact details. A Training Calendar for Victorian Fellows and Trainees is being established for inclusion on the web site. There will also be a secure area that would, for example, include the Chairman's Newsletter.

An ASM 2000 Organising Committee web site is also in the process of being established and would be up and running in April 1999. An Organising Committee for the ASM 2000 Virtual Congress has been established, and for medical personnel who have Internet access and wish to connect from their computer, the Virtual Congress will be run in tandem with the ASM 2000.

RURAL ACTIVITIES

There has been no issue of note regarding Victorian rural activities referred to the College during the last year.

SAFETY

Fortunately the safety officer has had little to deal with over the last year with no major issues brought to the attention of the Committee. There have been one or two unconfirmed reports of difficulties with "Bag/Ventilator" switching mechanisms on anaesthetic machines. Fellows are reminded that meticulous checking of anaesthetic equipment is essential.

ASM 2000 MELBOURNE 6 – 10 MAY 2000

The Victorian Region has pleasure in hosting the Year 2000 ASM at Crown Towers in Melbourne. The Organising Committee for the meeting consists of:

Dr Philip Ragg	Convenor
Dr Kate Leslie	Scientific Convenor
Dr Rowan Molnar	Deputy Convenor
Dr Ian Rechtman	College ASM Officer
Dr Mark Buckland	Younger Fellows Officer

Victoria (continued)

Dr Mark Fajgman	Social Activities
Dr David McCuaig	Audiovisual and Industry Officer
Dr Christine Ball	History Section
Dr Beth Ashwood	Victorian Regional Liaison
Dr Megan Robertson	Faculty of Intensive Care Convenor
Dr Terry Little	Faculty of Pain Medicine Convenor

The Professional Conference Organiser appointed to the meeting is Waldron Smith Convention Network and our Conference Managers are Mrs Fiona Waldron and Ms Michelle Fok. This meeting is the first opportunity in many years for the Royal Australasian College of Surgeons and the Australian and New Zealand College of Anaesthetists to coordinate many joint social and scientific events in the same city. Plenary Sessions in most specialty areas will be combined, and a huge joint informal party at the Southbank restaurant precinct are but a few of the planned activities with our surgical colleagues. Our overseas invited speakers are Professor Dan Sessler (San Francisco) and Professor James Bovill (Netherlands). The Australasian Visitor for the meeting is Dr Guy Ludbrook from Adelaide, and the Faculty visitors are Associate Professor Paul Hebert, Professor Paul Pepe (Intensive Care) and Professor Dan Carr (Pain Medicine). Younger Fellows will enjoy a stimulating weekend at the Cumberland Resort in Lorne. The meeting itself will include a refresher course, workshops, panels of experts, practical sessions in echocardiography, fibreoptics, simulators and the broad themes will include outcomes research and a focus on practical clinical anaesthesia.

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 Mark Fajgman. Several trainees presented their projects at national meetings, whilst others submitted published work.

Formal Projects approved were:

Yuri Kontrobarsky	Gluteal Compartment Syndrome Following Epidural Analgesic Infusion with Motor Blockade
Michael Barrington	Identification of the Epidural Space – an Historical Review
Kit James	Prospective Audit of Three Day Post-operative Outcome after Surgery
Andrew Purcell	The Effect of Intravenous Frusemide on Pelvic Urinary Oxygen Tension in Humans
Bernie Creati	Point of Care Coagulation Testing in an Intensive Care Unit
Anthony Poon	An Evaluation of Exercise Tolerance in Vascular Surgery Patients
Leo Cantwell	Safety of Gastrointestinal Endoscopy: A Review of the Literature
Gaylene Heard	Utility of the Health Quiz as an Aid to Pre-operative Assessment
Brian Hennessy	Quality Assurance
Daryl Williams	Factors Associated with the Recovery Room Stay Greater than Two Hours: An Important Clinical Indicator
Tim Webb	Pneumothorax and Pneumomediastinum During Colonoscopy
Andrew Buettner	Anaesthesia and Post-operative Pain Management for Bilateral Lung Volume Reduction Surgery: Experience of 55 Cases
Adam Molnar	Oral Medication for Post Caesarean Analgesia

Victoria (continued)	Malcom Hogg	Induction of Anaesthesia with Sevoflurane, Preprogrammed Propofol Infusion or Combined Sevoflurane/Propofol for Laryngeal Mask Insertion: Cardiovascular and Eeg Bispectral Index Responses
	Jo Melick	Validity and Reliability of a Post-operative Quality of Recovery Score: the QoR-40y
	Jennifer Wheelahan	Epidural Fentanyl Reduces the Shivering Threshold During Epidural Lidocaine Anaesthesia
	David Andrews	The Arterial Blood Propofol Concentration Preventing Movement in 50% of Healthy Women After Skin Incision
	Kenneth Ng	Use of Fiberoptic Bronchoscope via Bronchial Lumen to Position Double-lumen Endobronchial Tubes – (Pilot result of twenty patients in a prospective study of a hundred patients)
	Gail Aughterson	Post Caesarean Analgesia (outline)
	Sesto Cairo	Randomised Trial of Informed Consent and Recruitment for Clinical Trials in the Immediate Preoperative Period
	Debra Devonshire	The Development of a Latex Free Ambulatory Centre
	James Cooper	Randomised Trial of Informed Consent and Recruitment for Clinical Trials in the Immediate Preoperative Period
	Mark Rudelic	Administration of Nebulized Lignocaine via a Mapleson B Breathing System for Fibre-Optic Intubation – Assessment of Safety and Efficacy
	Eugene Cohen	To Determine the Contribution of Spinal Antinociceptive Systems to the Overall Analgesic Effect Following Administration of Opioids by Ordinary Perenteral (nonspinal) routes

Finally, the VRC would like to thank the administrative support staff at "Ulimaroa" for their valuable assistance over the past year. We farewell Veronica Quetglas and Monica Zbrodoff and wish them the very best for the future, and welcome Ms Corinne Millane.

Mark Buckland, *Chairman*

NEW SOUTH WALES

Office Bearers:

Chairman:
Dr Matthew Crawford

Vice Chairman:
Dr Frank Moloney

Honorary Secretary:
Dr Jenny Beckett-Wood

Honorary Treasurer:
Dr Michael Jones

Regional Education Officer:
Dr Ross Kerridge

Formal Project Officer:
Dr Brian Horan

Continuing Education Officer:
Assoc Prof Peter Klineberg

Councillors:
Dr Richard Walsh
Professor Michael Cousins AM
Assoc Prof Greg Knoblanche

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

Attendance of Elected Members

Dr Jenny Beckett-Wood	5 out of 6
Dr Matthew Crawford	6 out of 6
Dr Richard Halliwell	1 out of 4
Dr Brian Horan	3 out of 6
Dr Michael Jones	6 out of 6
Dr Michele Joseph	5 out of 6
Dr Ross Kerridge	5 out of 6
Assoc Prof Peter Klineberg	6 out of 6
Dr Ed Loughman	5 out of 6
Dr Frank Moloney	6 out of 6
Dr Richard Morris	4 out of 4
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. Cheques for $5,000.00 each were presented to the College and ASA from the NSWACE account as a distribution of profit from NSW CME activities. Both the College and ASA have audited NSW accounts to their satisfaction.

Education – Dr Ross Kerridge

Following a gradual increase in recent years, there are now over 160 accredited registrar positions in New South Wales. Most of these training positions are organised within one of nine comprehensive training schemes across the State (excluding ACT, which has its own training scheme). The rotational nature of these training schemes ensures a wide variety of exposure of trainees to different Consultants, hospitals, and anaesthetic techniques. It also presents considerable logistical difficulties for scheme supervisors.

Increasingly, most training schemes are incorporating a rural rotation of three to six months for registrars. This is seen as a valuable way of exposing registrars to the possibility of pursuing specialist practice in rural centres, where there is an ongoing shortage of specialist anaesthetists. Organisation of adequate exposure to subspecialty anaesthesia (particularly paediatrics) is a challenge for some schemes. The mobile nature of anaesthetic training in a rotational scheme also provides some difficulties for trainees undertaking formal projects. Trainees are gaining an increasing exposure to the relatively new fields of anaesthesia in Pain Medicine and Perioperative Medicine.

The major organisational challenges for anaesthetic training in New South Wales currently are:

1. Ensuring equitable exposure to subspecialty anaesthesia for all trainees;
2. Ongoing improvement in the organisation of rotational training schemes;
3. Improving the assessment of trainees, particularly in the setting of rotational training schemes;
4. Improving the selection process for trainees for their first appointment.

While these challenges are great, there has generally been an ongoing improvement in the quality of training provided in the State, which is a reflection of the commitment of the Consultants in general and the Supervisors of Training in particular. The organisational support provided by the State office, and the College in Melbourne, has also been crucial.

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 Australian College of Surgeons
Dr Frank Moloney
Joint Consultative Committee-Anaesthesia
Executive Committee, Rural Special Interest Group

Administrative Officer:
Mrs Janice Taylor
Course Secretary:
Mrs Jane Merrillees

Throughout the State, Anaesthetic Departments seem to have become somewhat stronger and better organised within the hospital system in general in the last five to ten years. This is a reflection of both the commitment of Fellows, and the increasing status and broad clinical relevance of our specialty. The high quality of anaesthetic trainees that we now see will be of great benefit to the future of our specialty.

Formal Projects – Dr Brian Horan

The Formal Project has been the subject of much discussion in New South Wales over the last year. This is prompted in part by the fact that the revised policy document of 1996 is already under review, and also by a general feeling among Fellows involved in the training and supervision of trainees that the College has not adequately defined the goals of the exercise and the standard expected.

In spite of these difficulties in the past year the standard of the submissions by trainees in NSW has been impressive. Thirty-seven projects have been submitted of which thirty have been approved. Six trainees were requested to resubmit their projects with amendments and twelve were asked to reply to specific questions about their submissions. Currently two submissions are still under consideration, a rewrite of another is yet to be received and in four cases replies are awaited in response to requests for more information.

The range of topics has been broad, and numerous have already been presented at meetings or been accepted for publication. It is appropriate to remind trainees and their supervisors that for many projects the interval from conception to completion is considerable. To leave the whole project until the Provisional Fellowship year is to run the risk that it will not be completed during the time laid down in the College Document (T11).

Continuing Education – Assoc Prof Peter Klineberg, Chairman NSWACE

Continuing education in NSW had another good year in 1998.

CME Activities:

There was no CME meeting in May as the Annual Scientific Meeting was held in Newcastle.

26th and 27th September
'Anaesthesia, Trauma, Altitude and Temperature' at Thredbo Alpine Hotel
72 registrants

7th November
'Anaesthesia & Obstetrics' at Sydney Regent Hotel
308 registrants

28th November
'Anatomical Workshop' at University of Sydney
48 registrants

City and country meetings were conducted in an attempt to accommodate the broad base of anaesthetists. The themes of meetings were chosen based on contemporary dilemmas in our area and emphasising new ideas and developments. We are particularly aware of the difficulty of transferring information from a continuing education seminar to changes of practice. Providing an updated information base does not necessarily lead to altered and upgraded practices. This dilemma is the same one which troubles researchers transferring new ideas into practice.

We have been reviewing the potential for workshop based continuing education, possibly incorporating simulation. To date we have been unable to come up with a workable formula, but will continue to negotiate over this.

New South Wales (continued)

Our anatomical workshop remains popular and we have increased and upgraded some of our specimens. We would like to see a broader use of these specimens in teaching and, on request, can make them available to various courses.

Our CME activities for 1998 produced modest profits which have been responsibly audited and managed by the Committee. Some funds have been distributed to both the ASA and the College.

Draft recommendations from the Anaesthetic Continuing Education Co-ordinating Committee have included a demand for the transfer of CME funds to the parent institutions. We believe that if this transfer occurs that the ownership of the funds should remain with the state committees of the ASA and the College and should be independently ledgered, with all transactions being reported back to the state committees.

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

The year 1998 - 1999 has been one of great change for the Regional Committee. It has seen the retirement of Prof David Gibb and Dr Chris Sparks. They have been replaced by Dr Richard Halliwell from The Westmead Hospital and Dr Richard Morris from The Royal North Shore Hospital. It has also seen the relocation of our offices from Quay West in Sydney, to the Federal A.S.A. offices in Eastpoint Tower at Edgecliff.

The year has also seen the continued development of the Standing Committee of College Chairmen, a body that has a close relationship with the Director General of Health and other members of NSW Department of Health. New health policy initiatives are discussed with the Department and areas of concern are given a fair hearing. The respective Colleges and the Health Department have agreed to fund a policy analyst to help the SCCC members to digest and interpret the sometimes complex and lengthy policy documents that require review. This committee significantly reduces the time taken from development to implementation of policy change.

It is also a forum that allows members to bring to the attention of the Department major flaws in policy or guideline circulars that may have gone unnoticed, if the Department has not contacted the appropriate Colleges for comment prior to publication. Currently we are dealing with guidelines for intravenous therapy, that preclude anaesthesia technicians and clinical perfusionists from administering intravenous medication, even when supervised. Once matters such as this are brought to their attention, corrective action is usually quite swift.

It was a busy year for Hospital reviews, a total of ten being conducted. They are becoming more frequent as the number and complexity of the training programs increase. There appears to be an imbalance in the distribution of exposure to paediatric anaesthesia training in NSW. As such, the NSW Regional Committee is surveying Provisional Fellows to determine whether they believe they have been adequately involved in this subspecialty during their first four years of training. Until we are assured that all trainees receive paediatric exposure, it is difficult to see that we can further increase the number of approved training posts in New South Wales.

The Regional Committee prepared a submission to the "Inquiry into Cosmetic Surgery", chaired by Merrilyn Walton. It has been requested to attend a Parliamentary hearing to present its views on the minimum requirements, in terms of training, equipment and physical facilities needed for the safe handling of patients undergoing such procedures.

The year also saw the review of the Medical Practice Act of NSW., and the development of the controversial Performance Assessment Proposal. This proposal has been developed by,

New South Wales (continued)

and will be operated under the auspices of, the NSW. Medical Board. It has been designed to cope with Medical Practitioners, who are neither impaired nor guilty of misconduct. By design it will deal with practitioners who seem to be suffering from an overall deficit in professional skill. It will allow a process of assessment, which will determine whether remediation or retraining is required. It may place conditions on the practitioner's ability to practice, but the practitioner will also have the right to appeal to the Medical Tribunal. Following retraining, a reassessment process will be put in place to ensure that the areas of concern have been adequately addressed. It is anticipated that this process will enable the Board to retrain and appropriately deal with practitioners who in the past would have been lost to the profession.

This year is likely to see a reduction in the volume of material presented to the Regional Committee for comment from NSW. Department of Health as this body concentrates on the development of Health Service Disaster Planning for the Olympic Games.

Rural Activities:

There is still a lack of trained specialist anaesthetists in a significant number of major rural centres and the Regional Committee is endeavouring to staff these vacancies on a locum basis until suitable applicants are found. A number of these areas request staffing on an 'Area of Need' basis and the Regional Committee looks at each application on its merits.

Matthew Crawford, *Chairman*

SOUTH AUSTRALIA

Office Bearers:

Chairman:
Dr. Alan Rainbird
Vice-Chairman:
Dr. Margaret Wiese
Honorary Secretary/Treasurer:
Dr Margaret Cowling
Regional Education Officer (Anaes)
Dr Peter Woodhouse
Members:
Dr Neil Maycock
Dr John Richards
Dr Tony Laver
Dr Lisa McEwin
Dr Robert Singleton
Dr Daryl Catt (Northern Territory Representative)
Younger Fellows Representatives:
Dr Andrew Michael
Dr Alisteir Norton
Regional Education Officer – IC:
Dr John Myburgh
Councillor:
Dr Richard Willis
Directors Representative:
Dr Peter Lillie
Administrative Officer:
Mrs Sue Harrison

Dr Alan Rainbird

Dr Margaret Cowling

Total No. of Regional Committee Meetings for Year = 8

Attendances of Elected Members (No. of Meetings)

Dr Catt	3	Dr Cowling	8	Dr Laver	6
Dr Maycock	7	Dr McEwin	5	Dr Rainbird	8
Dr Richards	4	Dr Singleton	4	Dr Wiese	6
Dr Woodhouse	7				

Continuing Education

The Annual General Meeting of the South Australian Regional Committee was held on Sunday, 18th October 1998 at The Stamford Grand Hotel, Glenelg.

Continuing Education Meetings - The South Australian Regional Committee thanks the Combined CME Committee for organising the following meetings throughout 1998/early 1999, and in particular congratulations to the CME Committee for a very successful weekend meeting:

1. **7th April 1998** at College of Surgeons Building – Presentations by Dr Steve Kinnear and Dr Graeme McLeay – "Anaesthesia and Exotic Locations".
2. **4th June 1998** at Calvary Hospital – Presentation by Dr Glenn Young, Senior Visiting Cardiologist, RAH – "Peri-operative Dysrhythmic Management".
3. **14th October 1998** "Maurice Sando Memorial Lecture" at Women's and Childrens' Hospital – Presentation by Professor Alan Aitkenhead, - "Medico-Legal Implications of Spinal Opiates".
4. **17th – 18th October 1998** at the Stamford Grand Hotel, Glenelg – "Anaesthesia – The Grand Update"
5. **21st October 1998** College of Surgeons Building – "Registrars Scientific Meeting"
6. **3rd March 1999** Wakefield Hospital – Presentations by Drs Guy Ludbrook, Elizabeth Tham, David Fenwick and Scott Germann – "Day of Surgery Admissions – Solutions for Anaesthesia in Adelaide".

Northern Territory

The Committee has determined to strengthen all ties with Fellows in the Northern Territory. It was agreed that a position on the Committee shall be reserved for a Northern Territory Fellow. Daryl Catt, from Alice Springs has been the first Fellow so co-opted and communication channels have already been thereby improved.

Burnell Jose Visiting Lecturer

The 1998 Burnell Jose Visitor was Professor Alan Aitkenhead. An international authority on medical litigation, Professor Aitkenhead continued the high standard of previous Visitors and for two weeks treated both trainees and specialists to some stimulating presentations. The Maurice Sando Memorial lecture, "The legal aspects of spinal opiates", was particularly controversial, and equally memorable was his jousting with the invited barrister in the "Hypothetical" during the weekend meeting.

Tim Semple and Sue Harrison deserve congratulations for their efforts in the organisation of the visit.

Rural Anaesthesia

The national problems of providing adequate anaesthetic services to remote areas are emphasised in South Australia with our small, widely spread community. Various issues arose during the past year arising from this essential problem. The Committee welcomes the new JCCA Maintenance of Professional Standards Program and it is hoped this will facilitate our role in ensuring the best standard of anaesthetic care in remote areas.

South Australia (continued)

Regional Education Sub-Committee:

Chairman – Regional Education Officer:
Dr Peter Woodhouse
Organiser – CME:
Dr Lisa McEwin
Course Organisers – Primary
Dr Tony Pearce
Dr Grace Koo
Course Organiser – Final Fellowship
Dr David McLeod

Legal Aspects of Pathology Testing

The implications of a high profile legal case in South Australia included the issue of Anaesthetic liability where pathology request forms are signed, on the surgeon's behalf, in theatre. This matter was subject to much debate. While opinion remains divided, the Committee welcomed Council's co operation in obtaining a legal opinion on the issue.

The Chairman served on a Working Party formed by the South Australian Branch of the AMA to formulate "best practice" guidelines for the handling of pathology requests and results.

Financial Report

The Committee continues to function according to budget. Our main expense last year was represented by a new photocopier, which was much appreciated by all involved.

Training Issues

The Training Scheme continues to function well in the capable hands of Peter Woodhouse and Neil Maycock. This year there were applications from interstate hospitals for inclusion the South Australian scheme. While appreciative of the interest expressed, it was agreed, as stated above, that the Northern Territory remained our focus for new training positions. To that end there was an expansion of training positions at the Royal Darwin Hospital.

ANZCA Medal

The Committee enthusiastically welcomed Council's decision to award the ANZCA Medal to Dr Bill Fuller. Bill's standing in this State is of the highest and we believe that this is an honour thoroughly deserved.

Regional Committee Secretariat

Again, I am pleased to express my appreciation of Sue Harrison's superlative efforts in the Regional office. I would also like to thank the other Office Bearers for their support and hard work. I would like to think that we have a very good team in Adelaide.

Alan Rainbird, *Chairman*

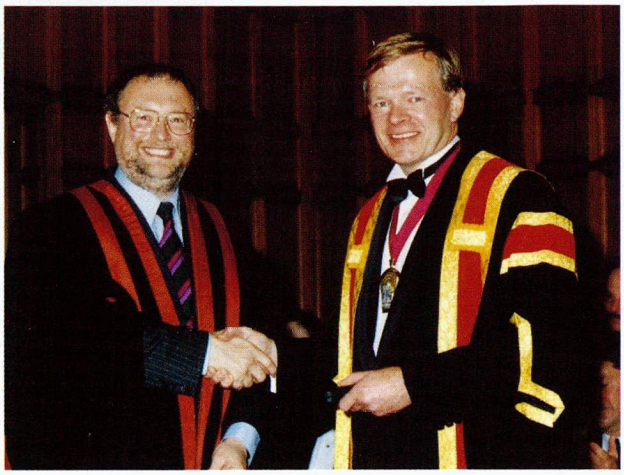
Final Examination Court – September 1999

Front L to R: *Drs Brian Trainer, Leona Wilson M O'Reilly, Peter Peres, Roman Kluger, Penny Briscoe, Kersi Taraporewalla, Ed Loughman (Chairman) Tim Costello, Geoff Mullins*

Back L to R: *Drs Andy Pybus, Jeremy Hammond, Tony Weeks, Peter Dawson, Maggie Bailey, Peter Moran, Tony Gin, Craig Morgan, Rob Beavis, Peter Gibson, Pat Farrell, Phillipa Hore, Chris Johnson, David Scott, David Jones, Michael Jones*

Foundation Visitors

1999 Annual Scientific Meeting



Professor David Rowbotham with Dr Richard Walsh

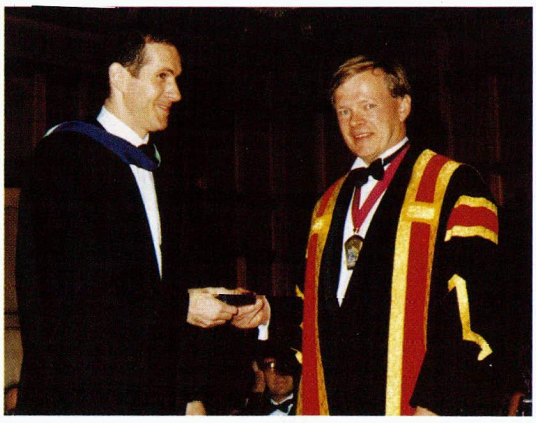
Professor Peter Moore with Dr Richard Walsh

Mr Michael Brooke, Director Hospital Business Unit, Astra Pharmaceuticals, with Australian Visitor, Dr Richard Morris and College President, Dr Richard Walsh.

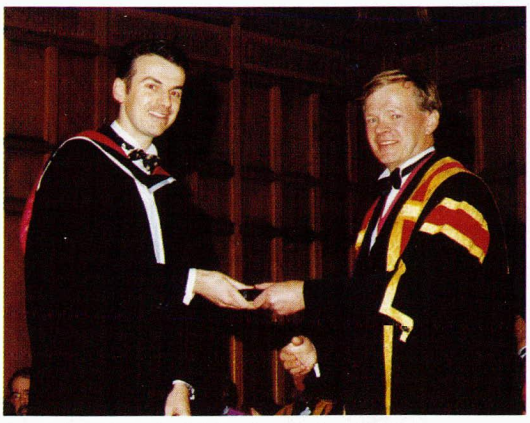
Examination Prize

presented during the College Ceremony

Renton Prize



Dr Craig Hargreaves, NSW – April 1998



Dr Brian Cowrie, VIC – September 1998

ELAIDE 1999

FORMAL PROJECT PRIZE

being presented by the President to Dr Sui-Cheun Yu, Hong Kong.

GILBERT BROWN PRIZE

being presented by the President to Dr Philip Cornish, NZ.

Left: Dr K. Inbasegaran presenting the College with a pewter plate (insert)

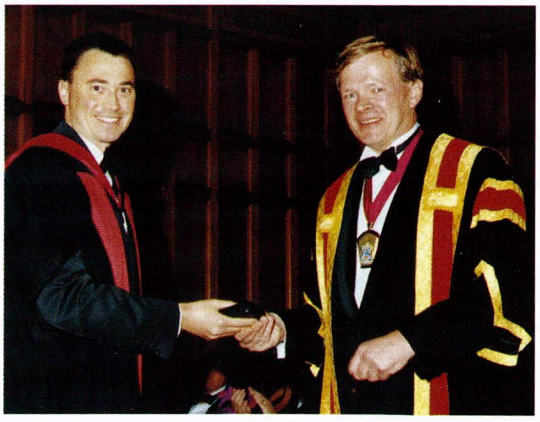
Right: Dr Gertrude Didei presenting to the President with a Fijian artefact

E WINNERS – 1998

of Annual Scientific Meeting in Adelaide

CECIL GRAY PRIZE

Dr Bernard Creati, VIC – May 1998

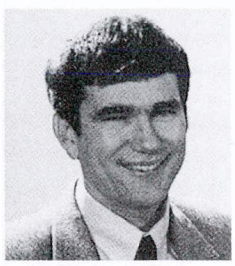


Dr Hugh Douglas, SA – September 1998

NEW ZEALAND

Office Bearers:

Chairman:
A/Professor Alan Merry
Deputy Chairman and Assistant Assessor (NZ):
Dr Malcolm Futter
Honorary Secretary:
Dr Sharon King
Honorary Treasurer:
Dr Peter Cooke
Regional Education Officer:
Dr Hugh Spencer
Formal Project Officer:
Dr Alan McKenzie
Committee Members:
Dr Forbes Bennett
Dr Rob Burrell
Dr David Jones
Dr Jennifer Weller
Councillor:
Dr Steuart Henderson
Faculty of Intensive Care
Representatives:
Dr Jack Havill, Chairman, FIC NZ Committee
Dr Ron Trubuhovich, Board of Faculty
NZSA Representative:
Dr David Chamley
Younger Fellows Representative:
Dr David Sidebotham
Administrative Officer:
Mrs Lorna Berwick
Administrative Assistant:
Ms Jan Graham



A/Prof Alan Merry

Total No. of Committee Meetings for year = 3

Attendance of Elected members:

All elected Members attended the Meetings in June and November 1998, and March 1999 apart from Dr Weller who tendered her apology for the March 1999 Meeting.

Financial Report – Dr Peter Cooke, Honorary Treasurer

The New Zealand financial position is sound with the National Committee expenses being covered by Annual Training Fees from trainees and interest received. Income from NZ National conferences continues to help fund continuing education. The Finals course in Auckland and the Primary courses in Christchurch and Hamilton were all run on sound financial lines. CECANZ, the joint CME agency of the NZSA and ANZCA remained a self funding operation during 1998.

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

Before approval of additional training posts, HAC required that NZ review its rotations to ensure that exposure for the trainees to sub-specialties was achieved. A subcommittee of NZRC suggested an amalgamation of several rotations to form three for the country was a reasonable measure, and that within about three years, a national rotation should be established. This would require national co-ordination and would need preparation and organisation to ensure it worked properly. The subcommittee anticipated there would be some centres who would not welcome change and accordingly it was emphasised that the rotations were not compulsory but an attempt at convenient geographical groupings of teaching hospitals which would co-operate in trainee placement for those few trainees who could not secure suitable positions. It was acknowledged that sub-specialty units in a small country with scattered facilities were best seen as national training resources and should not be subject to parochial protectiveness. The proposals were accepted by most of the country but will be discussed further during the Education sub-committee teleconference to be held in early April.

Auckland held a Final Exam Course in August 1998 and Primary Courses were held in Christchurch in February 1999 and Waikato in June 1998. We thank the convenors of these three courses for their time and commitment to running the courses successfully.

Four hospital training inspections were undertaken in the year to March 31st, and three further inspections will take place in April 1999.

There continued to be close liaison with the Clinical Training Agency with review of their training specifications and audit procedures being undertaken. Similarly submissions were made to other groups interested in postgraduate medical education.

Formal Projects Report – Dr Alan McKenzie, Formal Project Officer

The new Formal Projects Guidelines document, TE11 (1999), has been approved by Council and is now in effect. All trainees who have not yet completed project requirements need to be aware of the latest changes. This is the second revision in the last two years. Copy will be prepared for the next NZ Committee section of NZ Anaesthesia and Perioperative Medicine, publicising the new document.

All projects not automatically approved under TE11 (1999) are now being assessed by two reviewers, one of whom is the Formal Projects Officer. This is proceeding smoothly with no undue delays so far. With approximately 15 project per year being submitted and approved, it is expected that individual reviewers will not be used more that once a year. The review panel should be thanked on an annual basis for their work with publication of their names on the NZ Committee section of NZ Anaesthesia and Perioperative Medicine.

New Zealand (continued)

Nineteen Formal Projects were completed in the period April 1998 – March 1999:

Dr Alistair Gray: "Anaesthetic Involvement in Major Trauma"

Dr Michele Moore: "The Allergic Patient – a Multimodal Approach

Dr Michael Lorimer: Remifentanil and Propofol Total Intravenous Anaesthesia for Thymectomy in Myasthenia Gravis

Dr Charles McFarlan: The Use of Propofol Infusions in Paediatric Anaesthesia : A Practical Guide

Dr Michael Gilham: A Retrospective Audit of Blood Loss in Total Hip Joint Replacement Surgery at Middlemore Hospital in 1994

Dr Ian Carter: Isoflurane Anaesthesia for Status Asthmaticus: A New Delivery System and Case Report

Dr Paul Templer: Propofol does not show Tolerance in Children

Dr Paul Wilkins: Fibreoptic Intubation in Acute Adult Epiglottitis

Dr Bruce Anderson: Deep Hypothermia and Circulatory Arrest in Pregnancy

Dr Grant Waters: Erythromycin as a Gastric Prokinetic Agent : the Effects of 50mg, 100mg and 200 mg

Dr Andrea Nowitz: The Heimlich Manoevure following Foreign Body Aspiration may produce Acute Surgical Emphysema

Dr Janet MacPherson: Comparison of Oral Premedication for Laparoscopic Cholycystectomy: Labetalol versus Clonidine

Dr Polly Booth: Cardioventilatory Coupling in Atrial Fibrillation

Dr JoAnn Pahl: Reasons for Delay in Extubation after Cardiac Surgery

Dr Louise Trent: Cardioventilatory Coupling : The Effects of IPPV

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

Dr Mary Faigan: Intravenous Anaesthetics and Anaesthetic Vapours

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

Dr Alastair McGeorge: Sevoflurane Anaesthesia for the Removal of Chest Drains : A Case Series

CECANZ Report – Dr Vaughn Laurenson, Medical Director, CECANZ.

The Dunedin Jubilee combined CECANZ/ASA meeting held in August 1998 was a resounding success, as was the Single Theme meeting on "Complications of Anaesthesia and Intensive Care" held in Napier in March 1998. The 1999 Single Theme meeting on "Audit in Anaesthesia" has just taken place in Invercargill. Departments reported on their audit procedures and the MOPS program was discussed in depth. Comments on this meeting have also been most favourable.

The AGM of NZ Fellows of ANZCA was held on August 20th 1998 during the Dunedin meeting and was attended by 20 Fellows.

Three HELP modules have been produced over the last year.

Assistant Assessor (NZ) (Vocational Registration) Report – Dr Malcolm Futter

The numbers of overseas trained anaesthetists seeking vocational registration in New Zealand has declined in the last year.

New Zealand (continued)

To support applications to the Medical Council ANZCA still requires, as an absolute minimum, that the vast majority of these doctors pass the Final Fellowship exam and spend a year in a suitable post. In several instances the Medical Council has considered ANZCA's advice inappropriate and in effect granted vocational registration without examination or "formal assessment".

As Assistant Assessor (NZ) I continue attempts at alignment of the views of ANZCA and those of the Medical Council. We need a system that ensures the continuance of our high standards of specialist practice without discounting qualifications that are non FANZCA

Faculty of Intensive Care – Dr Ron Trubuhovich, Board Member

With the gazetting of Intensive Care Medicine (ICM) as a vocational specialty separate from Anaesthesia awaited (currently the matter still lies within the Ministry of Health – prior to Government acceptance) there was considerable and robust discussion re the implications of this for anaesthetists in (part-time) intensive care practice, but unable to claim vocational registration in ICM. A subcommittee will be formed for anaesthetists concerned, in liaison with intensivists.

The regular co-operation in the elaboration of responses to Government discussion papers etc. continues between the two committees.

Faculty of Pain Medicine – Dr David Jones, Censor

There were 170 applications for consideration as possible Foundation Diplomates. A set of criteria have been applied and the initial response is nearing completion. This process has assessed suitable practitioners from the several participating Colleges – ANZCA, RACS, RACP, RANZCP and AFRM and it should be noted that although hosted by our own College, it is in fact a conjoint effort. Once announced, NZ practitioners will be amongst the successful applicants. There will be further possibility for Election to Fellowship of practitioners who fulfil criteria within the regulations. There is still considerable work on which to proceed towards developing an examination, and accreditation of units for training towards this Fellowship - noting that it is a step further on since the original Certificate in Pain Management, which has now ceased.

CHAIRMAN'S REPORT – Dr Alan Merry

Professional Affairs

The year May 1998 – April 1999 has been characterised by a focus on internal matters of the NZ Committee, against the usual extremely busy background of business related to regulatory bodies, government agencies and Fellows.

Over the last 12 months activities have included:

Registration of overseas trained doctors

See Assistant Assessor (NZ) report. This has been an arduous task, ably undertaken by Malcolm Futter and very time consuming for Lorna Berwick. There are political moves to change the Medical Practitioners' Act and there is no doubt that more flexibility is going to be needed in the future. My opinion is that the status of our Fellowship needs to be protected more carefully than it has sometimes been in the past, but that we need also to acknowledge that there are people without our Fellowship who are capable of practising as specialists.

In the meantime, great care is taken to implement the rules fairly in the interests of maintaining safe standards of professional practice in Anaesthesia .

Council of Medical Colleges

The Council of Medical Colleges (CMC) in New Zealand serves a similar function to the Committee of Presidents of Medical Colleges in Australia. A Memorandum of Understanding (MOU) has been drawn up with the Ministry of Health to facilitate closer co-operation in

New Zealand (continued)

the development of policy and in dealing with matters in relation to health. Regular meetings with Ministry officials, frequent ad hoc communications, one on one, and small teleconferences have contributed to making the MOU work. There are inevitably, great difficulties in the culture change implied by suggesting that Government and doctors should talk to each other confidentially and constructively, instead of just sparring publicly on every issue. The initiative is in its infancy, but it is an important step forward.

NZPODS

I am a member of this working party, chaired by Dr Leona Wilson, ex NZ Committee. We are attempting to establish a broadly based mortality and morbidity survey of healthcare procedures in New Zealand. The Ministry of Health has agreed to provide 50% of the funding. The remainder is to come from all participating Colleges. It is likely that the eventual survey will operate under the auspices of CMC, and that all NZ Colleges will be contributors. The final details of implementing this idea are still being negotiated. This is a project focused on patient standards and improved safety in procedural medicine. This multidisciplinary project has clearly arisen from the efforts and commitment of anaesthetists and Leona has provided good leadership and much hard work. We hope to reach a stage where the committee can start to function within the next few months.

New Zealand Society of Anaesthetists

NZC is working towards a closer relationship with the NZSA. As a first step, NZSA secretariat has been relocated in Elliott House; NZSA now shares the facilities and resources of our secretariat. Dr David Chamley, NZSA President, has attended recent NZC meetings and is showing great commitment to fostering an improved partnership. This is an initiative which has my full support. I think an independent "trade union" is a good idea, but in reality the majority of NZSA activities are related to patient care, standards, welfare of anaesthetists and other matters which are core business for ANZCA. There is much to be gained by closer co-ordination and co-operation, and sharing of resources.

Newsletter

NZ Anaesthesia and Perioperative Medicine is a conjoint newsletter of high standard, shared by NZC, NZSA and CECANZ. It has evolved from much humbler origins, and Rob Ebert's recent appointment as editor has revitalised the enthusiasm for developing NZAPM into something which may eventually become a peer review Journal. Much work has gone into setting the framework for the ongoing operation of this journal and if it is to grow under present and future leadership, clear delineation of ownership, responsibilities, liabilities and policies is worthwhile. Rob Ebert is to be congratulated and Dr Dave Chamley has also played a major role is guiding the process over the last year. Dr Rob Burrell has been appointed sub editor for ANZCA and has promoted ANZCA' s section of NZAPM very effectively.

Other Professional Matters

Ongoing active liaison with the Medical Council of New Zealand, the Clinical Training Agency, the Anaesthetic Technicians' Board, the ACC, the NZMA and other organisations keeps the NZ Committee very busy. The workload has become a major problem. At secretarial level, we have appointed Jan Graham to assist Lorna Berwick (Jan works three days for ANZCA and two for NZSA). She has been a great asset, and I would like to welcome her formally at this point. The future may include an executive officer. Both Lorna and Jan are very able and Lorna, with her years of experience and considerable knowledge of College affairs is a great support to the Office, Examiners and Committee members.

Nevertheless, the burden falling on the Chair, the Secretary, the NZ Assessor, the Education Officer and the other officers of the NZ Committee is increasing. The demands for representation at numerous meetings is never ending, often at increasingly short notice. I have just declined to attend an urgent meeting in a different town set up by the Ministry of Health over a problem that has been going on for years – called at two days notice! Similarly, the need for submissions on various topics is ever increasing.

New Zealand (continued)

Medico-Legal Matters

These continue to arise and the NZ Committee is often asked to respond or provide advice. Mr Bruce Corkill our legal advisor, has been a great help in dealing with these matters and I would like to record my appreciation of his excellent advice.

Maintenance of Professional Standards Program – Confidentiality

The ANZCA MOPS program has been registered under the provision of section VI of the Medical Practitioners' Act. For all reasonable purposes, this provides a considerable measure of confidentiality.

Submissions and Reviews

Submissions have been made to the Ministry of Health on confidentiality through the Medical Practitioners' Act and also on the Transport Accident Investigation Amendment Bill. Among reviews carried out have been; the Council of Medical Colleges document on RMO training; the Memorandum of Understanding with the Health Funding Authority; the Memorandum of Understanding between the Ministry of Health and Council of Medical Colleges; Nurse Prescribing and Medical Electrical Equipment Standards. Members of the Committee have attended a workshop on recertification at the Medical Council, a meeting with representatives of the Clinical Training Agency and regular meetings of the NZ Medical Association.

NZ Committee in ANZCA

As always, Joan Sheales, successive Presidents and several Councillors have provided considerable help to New Zealand in dealing with problems of New Zealand national interest. I would particularly like to thank Bill Peachey and Dick Willis who visited NZ last year and Dick is coming again to help improve the way we handle GST in New Zealand. Similarly, the President, Richard Walsh will be attending our next NZC meeting and has been a ready source of support and advice over the past year.

I was invited to attend Council as an observer during last year. This opportunity was very valuable in improving understanding on both sides concerning some of the difficulties facing NZC at a national level. I understand this opportunity will be extended to the Chairs of other Regional Committees and to future Chairs of NZ Regional Committee. Notwithstanding the logistical difficulties (flight to Melbourne diverted to Sydney because of cracked windscreen; flight home delayed 10 hours because of engine trouble!), this visit was very valuable and much appreciated.

The NZ Committee must continue to develop if ANZCA is to contribute optimally in health related matters in NZ, to ensure that our high standards are maintained in the interests of patients . It is a battlefield, and there are many pressures which seek to undermine the position of doctors in general and anaesthetists specifically. These are motivated by the idea that organisations such as ANZCA are essentially cartels designed to protect their Fellows.

There is inadequate recognition of how difficult and dangerous specialist medicine really is, and how essential high standards of education, skill and practice are to patient safety. To be effective in New Zealand, ANZCA must have a clearer New Zealand identity and a greater ability to act in New Zealand from a New Zealand perspective. The structure in which bi-nationalism is recognised does vary from College to College. In ANZCA, good will of all parties has been the key to success. It would be a significant advance if this could be underpinned by an organisational structure which more readily facilitates national activities.

Acknowledgements

As always I would like to thank every member of the NZ Committee for taking up their various tasks and dispatching them professionally and willingly. Lorna Berwick has coped admirably with a very difficult year and Jan Graham has fitted in and contributed effectively from day one. We are well served by our secretariat.

Alan Merry, *Chairman*

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

Formal Project Officer:
Dr Grant Turner

Members:
Dr Gavin Coppinger
Dr Nedra vanden Driesen

Councillors:
Prof Teik Oh
Dr Wally Thompson

Co-opted:
Dr Paul Tucker, CE Committee

Younger Fellows Representative:
Dr Lindy Roberts

Welfare Officer:
Dr Lindy Roberts

Dr Leigh Coombs

Dr Stuart Inglis

The Fellows listed above were elected to the ANZCA WA Committee in July 1998. Committee members retiring at that time are thanked and acknowledged for their contribution; Dr Hugh Speirs (Chairman), Dr Geoff Mullins (Secretary), Dr Michael Hellings (Treasurer), Dr Phil Smith, Dr Terry McAuliffe and Dr Craig Sims (Committee) and Dr Moira Westmore (Councillor).

Total No. of Regional Committee Meetings for Year = 5

Attendance at WA Regional Committee Meetings July 1998 - February 99

Dr Leigh Coombs	5	Dr Grant Turner	3	Dr Stuart Inglis	4
Dr Michael D'Souza	5	Dr Michael Paech	4	Dr Gavin Coppinger	4
Dr Wilson Lim	3	Dr Nedra vanden Driesen	4	Dr Neville Gibbs	4
Prof Teik Oh	5	Dr Wally Thompson	2	Dr Lindy Roberts	3
Dr Aileen Donaghy	0	Dr Stephen Edlin	0	Paul Tucker	2
Simon McLaurin	1	Roger Goucke	2		

The Western Australian Committees of ANZCA and ASA have held a combined meeting preceding their separate meetings on 28.7.98, 8.12.98 and 23.2.99. This pattern will continue.

Dr Aileen Donaghy (Chairman ASA WA) chairs the ASA WA Committee meeting held at the same time and same venue as the ANZCA WA Committee meeting.

Dr Wally Thompson (past President ASA) often attends the ASA WA Committee meeting held at the same time and same venue as the ANZCA WA Committee meeting. Prof Oh therefore represents Dr Thompson at the ANZCA WA meeting.

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 at the June 99 ANZCA WA AGM.

Financial Report - ANZCA – ASA Continuing Education Account – 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 ASA WA and ANZCA WA AGMs.

Regional Education Officer's Report - Dr Grant Turner

Trainee Allocation
The Western Australian Training Rotation has the following training hospitals:

	Supervisors of Training
Royal Perth Hospital	Dr J Akers
Sir Charles Gairdner Hospital	Dr L Roberts
Fremantle Hospital	Dr L Avraamides
Hollywood Private Hospital	Dr J Storey
King Edward Memorial Hospital	Dr M Paech
Princess Margaret Hospital	Dr P Tucker

There is only one non trainee in a training position at present. He is currently sitting the Primary Examination.

Trainee Teaching

A Primary course is run every Friday for all primary candidates and covers Physiology and Pharmacology in a structured manner such that the entire curriculum is covered in 12 months. This is run at Royal Perth Hospital by Dr Wong and Dr vanden Driesen.

A structured course for final candidates is run at SCGH by Dr Weightman on Wednesday evenings. This is supplemented by clinical and viva sessions run at Royal Perth Hospital on Thursday afternoons by Dr Cokis.

Western Australia (continued)

ASA Representative:
Dr Aileen Donaghy

Faculty of Intensive Care Representative:
Dr Stephen Edlin

Faculty of Pain Medicine Representative:
Dr Roger Goucke

Rural Anaesthesia Representative:
Dr Wilson Lim

Continuing Education Committee:
Dr Simon Maclaurin

Regional Education Sub Committee:
Dr Grant Turner (Chairman)
Dr Leigh Coombs
Dr Nedra vanden Driesen

Administrative Officer:
Ms Penny Anderson

The success of these courses is reflected in the consistently high pass rates achieved by Western Australian candidates.

ITA Forms

All ITA forms are up to date and have revealed a satisfactory or greater level of performance from all trainees.

Miscellaneous

There have been no requests for accreditation in the last 12 months though the possibility exists of training positions being organised for Bunbury Regional Hospital and Joondallup Hospital in the future. Proposals have been received regarding the involvement of Trainees in Hyperbaric Medicine and Medical Simulation in WA.

Anaesthesia WA Continuing Education Committee – Dr Michael Paech

This is a Combined Committee of ANZCA WA and ASA WA responsible for CE activities. The Committee meets approximately every three months.

State Meetings

Anaesthesia WA Winter Scientific Meeting - July 98
A one day meeting featuring the ANZCA WA AGM, free papers, invited speaker Dr Brian Horan (1998 Dr Ian Miller Lecturer) and a hands-on workshop on Paediatric anaesthesia.

Anaesthesia WA Autumn Scientific Meeting – March 99

A one and a half day meeting featuring the ASA WA AGM, interstate speakers Dr Greg Knoblanche (1999 Dr Peter Brine Lecturer) and Dr Charles Minto, invited WA speakers, free papers, presentation of Gilbert Troup Prize for Medical Students in Anaesthesia, the Nerida Dilworth Prize for the best scientific paper presented by a Registrar in WA over the previous 12 months and the D R C Wilson Memorial Lecture presented by Professor Teik Oh. Dr Knoblanche also presented a special tutorial for Trainees. The meeting also featured a 31 booth Industry Exhibition, Art Exhibition and Annual Western Australian Anaesthesia Dinner.

Anaesthesia WA 1998-2000 Autumn Lectureships Honouring Dr Peter Brine and the Anaesthesia WA 1998 - 2000 Winter Lectureships Honouring Dr Ian Miller.

In 1998 the CE Committee inaugurated the naming of the Autumn and Winter Lectureships to honour outstanding Western Australian Anaesthetists Dr Peter Brine AM and Dr Ian Miller AM. These annual lectureships are generously sponsored by Abbott Australasia and Glaxo Wellcome Australia respectively.

Anaesthesia Continuing Education for WA Rural GPs, Technicians and Recovery Room Nurses
As in previous years, Anaesthesia WA Continuing Education with the assistance of Industry, University and Health Department sponsorship continued to conduct country visits (Kalgoorlie in July '98 -coinciding with the visit of Dr. Horan and to Broome in October). These meetings provide an important source of CE for general practitioner anaesthetists, technicians and nursing staff who practise in rural areas in WA.

Registrar Meetings

This year saw the initiation of CE meetings designed especially for Registrars, the first on the concept of "Thriving and Surviving in your Anaesthetic Career" and the second, in December, on several topics related to training and examination, research and publication. Further such meetings, including themes central to welfare, are being developed currently.

Foundation Visitor's Tour to WA

Professor Hugo Van Aken visited Western Australia in May 98 and presented lectures to Fellows and tutorials to Trainees.

Western Australia (continued)

CASMS Centre for Anaesthesia Skills and Medical Simulation

The WA simulator is an excellent facility expertly run by a dedicated Committee under the auspices of ASA WA. ANZCA WA is represented on the board of management.

National Scientific Congress of the ASA – Perth in October 2000

Planning is in progress for an excellent meeting next year. Members of the ANZCA WA Committee are contributing to the Conference Organizing Committee.

Faculty of Intensive Care

Represented on the ANZCA WA Regional Committee by Dr Stephen Edlin.

Faculty of Pain Medicine

Represented on the ANZCA WA Regional Committee by Dr Roger Goucke (Vice Dean).

ANZCA WA – MOPS Report for 1998 – Prof Teik Oh

A large number anaesthetists (124) in Western Australia participated in the ANZCA Maintenance of Standards Program (MOS) for 1998. Of these, 117 were FANZCAs and this is probably the highest proportion of participation by ANZCA Fellows in a Region. The demographic figures are given below. There were no major queries by Western Australian participants on the MOPS Program, which saw its last year in 1998.

The new ANZCA Maintenance of Professional Standards Program (MOPS) came into effect on 1 January 1999. Participants have been issued with the Manual, and paper or computer diaries (Portfolio of Activities) to record activities will be issued in March 1999.

MOPS 1998, Western Australia

Number of Participants:	ANZCA Fellows	117
	Non Fellows	7

ANZCA and ASA in Western Australia

The WA committees of the Society and College choose to work closely together for the benefit of Anaesthesia in Western Australia. The Chairmen confer on most matters. A combined meeting of the committees is held every two months. It is jointly led by the respective Chairmen. Many issues of common interest are debated and discussed at these valuable forums.

Western Australian Anaesthesia Mortality Committee – Dr Neville Davis

The WA Anaesthetic Mortality Committee is a statutory body which was set up to comply with section 336 B (amendment No. 47,1978) of the WA Health Act. It is mandatory for the medical practitioner involved to report any death which occurs within 48 hours of the administration of an anaesthetic, and any death which is the result of complications arising from administration of an anaesthetic. The ANZCA WA nominee, Dr Davis, is also chairman of the Committee.

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, special services, continuing education, news, links to other Perth Hospitals and useful national and international sites. All material on the site is checked by the Chairmen of the WA Committees and the head offices ANZCA and ASA. The website is a project of ANZCA and ASA in WA and is sponsored by ASTRA Australia.

Chair of Anaesthesia in Western Australia – Prof Teik Oh

The University of Western Australia has selected Professor Teik Oh for the position of Chair of Anaesthesia. This will be funded by and located within the Department of Anaesthesia at Royal Perth Hospital. The Chair has been established within the UWA Department of

Western Australia (continued)

Pharmacology. Professor Oh is currently Vice President of ANZCA, Councillor, QA/MOPS Officer, Chairman of the Executive and Asia-Pacific Committees and member of Education, CE&QA and Research Committees.

Western Australian Health Authority

ANZCA WA and ASA WA have made joint submissions in reply to the Health Department's request for comment on plans for reorganization of the health care delivery system in the metropolitan area.

ANZCA WA is represented on the WA Health Department's Statewide Anaesthesia Reference Group. This tripartite committee also has representatives from Rural GPs. It addresses matters relating to the provision of anaesthesia services in rural centres of WA.

The WA Health Department has also been very supportive of the development of the simulator in WA for anaesthesia and medical simulation.

Western Australian Centre for Remote and Rural Medicine and RACGP-WA

ANZCA WA has a helpful and productive relationship with WACRRM and RACGP - WA, the GP organizations responsible for coordination of training and aspects of continuing education of GPs providing anaesthesia in rural areas of WA. The development of the training guidelines and MOPS programs by the JCCA (ANZCA - RACGP-ACRRM) will impact on the current arrangements in WA and the current processes of liaison will facilitate their smooth integration.

Medico Legal Matters

The Medical Defence Association of WA has had a close and productive collaboration with Anaesthesia in WA for many years. The MDAWA Council includes a Fellow of the College. Special joint risk management seminars have been conducted for many years with a favourable impact on Anaesthesia practice and medical defence premiums for WA Anaesthetists.

ANZCA WA also receives requests to recommend Fellows for duties as expert witnesses in medico legal cases.

Western Australian Anaesthetists Support Group

A small informal group of WA Anaesthetists offers support to Colleagues in the midst of professional or personal crisis. It is a joint project of ASA and ANZCA in WA.

I thank the members of the ANZCA WA Committee, the ANZCA Councillors and the many Fellows who give their time and talents to the work of the College in WA.

Leigh Coombs, *Chairman*

TASMANIA

Office Bearers:

Chairman:
Dr Margaret Walker
Honorary Secretary:
Dr Ruth Matters
Honorary Treasurer:
Dr David Allen/Phillip Browne
Regional Education Officer:
Dr Michael Grubb
Continuing Education Officer:
Dr Richard Waldron
Councillor:
Dr Mike Martyn
Administrative Officer:
Mrs Di Cornish

Dr Margaret Walker

Dr Ruth Matters

Regional Committee Meetings for the Year since July 1998 = 2

Dr Walker	2	Dr Grubb	2
Dr Waldron	2	Dr Martyn	1
Dr Allen	2	Dr Matters	1

Supervisor of Training - Dr Margaret Walker

Rotation program to Burnie is in its first year. This is our rural training position and is a popular rotation with trainees.

Final Examination had a 100% pass rate with 5 out of 5 candidates passing the exam.

Annual General Meeting was held at Launceston Country Club.

Our three Continuing Education Meetings throughout the year were most successful and well attended by both local and interstate registrants.

In August, the Meeting held at the Launceston Country Club heard Professor Felicity Reynolds (UK), Dr Mochael Paech (WA) and Mr Michael Gorton, the College Honorary Solicitor provide an Update on Obstetric Anaesthesia.

Thoracic Anaesthesia was the theme for the Meeting held in October at Cradle Mountain. Professor J. Brodsky from Stamford University California, Dr Rod Westhorpe and Dr Rod McRae from Victoria and Dr Richard Wood-Baker were the guest speakers.

Drs Roman Kluger and Colin Royse, Victoria with Dr Richard Walsh, the College President and Dr Luke Galligan, Tasmania addressed the topic "Anaesthesia and the Heart" during the Meeting at Free Lodge in February.

Ruth Matters, *Honorary Secretary*

AUSTRALIAN CAPITAL TERRITORY

Office Bearers:

Chairman:
Dr Paul Burt
Honorary Secretary/Treasurer:
Dr Frank Lah
Continuing Education Officer:
Dr David Kinchington
Member:
Dr Ray Cook
Faculty of Intensive Care Representative:
Dr Trevor Dobbinson
ASA Representative:
Dr Vida Vilunas

Dr Paul Burt

Total No. of Regional Committee Meetings for the year = 4

All meetings were fully attended by the elected Regional Committee members.

1998 saw the introduction of the three year accreditation of registrar training at the Canberra Hospital. Advertisements for the accredited positions drew a wide field of applicants of whom three were chosen.

Three out of the four registrars obtained their Primary with Dr Craig Hargreaves being awarded the Renton Prize at the May examination.

The Annual General Meeting of Fellows was held in conjunction with "The Art of Anaesthesia" Continuing Education Meeting on 17th September 1998.

REPORT

1998 was a frustrating year for Canberra Fellows of the College. Much of the first half of the year was involved in negotiating individual contracts with the two Public Hospital Authorities. Attempts to write into the contracts clinical performance conditions set by non Anaesthetic Clinicians were strongly resisted by the individual anaesthetists.

The Continuing Education Meeting "The Art of Anaesthesia" held in September was well attended by both local and interstate Fellows. The feedback from the attendees was that the Meeting was both stimulating and entertaining.

Paul Burt, *Chairman*

HELP MODULE REPORT 1997-1998

There were 6 modules produced during this report period. The subjects were:

Anaesthesia for endocrine and metabolic disorders
Aspects of pain management
Equipment, safety and monitoring
Anaesthesia immunology and infection
Anaesthesia for abdominal and pelvic surgery
Recovery, acute pain management and day surgery

The scores have remained consistently in the mid 70% range despite a change in editorship. This is encouraging as it suggests the editorial policies are consistent. If too many anaesthetists were getting high scores we would feel that the educational value was low.

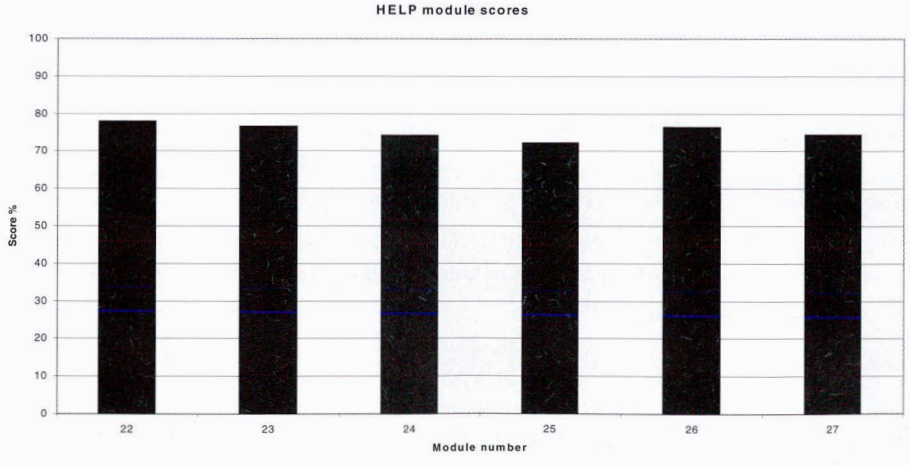
During the 2 years the returns have continued to climb from around 300 to 360 per module (2800 are distributed). The names of those who return answers are supplied to ANZCA for MOPS returns.

It is worth commenting on the process for the production and marking the modules.

Questions are sought from anaesthetic departments in New Zealand. The editor is directive about the subjects of the questions to avoid repetition. Special mention should be made of Mike Buist and Gillian Bishop who have for years provided the intensive care questions. Questions obtained by this process make up about 2/3 of the questions in most modules, the rest being written by the editor. The references for all questions are checked and where possible the papers obtained and read. The draft module is then reviewed and edited by the CECANZ committee, before being assembled into final form for publication.

Because the questions are contributed by many anaesthetists, they reflect the individual's interpretation of the literature. The editorial committee checks the references to try and ensure correct interpretation, but many of the areas we ask questions about are contemporary practice where there may not be black and white answers. We note the many comments we receive on the answer sheets, but they do not usually follow a consistent pattern. If we have made you think differently about an aspect of your practice we have succeeded in our aim.

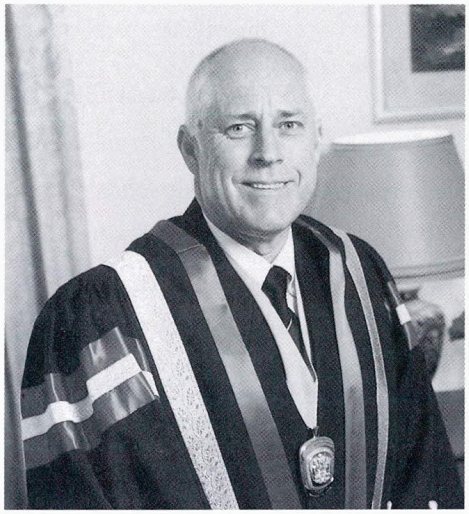
CECANZ Committee.



Help modules count

module	21	22	23	24	25	26	27	28
totals	294	249	302	306	304	310	334	361

FACULTY OF INTENSIVE CARE
DEAN'S MESSAGE



The 1999 Annual Scientific Meeting held recently in Adelaide has been acclaimed an outstanding success. Delegates to the meeting numbered over 800 and the Organising Committee is to be congratulated on the quality of the Scientific Program. Although the number of delegates who register solely for the intensive care program is relatively small, attendance at the intensive care sessions was extremely healthy. This reinforces the need for a quality intensive care program not only for specialists who are qualified and work in intensive care but also for the many anaesthetists who continue to make an important contribution to the provision of intensive care services in Australia and New Zealand and have a need for continuing education in the field.

Undoubtedly the success of this combined meeting hinges on the quality of speakers and topics chosen by the Organising Committee. In this regard, the presentations of the Faculty Foundation Visitor, Professor Rick Albert, were not only of superb standard but also of broad interest.

An important observation was made during the meeting regarding the benefits of the Faculty of Intensive Care being associated with such a large medical meeting. It is perhaps a pity that more physician intensive care specialists did not avail themselves of the opportunities provided by the program. We hope that this will occur at the 2000 Annual Scientific Meeting to be held in Melbourne. The intensive care component of the meeting will be held in conjunction with the Victorian Branch of ANZICS. It is to be hoped that success of this format leads to further combined meetings of these bodies at a National level. Certainly, the enthusiasm of the Organising Committee, the choice of international speakers and the preliminary Scientific Program would appear to guarantee that success in 2000.

In the last Dean's Message, I outlined the process that has been put in place to examine the issue of an independent College of Intensive Care Medicine. Since that time, the JSAC-IC Working Party has invested considerable effort in producing a Discussion Paper for consideration by all intensive care specialists and trainees. The cooperative and flexible attitudes of the Working Party that I stressed as being important have been fully evident. The Discussion Paper is currently being finalised prior to presentation to the June meeting of JSAC-IC and prior to circulation to all intensive care specialists and registered trainees. The accompanying survey will provide important information as we proceed along this path. It is to be hoped that we can all pursue this matter in a calm and considered manner and so ensure the best outcome for the specialty of intensive care and our future trainees.

With regard to trainees, it is interesting to note that the Faculty now has 146 registered and active trainees. This represents an increase of over 30 in the last few months, largely due to the requirement that trainees must now be registered with the Faculty in order for their core intensive care training to be recognised. The evidence is emerging both from the number of registered trainees and candidates for the examination, that we will meet the targets required to satisfy intensive care workforce demands over the coming years.

Alan Duncan

A.W. DUNCAN, DEAN

STAFF PROFILE

MRS SEVERINE MONNET-GEARON

Severine is the Administrative Assistant for the Faculty of Intensive Care, ANZCA. Her duties include monitoring the Faculty's Maintenance of Standards Program, assisting the Hospital Accreditation Committee and handling training enquiries.

Severine arrived in Australia from Avignon, France in 1995 to complete the work experience component of her Business/ Languages Degree by participating in the organisation of the Geelong Airshow. She returned to Australia in 1996 and joined the Faculty in September 1998.

Severine has been awarded the Gold Medal for the Violin by the Conservatoire in Avignon. She also enjoys tennis and swimming and in 1991 she and her family were recorded in the Guinness Book of Records as the fastest family to complete a relay race.

FACULTY FINAL FELLOWSHIP EXAMINATIONS

AUGUST/SEPTEMBER 1999

General Intensive Care Fellowship Examination

CLOSING DATE	**21 June 1999**
WRITTEN SECTION	**9 August 1999**
ORAL SECTIONS	**16 – 17 September 1999, Liverpool Hospital, Sydney**

Paediatric Intensive Care Fellowship Examination

CLOSING DATE	**21 June 1999**
WRITTEN SECTION	**9 August 1999**
ORAL SECTIONS	**14 September 1999, New Children's Hospital, Sydney**

Candidates may be interested in the **Australian Intensive Care Clinical Refresher Course**. It will be held in Brisbane from 27 – 29 August. Further information is available from Dr B. Venkatesh, Department of Intensive Care Medicine, Royal Brisbane Hospital, Herston, QLD 4029.
Tel: 07 3253 8111
Fax: 07 3253 3542
email: venkateshb@health.qld.gov.au

The **ANZICS Annual Registrars Course** will be held on 23, 24 and 25 of July, at the University of Melbourne.
Enquiries Mrs A.M. Burger, on 03 9639 3699.
email: anzicsoc@ozemail.com.au

Faculty Fellowship Examination Melbourne, May 1999

The May 1999 Fellowship Examination saw the introduction of the revised examination format. The Investigation Section was conducted in an OSCE (Objective Structured Clinical Examination) format, with candidates rotating through 12 stations to encounter a variety of investigations, and included a communications scenario involving an actor. The Cross Table Viva Section consisted of six tables of examiners with standardised scenarios and questions. The Clinical Section was held at the Alfred Hospital, Melbourne.

The changes are aimed to accommodate the increasing numbers of candidates and to ensure a consistent and objective means of assessment. An Examiner assessor has also been appointed to provide feedback on the performance of examiners.

The Court of Examiners: Drs Peter Morley, John Myburgh, Felicity Hawker, Richard Lee (Chairman), Steve Edlin, Jim Tibballs, Ron Trubuhovich, Graeme Hart and Jamie Cooper (J. Morgan unavailable)

Dr Peter Harrigan and Dr Nick Edwards celebrate following the Examination

Successful candidates: Drs Antony Stewart, NSW, Ross Calcroft, HK, Anne Leung, HK, Peter Harrigan, WA, Nick Edwards, SA and Neil Widdicombe, SA

REGIONAL COMMITTEES

ANNUAL REPORTS 1998 – 1999

NEW ZEALAND

Office bearers and members

Chairman :	A/Professor Jack Havill
Vice Chairman:	Dr Ron Trubuhovich
Hon Secretary:	Dr Ross Freebairn
Hon Treasurer	Dr Forbes Bennett
Education Officer:	Dr Forbes Bennett
Committee member	Dr Jim Judson
Ex officio members:	
Board representative:	Dr Ron Trubuhovich, NZ
Younger Fellow representative	Dr Ross Freebairn

Number of meetings per year

20th June 1998 – Wellington	Attendance – 4 (2 apologies)
28th November 1998 – Auckland	Attendance – 5 (1 apology)
29th March 1999 – Wellington	Attendance – 5 (1 apology)

Annual Meeting for New Zealand

27th November 1998
This was held in association with the one-day ANZICS meeting in Wellington.

Offices and Secretariat

Elliott House, 43 Kent Terrace, Wellington

Administrative Officer :	Mrs Lorna Berwick
Administrative Assistant :	Ms Jan Graham

Education

NZ based trainees as at December 1998

Auckland Hospitals	– 5
Waikato Hospital	– 5
Wellington Hospital	– 2

Because trainees move in and out of different disciplines and hospitals it is very difficult to keep complete information on them, as they are often out of the area where intensive care supervisors are active. There needs to be a much better system developed across Faculty records, and liaison between the central office and the local Education Officer needs to be streamlined.

General Activities

a) Submissions:

i) To the Health and Disability Commissioner on the Review of the Health and Disability Commissioner Act 1994 and the Code of Rights for Consumers of the Health and Disability Services. This Act and Code are being reviewed. We combined with the NZ Registration Sub-committee of ANZCA to make a substantial submission. Submitted April 1999.

ii) On the discussion paper "Health and Hospital Services Review of RMO Training – the Employer's Perspective" – February 1999. This was a detailed discussion paper on workforce planning in New Zealand.

Suggestions included :

- that an alternative pathway for RMOs be explored by a working party comprising the Hospital and Health Services, the Medical Council and Vocational representatives, the Clinical Training Agency and some current and potential practitioners
- that a National Workforce Planning Group be established around suggested stakeholders to develop a New Zealand model.
- physician extenders to be looked at

iii) As "Part VI of the Medical Practitioners' Act 1995: Quality Assurance Activities" is about to be reviewed, we have been asked to make a submission by May 28, and a discussion paper produced by the Ministry of Health

b) Speciality status for intensive care medicine in New Zealand

Due to the persistence of Ron Trubuhovich this matter has progressed, albeit slowly. It has been agreed by the Medical Council that intensive care medicine should be a recognised separate "vocational" discipline, i.e. specialty. The matter is now in the hands of Government agencies who are progressing slowly with formal gazetting. We are assured that it is merely a matter of time, but there may be some purposeful delay.

One of the problems to be faced is that under the Act, to be admitted to vocational registration, an individual has to have the qualifications which the Medical Council (usually on the

recommendation of the College) will approve for a specialist. This leaves those without a FFICANZCA and practising intensive care, i.e. many FANZCA anaesthetists and some overseas trained specialists without either of the above qualifications, in an awkward situation. The solution of the Act is that they require "oversight" from those who are vocationally recognised. Thus we have a complex situation developing for intensive care and there will clearly have to be some accommodation of the various interests. Our anaesthesia and medical colleagues have some major reservations about the idea of intensive care becoming a separate vocational speciality. The place where intensive care starts and anaesthesia ends is not clear, especially in such areas as after open heart surgery. Smaller hospitals with a local intensive care unit will also have to have most of their "intensive care" anaesthetists and physicians under "oversight", quite often from afar. The New Zealand Committee is going to have to do quite a lot of work in this area and will have to work closely with the Medical Council in interpretation of the Act.

c) New Zealand JSAC

The Medical Council has expressed a wish to have one intensive care body making recommendations about entry onto the Vocational Register. Hence a NZ JSAC is in the process of being set up to combine the Faculty, Physician and ANZICS interests in New Zealand. It is complicated, as some of its functions will differ from the (Australasian) JSAC which supervises all trainees, including NZ Faculty trainees. However, in New Zealand the physician intensive care trainees are supervised by the NZ Specialist Advisory Committee (SAC), separate from their Australian counterparts. At the moment it is expected that the NZJSAC will not supervise Faculty trainees and leave this to the Australasian body. However, it will make combined recommendations to the Medical Council re entry of New Zealand and overseas specialists to the Vocational Register and act as an advisory group to the Medical Council and Government on relevant matters.

This complex issue has been a source of great confusion to the physicians and we hope to hold a teleconference on the matter soon.

d) Research on the unconscious intensive care patient

The New Zealand Bill of Rights says that for experiments to be carried out on a person, they must give consent. Although this has been largely ignored and ethical committees in New Zealand regularly give assent to such projects, it is nevertheless an anomaly and should be corrected. Also, some phrases in the Code of Rights (Health Commissioner Bill) tend to support the above Bill and are ambiguous. Thus, largely through the efforts of Ross Freebairn, we are addressing these issues with the National Ethical Committee, and also the Health Commissioner in our recent submission. If necessary, we will seek to have the Bill of Rights altered to something nearer standard world-wide recommendations, which include the option of consent by relatives etc.

e) Quality Assurance

We are in the process of applying to gazette quality assurance projects which are eligible for medico-legal protection under the Medical Practitioners' Act 1995. These will include the Faculty MOPS program and the intensive care AIMS program.

f) "NZ Anaesthesia and Perioperative Medicine"

NZ groups of anaesthetists including the Society and the College have combined to publish news etc. in one publication with the above name. This was done because a lot of the interests were shared. The New Zealand Committee of the Faculty has decided to "claim" a section of this for the time being, as many anaesthetists are practising intensive care and we see it as a means of keeping them up to date with Faculty happenings. It is important to realise that there is a significant group of people practising intensive care who are not members of the Australasian College or Faculty.

g) Liaison with NZ Regional Committee of ANZCA

The Chairman of the NZ Committee and the Board member have been invited to attend the NZ ANZCA committee meetings. This is important as many issues are closely intertwined. In particular, it allows the Faculty Committee to have entry into some established government pathways and connections, which the Anaesthesia Committee has previously established. We will probably be involved in combined submissions where appropriate, but intend to establish our own identity as quickly as possible and ensure that others are not speaking for us. For the moment, we rely on our anaesthesia colleagues to represent us at the Council of Medical Colleges, which is becoming increasingly important in New Zealand. Absence from this Council may not be able to be rectified until we become a separate College.

h) Workforce

Forbes Bennett, our Education Officer, is about to carry out a NZ Workforce Survey in Intensive Care on behalf of the NZ Committee. Previous work in New Zealand has merely added intensivists onto anaesthesia surveys. We hope to get a good comprehensive grasp of our New Zealand intensive care workforce.

i) New Zealand is a sovereign country

Increasingly, New Zealand intensivists and anaesthetists on our NZ 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 and what is an appropriate response in Australia is not necessarily appropriate in New Zealand. At the same time, we value extremely highly the benefits and strength from being linked to the wider College body and the strong leads in quality and education which has been provided by our Australian colleagues.

Nevertheless, we do feel that there needs to be a recognition of our "different" status as a sovereign country and both committees will be addressing this issue in the future.

JACK H HAVILL
Chairman
New Zealand Committee

Western Australia

Composition of the Executive of the WA Regional Committee

Following a postal ballot in March 1998, the current members of the executive are:

Dr. P.V. van Heerden (Sir Charles Gairdner Hospital) – Chairman
Dr. J. Weekes (Royal Perth Hospital) – Vice Chairman
Dr. F.X. Breheny (Fremantle Hospital) – Secretary
Dr. S. Edlin (Royal Perth Hospital) – Regional Education Officer
Dr. B. Power (Sir Charles Gairdner Hospital) – RACP/ANZICS representative
Dr. A. Duncan (Princess Margaret Hospital for Children) – Dean of the Faculty.

I should like to take this opportunity to thank Dr Weekes for his superb chairmanship of the Committee from its inception until the end of his term in 1998. I thank him also for his continued support of my new role as Chairman. My thanks also go to all the other committed members of the Executive. We are especially privileged to have Dr Alan Duncan as a member of our Executive. This certainly makes for effective communication between the Board and the Regional Committee.

Annual Scientific Meeting

The Faculty regional ASM in 1998 was conducted as a component of the WA ANZICS/CACCN meeting, with one session being dedicated to Faculty scientific presentations. This format was deemed a great success and congratulations are due to Drs Power and Edlin for making this such a successful meeting. Due to the curtailment of the ANZICS meeting for 1999 to one day only, the WA Regional Committee is planning a separate ASM. The ASM will follow the Faculty of Intensive Care Regional AGM on the 1st June 1999. Registrars from each of the teaching hospitals will be invited to present an interesting case or topic for discussion.

Review of Accreditation of Units for training

This process has seen the accreditation of four units for training in WA – Sir Charles Gairdner Hospital and Royal Perth Hospital (C24) and Princess Margaret Hospital and Fremantle Hospital (C12). This provides for ample scope for Intensive Care training in Western Australia.

Trainees, examination preparation

Western Australian Intensive Care trainees continue to perform well in the Faculty examinations. Fellows at the training hospitals support their efforts by conducting ongoing tutorials and examination practice sessions. We are fortunate to have the input of current (Drs.S. Edlin and W.R. Thompson) and former (Drs J. Weekes, G. Clarke and A.M. Forbes) examiners of the College and the Faculty for this process.

Younger Fellows Conference (YFC)

The Regional Committee's nomination of Dr M. Corkeron as the Region's representative for the YFC this year has been accepted. We look forward to the feedback Dr Corkeron will provide from that meeting.

Local achievements

Local Fellows continue to play prominent roles in all aspects of professional life. These include:

- **Faculty and College affairs** (Prof T. Oh, Dr A. Duncan, Dr W.R. Thompson, Dr S. Edlin)
- **ANZICS(WA)** (Dr I. Jenkins)
- **scientific publication** (Dr A. Duncan, Dr W.R. Thompson, Prof T. Oh)
- **research** (Prof T.Oh, Dr P.V. van Heerden, Dr G. Dobb, Dr M. Pinder, Dr M. Schneider, Dr D. Simes),
- **hospital administration and politics** (Dr G. Clarke, Dr I. Jenkins) and
- **national and international organizations** (Dr G. Dobb (ANZICS), Dr W.R. Thompson (ASA), Dr S. Towler (AMA)).

I apologize for any omissions.

National Intensive Care Day

This Faculty initiative was very successful in WA, with good support from the media.

P.V. van HEERDEN
Chairman

New South Wales

Office Bearers and Members

Chair:	Phil Byth
Vice Chair:	Theresa Jacques
Secretary:	Eddie Stachowski
Regional Education Officer:	Gill Bishop
ACT Representative:	Trevor Dobbinson
Younger Fellows Representative:	Dorothy Breen
RACP Representative:	Ray Raper
Ex-officio Board Member:	Richard Lee

Total number of Regional Committee meetings held: 3

Dates of meeting:	26 August 1998
	9 December 1998
	18 March 1999

Attendances of elected members:

Phil Byth	2
Theresa Jacques	2
Eddie Stachowski	3
Gill Bishop	0

Hospital inspections

The following hospitals in the NSW Region were inspected for the purposes of accredited training:

Liverpool
Canberra
Gosford
John Hunter
Hornsby
Careflight Ltd

At present 15 hospitals are accredited for training purposes in NSW and ACT. The following hold C24 classification:

John Hunter
Liverpool
Westmead
New Children's
Prince of Wales/Sydney Children's
Royal North Shore
Royal Prince Alfred
St. George
St. Vincent's

C12 classification is held by:

Concord
Wollongong
Canberra
Nepean

C6 classification is held by:

Gosford (currently under review)

The medical retrieval service Careflight Ltd holds S3 classification.

Younger Fellows Issues

The NSW Regional Committee nominee for the May 1998 Younger Fellows conference was Dorothy Breen. It was noted that there was a particular emphasis at the Conference on the issue of ethics and the law, and that consideration should be given in the future to trainees being exposed to these issues in a more formal manner.

Dorothy now serves as the Younger Fellows Representative on the NSW Regional Committee.

For the 1999 Younger Fellows Conference Michael O'Leary was nominated to attend.

Supervisors of Training

Ray Raper (RACP representative) organised, in conjunction with the RACP, a training session for the Supervisors of Training. This was held on March 12 1999. The material covered was found to be beneficial for all who attended. It was noted that the actual attendance could have been better.

Continuing Medical Education

Prof. Rick Albert, the Faculty's Foundation Visitor for the ASM held in Adelaide, was a guest speaker at a meeting held May 13 1999. This dinner meeting focused upon the utilisation of 'Prone Ventilation'. It was held in conjunction with NSW ANZICS.

NSW Medical Board Performance Review

Dorothy Breen was able to be the NSW Regional Committee representative at meetings held to detail the proposed new program for dealing with the problem of under-performing (unsafe) medical practitioners. 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. Continued involvement by Faculty of Intensive Care Representatives is deemed important, and Dorothy Breen is to continue in this capacity.

Admission to Fellowship by Examination

Myrene Kilminster
Michael O'Leary
David Green
Clive Woolfe

Admission to Fellowship by Election

Simon Finfer

Future activities

Phil Byth is coordinating a meeting focussing on quality and management issues pertinent to intensive care practice. The

venue is to be Rafferty's Resort at Lake Macquarie. It is proposed that the meeting will be in the second half of 1999.

The NSW Regional Committee supports the concept of this meeting.

Future meetings

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.

Election of office bearers will be conducted for the coming year at the next meeting in July. It is noted that Phil Byth is about to complete his third year as Chair of the Regional Committee. A vote of thanks is extended to Phil for his service and commitment.

E.R. STACHOWSKI
Honorary Secretary

VICTORIA

Office Bearers and Members

Chair:	Dr Megan Robertson
Deputy Chairman and Regional Education 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
Ex-officio Board Member:	Dr Felicity Hawker
	Dr Jamie Cooper
Regional Administrative Officer	Ms Corinne Millane

Meetings

Regional Committee meetings were held in June, August and November 1998 and February and May 1999.

In addition, an extraordinary Meeting was called in August 1998 to canvas opinion regarding the formation of a new College of Critical Care Medicine.

Meetings were well attended.

Specifically:	Dr Megan Robertson	6/6
	Dr Graeme Duke	6/6
	Dr John Green	5/6
	Dr Peter Morley	5/6
	Dr Craig French (co-opted)	5/6
	Dr David Ernest	5/6
	Dr Felicity Hawker	3/6
	Dr Jamie Cooper	2/6

Hospital Inspections

The Victorian Regional Committee has been involved in the Faculty Inspection Teams for Accreditation of Intensive Care Units at Geelong Hospital, Northern Hospital, Knox Private Hospital and Epworth Private Hospital. A local Inspection Team is currently being arranged to inspect the new facilities at Warringal Private Hospital.

Review of College and Faculty Policy Documents

Comments were submitted to the Board regarding proposed Policy Documents including:

"Intrahospital Transport of Critically Ill Patients"
"Recommendations Governing Trainee Selection and Registration"

It was resolved that the VRC would commence a regular process of review of existing Faculty Policy Documents as part of our annual activities.

General Business

1. **The VRC FICANZCA and the VRC ANZICS** work closely to represent the Victorian interests of Intensive Care. Committee meetings have been held at the same location over the past 12 months and this has facilitated discussion and management of several important issues. The Chairmen, Drs Carlos Scheinkestel and Megan Robertson, have held informal talks with representatives of the Department of Health Services regularly during the year in an attempt to improve communication between Intensivists and the Victorian Government. We believe that in the current environment of increasing cooperation between the different groups representing Intensive Care, close liaison between the Regional Committees of ANZICS and the Faculty is an important development.

2. The VRC submitted **statements for consideration by the Board** on several key issues addressed by the Faculty in the past year. Particular statements concerned consideration for exemption from First Part examinations by holders of other specialist qualifications and the process of formation of a new College of Critical Care Medicine.

3. The VRC continues to have valuable input into credentialling for **Hospital Appointments for Intensive Care staff**. the Committee believes that an intensivist from either the Faculty or RACP, should be included on the Appointments Board for Intensive Care appointments to major teaching Hospitals. Some

difficulties have arisen when the Faculty has been requested to participate in or comment on credentialling of RACP qualified intensivists. It has been agreed that such requests will be conveyed to the RACP representative, VRC who will liaise with the SAC-RACP.

4. The **Younger Fellows Conference** prior to the Adelaide ASM (May 1999) was attended by Dr Helen Opdam. Dr Opdam is the first FRACP, FFICANZCA Fellow to be proposed to attend the Younger Fellows Conference by the VRC FIC and we were pleased by her enthusiasm to attend. The theme of "Striving for a Job Well Done" was successful and enjoyed by all. Dr Opdam will present the conclusions of the Meeting to the Board.

5. A **combined ANZICS/FICANZCA educational meeting on Trauma Management** is planned for 23rd July 1999. This will be held at The Royal Melbourne Hospital immediately prior to the Annual Registrars' Weekend at Melbourne University. This is the first new format Meeting after the VRC ANZICS have split their annual Meeting from CACCN and it is hoped that the new format will attract a strong medical attendance.

6. Planning for the **Melbourne ASM 2000 Meeting** is well underway, with Dr Megan Robertson as the Scientific Convenor, Intensive Care. The Intensive Care component of the Meeting is to be held at Crown on Southbank from May 5 – 8 2000. Two International Speakers have been invited: Professor Paul Pepe from Pittsburgh, USA and Professor Paul Hebert from Toronto, Canada. The complete scientific programme will be available later this year and will include a Refresher Course on Saturday morning to be run in conjunction with the Anaesthetic Refresher Course programme. The Intensive Care Dinner is to be held at the Melbourne Cricket Ground with a tour of the Museum of Sport and the historic ground prior to dinner. We hope to see a strong Intensive Care representation among the attending delegates.

7. **A satellite meeting** will be held on Friday 4th May 2000, prior to the commencement of the Melbourne ASM 2000, on the topic **"CPR – State of the Art"**. This will be held at The Royal Melbourne Hospital and will address current areas of controversy in cardiopulmonary resuscitation.

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 for her continued support and excellent advice in all matters pertaining to the Faculty.

MEGAN ROBERTSON
GRAEME DUKE
JOHN GREEN
PETER MORLEY
CRAIG FRENCH

South Australia

Members:

NT Matthews (Chairman)
A Bersten
M Chapman
E Everest (RACP Representative)
M Finnis
J Myburgh
M O'Fathartaigh
P D Thomas (Board Member)
Ms S Harrison – Regional Administrative Officer

The following are the highlights of meetings held during the last year:

Congratulations were extended to Dr JE "Fred" Gilligan following his award of the Officer in the Order of Australia.

Dr Andrew Bersten was congratulated for his achievements as the Intensive Care Scientific Convenor for the ASM in Adelaide. The Intensive Care component of the Conference was very well attended, 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.

The Committee received important feedback from Fellows on "IC-3" and "Single Certification" documents, and these comments were forwarded to the Board.

The Committee elected to hold meetings in the month prior to each Board meeting, in order to forward comment and opinion to the Board in a timely fashion. The Chair and the Committee acknowledged that the Chair of the Regional Committee should preferably be held by a non-Board representative.

N.T. MATTHEWS
Chairman

QUEENSLAND

Office Bearers and Members (* denotes co-opted members)

Chair:	Robert F Whiting
Hon. Secretary:	Jerome Cockings
Regional Education Officer and Board Representative:	Robert Barnett
Committee Member:	Chris Anstey
	Jeffrey Lipman*
Physician Intensivist and ANZICS Representative:	David Fraenkel*
Younger Fellow Representative:	John SM Evans*
Regional Administrative Officer:	Ms Joyce Holland
Administrative Assistant:	Ms Denise Schultz

Total No. of Regional Committee Meetings for Year 4

Attendances of Elected Members (No. of Meetings)

1. Robert Whiting	4:4
2. Jerome Cockings	4:4
3. Robert Barnett	4:4
4. Chris Anstey	2:3
5. Jeffrey Lipman	3:3
6. John Evans	2:3
7. David Fraenkel	3:4

Education

Trainees

There are currently 12 registered Intensive Care trainees in Queensland. These comprise 8 in Brisbane, 2 in the Gold Coast and there are 2 Junior trainees registered but not currently occupying ICU positions.

In-Training Assessments

All in-training assessments for Queensland are up to date and satisfactory.

Formal Projects

Roslyn Breadsell has recently had her Formal Project protocol accepted and this is progressing well.

Supervisors of Training

Jerome Cockings resigned as Supervisor of Training at the Princess Alexandra Hospital and this role has now been taken up by Chris Joyce.

The current supervisors of training in Queensland are:

Townsville General Hospital	Geoff Gordon
The Prince Charles Hospital	Dan Mullany
Royal Brisbane Hospital	John Morgan
Princess Alexandra Hospital	Chris Joyce
Mater Misericordiae Hospital	Peter Lavercombe
Greenslopes Private Hospital	Bob Whiting
Gold Coast Hospital	Ron Quinn
Cairns Base Hospital	Drew Wenke

Conjoint Training

There is currently one conjoint trainee registered in Queensland.

Unit Reviews and Accreditation

One unit, Nambour, was reviewed during this year and was assessed as suitable for C6 for training purposes. There have been applications from Greenslopes Private and Toowoomba Hospitals for consideration for C12 and C6 accreditations respectively. The Prince Charles Hospital has also applied to be increased from C6 to C12.

Examinations

Two trainees sat for the Fellowship examination from Queensland during this year, with both being successful. Drs Derek Chu and Hugh Playford are to be congratulated on their success.

Other Educational and Training Matters

There has been further development of a wider training rotation within Queensland during this year. Many of the posts in Brisbane for the year 2000 have been advertised together for a single appointment process. It is hoped that this can involve non-metropolitan hospitals and other posts in the future.

Continuing Education

Annual General Meeting

The AGM was held on Saturday 22nd August 1998. The Annual Reports were presented and a wide ranging discussion ensued, with considerable attention given to the concept of a separate College of Intensive Care.

Local CME Meeting

The local CME meeting for this year is to be held on 21st August 1999.

Professional Affairs

The revision of IC-3 Policy Document has potentially made more comprehensive training rotations possible in Queensland. There may also be scope for more C12 accreditations in the years to come as hospitals expand. There is currently considerable building and redevelopment being undertaken across the state by Queensland Health. This year has seen much discussion with regard consent for research in the unconscious patient in Queensland. The Power of Attorney Act left the situation unclear. The Guardianship Bill, however is now under development to supplement this. This will be presented to Parliament in the third quarter of 1999 and contains wording similar to legislation currently operating in New South Wales.

JEROME COCKINGS
Honorary Secretary

Annual Scientific Meeting

Adelaide, May 1999

The 1999 Annual Scientific Meeting was held in Adelaide with the Faculty of Intensive Care program running from 8-10 May. The Faculty's Foundation Visitor was Professor Rick Albert from Denver, Colorado. Professor Albert was accompanied by his wife Linda, and their easy and gracious interactions were widely appreciated.

Both Professor Albert's clinical and research backgrounds were evident from his outstanding talks in sessions on "Lung Volume Reduction Surgery" and the "Pulmonary Circulation" which bridged physiology and the bedside. Certainly, the minimal impact of gravity upon the distribution of pulmonary blood flow was novel to most attendees. His lecture on "Management of ARDS" was a *tour de force* which covered novel therapeutic approaches, prone positioning and the recently completed NHLBI study examining small tidal volume ventilation.

Other highlights included insights by Professor Ron Slocombe gained from cardiopulmonary exercise testing in horses and Associate Professor Trevor Williams' lectures on "Opportunistic Lung Infection" and "An Australian Perspective on Lung Volume Reduction Surgery". It is noteworthy that local speakers also made major contributions to the meeting and that generic sessions on retrievals, consent issues and rapid opiate detoxification were well attended, quality sessions.

Finally, the whole organizing committee must be thanked for their efforts to make the scientific and social components of the meeting a great success.

Professor Rick Albert was presented with the Faculty Foundation Visitor's Medal at the College Ceremony by Dr Alan Duncan

Professor Peter Moore introduced the session from Professor Rick Albert entitled 'Lessons in Chronic Lung Disease'

Faculty Fellows Drs Dianne Stephens, Helen Opdam, Michael O'Leary, Ho Kwok-ming, Stuart Green and Claudia Ai Yu Cheng following their presentation at the College Ceremony

The Dean Dr Alan Duncan with Drs Michael O'Leary, Helen Opdam, Dianne Stephens and Stuart Green at the reception following the College Ceremony

FACULTY OF INTENSIVE CARE
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

A.C.N. 055 042 852

POLICY DOCUMENTS

IC-1	(1997)	Minimum Standards for Intensive Care Units *Bulletin Aug 94, pg 44*
IC-2	(1994)	The Duties of an Intensive Care Specialist in Hospitals with Approved Training Posts *Bulletin Aug 94, pg 49*
IC-3	(1998)	Guidelines for Intensive Care Units seeking Faculty Accreditation for Training in Intensive Care *Bulletin Nov 98, pg 70*
IC-4	(1994)	The Supervision of Vocational Trainees in Intensive Care *Bulletin Aug 94, pg 54*
IC-5	(1995)	Duties of Regional Education Officers in Intensive Care *Bulletin Nov 95, pg 50*
IC-6	(1995)	Supervisors of Training in Intensive Care *Bulletin Nov 95, pg 46*
IC-7	(1994)	Secretarial Services to Intensive Care Units *Bulletin Aug 94, pg 57*
IC-8	(1995)	Ensuring Quality Care - Guidelines for Departments of Intensive Care *Bulletin Mar 95, pg 32*
IC-9	(1997)	Statement on Ethics and Patients' Rights and Responsibilities *Bulletin Nov 97, pg68*
IC-10	(1996)	Minimum Standards for Transport of the Critically Ill *Bulletin Mar 96, pg42*
IC-11	(1996)	In-Training Assessment of Trainees in Intensive Care *Bulletin Mar 96, pg 46*
IC-12	(1996)	Examination Candidates Suffering from Illness, Accident or Disability *Bulletin May 96,*

FACULTY OF PAIN MEDICINE
DEAN'S MESSAGE

Foundation Fellowship

At the ANZCA College ceremony in Bonython Hall, University of Adelaide, Saturday 8 May 1999, twenty two of the forty seven Foundation Fellows of the Faculty were presented at the ceremony. It is hoped that the residual Foundation Fellows will be presented at the College ceremony in Melbourne in 2000. The Foundation Fellows were elected by the Board of Faculty, comprising representatives of ANZCA and the participating Colleges/Faculty, based upon the criteria advertised in the August and November 1998 ANZCA Bulletins and equivalent publications of the participating Colleges/Faculty. Foundation Fellows included a significant number of individuals from the Australian and New Zealand College of Anaesthetists, Royal Australasian College of Physicians, Royal Australasian College of Surgeons, Royal Australian and New Zealand College of Psychiatrists and the Australasian Faculty of Rehabilitation Medicine of the Royal Australasian College of Physicians.

Foundation Fellows are listed in this Bulletin.

Honorary Fellowship

Two distinguished Honorary Fellows were elected under Article 4.2 of the Faculty Regulations. Professor James Lance is a distinguished neurologist who has played a leading role in pioneering research and treatment of headache, in particular migraine. Professor Issy Pilowsky is a world-renowned psychiatrist who has pioneered many aspects of the contribution of the psychiatrist to the multidisciplinary pain centre. He initiated the concept of "Abnormal Illness Behaviour" and in particular has applied it to patients with chronic pain. (See accompanying citations for Honorary Fellows).

Fellows by Election

Under Article 4.4.3 of the Faculty Regulations, a number of individuals who applied for consideration for Foundation Fellowship, have been nominated by two Board members for consideration for election. This process will be completed by the end of June, using the criteria outlined in Article 4.4.1 of the Regulations. It is important to point out that the Fellowship qualification bestowed on individuals who are elected to Fellowship will in no way differ from that bestowed on Foundation Fellows.

Fellowship by Election, Subsequent Applications

Under Article 4.4.3 of the Regulations, Fellowship by Election is open to any individual with appropriate experience and qualifications, to make a nomination for admission to Fellowship, on the prescribed form by obtaining the signatures of two members of the Board, or one member of the Board and five other Fellows of the Faculty. Fellows intending to take this course should note the criteria set out in Article 4.4.1 of the Regulations. Some Fellows considering taking this course may wish to seek advice of a Board member and also to take into consideration

the intention of the Board's Hospital Accreditation Committee to commence inspecting units which have applied for recognition of training. This process could add to the Board's knowledge of individual Fellows' contribution to the field of Pain Medicine.

As a related matter, Pain Centres are strongly encouraged to apply for recognition as training centres, even if there are currently some deficiencies in the resources of such units. Recent experience with inspected units is that the hospitals have, without exception, moved to provide the resources identified as being deficient and this has been of great assistance in helping Pain Centres to consolidate their resources for recognition as training centres.

ANZCA Certificate in Pain Management Holders

The Board of Faculty took the decision that Certificate holders who had completed their Certificate prior to the deadline for application for Foundation Fellowship (28 February 1999) would be eligible to apply for induction as Foundation Diplomates, provided they had remained in Pain Medicine practice since the completion of their Certificate. Certificate holders who have completed their Certificate after 28 February 1999, or who are still completing their Certificate, will be eligible to apply to the Censor for admission to the first Fellowship examination on 25-26 November 1999, provided they complete their Certificate prior to the closing date for admission to the examination.

Exemption from Further Training and Admission to First Examination

Individuals who have accumulated relevant experience and training other than Certificate holders, may apply to the Censor for exemption from further training to enable them to present for the first examination in November, provided such applications are approved prior to the closing date for the first examination. The Censor has already received applications from individuals from a number of specialty areas.

Acute Pain Management Practitioners

There is a detailed coverage of this area in the accompanying article.

Paediatric Pain

The Board of Faculty quite deliberately included on the Board an individual with substantial experience and training in the field of Paediatric Pain, namely Dr Suellen Walker. The Board has asked Dr Walker to form a Working Party comprising paediatric pain practitioners, to examine all aspects of the development of Paediatric Pain, development of training programs and appropriate measures to include practitioners of acute pain management within the new Faculty. One major Pain Centre has already developed linkages with a Paediatric Pain Program to enable the rotation of trainees between an ANZCA approved adult Pain Centre and a Paediatric Pain Program. Discussions are underway for at least one further Centre to follow this model. The Board of Faculty has a strong commitment to assisting in the development of Paediatric Pain Medicine.

Palliative Care and Pain Medicine

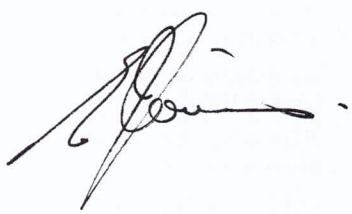
The Joint Advisory Committee on Pain Medicine included a representative from the field of Palliative Medicine, Dr Richard Chye FRACP. A number of Palliative Care physicians who have worked closely with ANZCA approved Pain Centres and assisted in training programs, are under consideration for election to Fellowship to the Faculty of Pain Medicine. The Board is strongly committed to developing close interaction and collaboration with Palliative Care units in order to foster training in Pain Medicine and Palliative Medicine, to enhance clinical programs and to facilitate research in these closely related areas. The Royal Australasian College of Physicians is currently exploring a proposal to develop a training program in Palliative Medicine within the College of Physicians. The Board is keeping close contact with the RACP.

November 1999 Fellowship Examination

Those currently in ANZCA approved training positions in Pain Medicine may be eligible to sit for the first Fellowship examination on 25-26 November 1999. This can be clarified by writing to the Censor, outlining previous experience relevant to Pain Medicine. The Board has decided to adopt a generous approach to the assessment of prior experience, only on the occasion of the first examination. Thus trainees in Pain Medicine posts are encouraged to apply, if they wish to sit for the first examination, and are confident that they can prepare adequately for the range of topics outlined in the Training Manual.

Trainees Commencing Training in 2000 and Beyond

Trainees will progressively be required to meet specific requirements for the first year of the two year training program. However it will be possible to meet the criteria for year one of training during year 1 to 4 of training for FANZCA, by complying with requirements obtained by writing to the Faculty Executive Officer.



MICHAEL J COUSINS AM

Faculty of Pain Medicine Foundation Fellows

Foundation Fellows formally admitted to the Faculty are:

Carolyn Arnold FAFRM (RACP), Vic
Leigh Atkinson FRACS, Qld
Thomas Berrigan FANZCA, WA
Geoff Booth FAFRM (RACP), NSW
James Bradley FANZCA, Qld
Penelope Briscoe FANZCA, SA
Charles Brooker FANZCA, NSW
Michael Butler FRACP, NZ
Robyn Campbell FANZCA, SA
Mary Cardosa FANZCA, Kuala Lumpur, Malaysia
David Champion FRACP, NSW
David Cherry FANZCA, SA
Milton Cohen FRACP FAFRM (RACP), NSW
Michael Cousins AM FANZCA, NSW
Tess Cramond AO, OBE FANZCA, Qld
Matthew Crawford FANZCA, NSW
John Ditton FANZCA, NSW
Roger Goucke FANZCA, WA
Paul Graziotti FANZCA, WA
David Gronow FANZCA, NSW
Newman Harris FRANZCP, NSW
Chris Hayes FANZCA, NSW
Robert Helme FRACP, Vic
Ted Hughes FANZCA, NZ
David Jones FANZCA, NZ
Kok Eng Khor FANZCA, NSW
Bruce Kinloch FAFRM (RACP), Vic
Terence Little FANZCA, Vic
Pam Macintyre FANZCA, SA
Ben Marosszeky FAFRM (RACP), NSW
George Mendelson FRANZCP, Vic
Allan Molloy FANZCA, NSW
Andrew Muir FANZCA, Vic
Frank New FRANZCP, Qld
James O'Callaghan FANZCA, Qld
Peter Ravenscroft FRACP, NSW
Graham Rice FRANZCP FANZCA, Qld
Edward Glyn Richards FANZCA, NZ
Lindy Roberts FANZCA, WA
Bruce Rounsefell FANZCA, SA
Daryl Salmon FANZCA, NSW
Stephan Schug FANZCA, Auckland, NZ
Tim Semple FANZCA, SA
Barrie Tait FAFRM (RACP), NZ
Richard Vaughan FRACS, WA
Suellen Walker FANZCA, NSW
Peter Wilson FANZCA, USA

HONORARY FELLOWSHIP

CITATION – JAMES WALDO LANCE AO, CBE

"The Board of the Faculty of Pain Medicine may admit from time to time distinguished persons who have made a notable contribution to the advancement of the science and practice of Pain Medicine, who are not practising Pain Medicine in Australia or New Zealand"

Mr President, I have the honour of presenting to you James Waldo Lance.

James Lance is Professor Emeritus at the University of New South Wales and Consultant Neurologist at the Institute of Neurological Sciences at the Prince of Wales Hospital in Sydney. His outstanding career in Medicine began with an Honours degree from the University of Sydney in 1950. He obtained his Doctorate in Medicine five years later, followed by Membership then Fellowship of the Australasian and English Colleges of Physicians.

James Lance's name is almost synonymous with the study of headache and of migraine in particular. Over the almost five decades of his career, he has published more than 300 original articles and books, including *The Mechanisms and Management of Headache*, now in its sixth edition, *A Physiological Approach to Clinical Neurology* and *Introductory Neurology*.

After clinical training at Royal Prince Alfred Hospital in Sydney and at Queens Square in London, Jim Lance lectured in Physiology at the University of Sydney for six years, then taking up a Fellowship in Boston before returning to Sydney, to the new Faculty of Medicine at the University of New South Wales as Senior Lecturer. In 1964 he was appointed Associate Professor and in 1975 to a Personal Chair in Neurology. He was Chairman of the Department of Neurology at the Prince Henry and Prince of Wales Hospitals from 1961 to 1992. In that year, on his formal retirement, he received an Honorary Doctorate in Science from the University of New South Wales. Other honours bestowed upon Jim Lance have included Companion of the Order of the British Empire in 1977, Fellowship of the Australian Academy in 1980 and Officer of the Order of Australia in 1991.

Jim Lance's best known contribution to Neurology is his work on the mechanism and management of headache, migraine in particular. His list of publications tells a tale of clinical investigation sufficient to induce an aura of awe. His work on cerebral blood flow and on serotonin has been dazzling. He played a major role in highlighting the role of serotonin in nociception generally. But there is another, less well-known dimension to his work, the field of movement disorders, including possibly the first description of dysaesthesia-dyskinesia: the syndrome of painful legs and moving toes.

How can one do justice to this anthology? Perhaps by recounting just some of the offices and awards held by James Lance. He has received the Harold G Wolff Memorial Award of the American Association for the Study of Headache twice, in 1967 and 1983, the Gold Medal of the British Migraine Association in 1975 and the John Graham Senior Clinician Award of the American Association for the Study of Headache in 1991. In 1995 the International Headache Society of which he was Vice-President then President from 1985 to 1989, established the James Lance Award for research work. He was Vice-President of the World Federation of Neurology from 1989 to 1993, in which year he was made an Honorary Fellow of the Royal Society of Medicine. He was President of the Australian Association of Neurologists from 1978 to 1991 and Foundation President of the Australian Movement Disorders Society.

Headache is a feared form of human suffering, not least as it shares with other forms of pain the predicament of invisibility but perhaps because it involves the head, the major conduit of our communication with the outside world. And it is onto this area of suffering, of pain, that James Lance has shone a powerful beam of insight, understanding and treatment.

Mr Dean, I have the great honour to present to you **JAMES WALDO LANCE** for conferment of Honorary Fellowship of the

HONORARY FELLOWSHIP

CITATION – ISSY PILOWSKY AM

Mr President, I have the honour of presenting to you Issy Pilowsky AM, MD, FRACP, FRANZCP, FASSA.

Issy Pilowsky is a graduate of the University of Cape Town. He studied psychiatry in Sheffield, where he was a Senior Lecturer in Psychiatry prior to his appointment as Professor of Psychiatry at the University of Adelaide in 1972 – a position held until his retirement in 1998.

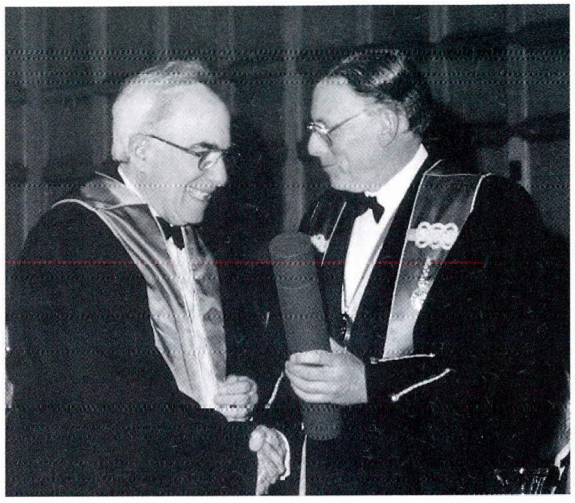
He is a Fellow of the Royal Australian and New Zealand College of Psychiatrists, a Fellow of the Royal College of Psychiatrists, a Fellow of the Royal Australasian College of Physicians and a Fellow of the Academy of Social Sciences in Australia.

He has also been Visiting Professor at Washington and Rochester Universities, and at the Institute of Psychiatry, University of London and Dean, Faculty of Medicine, University of Adelaide. Amongst his other positions, he has been the President, International Association for the Study of Pain Australasian Chapter; Councillor International Association for the Study of Pain (IASP); Chair IASP Committee that developed the world's first Undergraduate Curriculum on pain; Member NHMRC working party that developed the document "Management of Severe Pain".

In addition to over 150 publications, he has been on the Editorial Board of several peer review journals including Clinical Journal of Pain, The Pain Clinic, and the European Journal of Pain.
His first paper on Abnormal Illness Behaviour was published in 1969. He continued development of the concept often in the context of a multidisciplinary pain clinic. Pain medicine practitioners, and our patients, have benefited from the clarity with which he described how we can better understand pain, suffering and their presentations as Pain Behaviour.

An erudite teacher, he has had amongst his pupils undergraduate and post-graduate students and specialist colleagues – all and each of whom has benefited from that teaching; not least in relation to the importance of doctor-patient communication and how this is influenced by illness behaviour. An incredibly modest human being, Issy Pilowsky never lost sight of the equality of everyone within a multidisciplinary team – be that the family, the hospital, the institution, society at large or the pain clinic.

His publications on pain have ranged from phantom pain to cancer pain, postherpetic neuralgia, facial pain, low back pain.



He was a key member of one of this country's first multidisciplinary pain centres at the University of Adelaide, Royal Adelaide Hospital, with the late Dr Evan Hallett. In 1976 he published one of the first accounts of "The Psychiatrist in the Pain Clinic" in the American Journal of Psychiatry.

Issy Pilowsky's seminal work, his text "Abnormal Illness Behaviour", was published in 1997. The enormity of his contribution to medicine, and pain medicine in particular, is summarised by Professor Scott Henderson.

> "Anyone who wants to practise medicine – in any specialty – needs to carry in their head what has been set out in that volume. It is not hyperbole to suggest that it be mandatory reading prior to medical registration in any decent country. This book is an exceptional contribution to medicine".

Mr President, I have the honour and privilege to present to you, in the city where he held the Chair in Psychiatry, **Issy Pilowsky** for conferment of Honorary Fellowship of the Faculty of Pain Medicine.

GRAHAM I RICE

FACULTY OF PAIN MEDICINE AND ACUTE PAIN MANAGEMENT

The Faculty of Pain Medicine

The Faculty has a Board comprised of a majority of ANZCA Fellows, with a FFPMANZCA. There are also representatives of RACS, RANZCP, RACP and AFRM (RACP). Fellows of the Faculty will largely be those with a broad interest and activity in Pain Medicine, *including acute pain*. As discussed below those practising in anaesthesia and only in acute pain will generally do so under ANZCA using their FANZCA qualification; however there are now new opportunities for FANZCA[S] (see below).

During the ANZCA Annual Scientific Meeting in Adelaide, there were a number of questions concerning the relationship of those who have varying roles in the treatment of acute pain and the new Faculty of Pain Medicine. These issues were addressed at the Annual Business Meeting of ANZCA and various Fellows have indicated that this article would be of assistance to many Fellows, and thus it is reproduced here.

Why the terminology "Faculty of Pain Medicine"?

The recently released document of the National Health & Medical Research Council "Acute Pain Management: Scientific Evidence" emphasises the substantial overlap in the scientific evidence which underpins the treatment of acute, chronic and cancer pain. Thus there is strong encouragement for teaching and research to be integrated across these three major areas of pain management. Also it is clear that many of the clinical presentations of patients represent an overlap, for example a cancer patient with an acute exacerbation of pain, a postoperative or post-trauma patient with emerging persistent pain problems, a patient with chronic pain with an acute exacerbation. Thus it seems desirable to develop "Pain Management Services" which have the capacity to assist patients with a wide variety of presentations of pain. Thus the terminology "Pain Medicine" was deemed by the Joint Advisory Committee representing the Specialist Colleges to be most appropriate. In the United States, there is an American Academy of Pain Medicine and the American Society of Regional Anesthesia uses the term "Pain Medicine". It should be noted that none of these international bodies has attempted to isolate a field of "chronic pain". Thus there is a clear intention to make appropriate connections with practitioners who have as a primary activity, acute pain management. This is certainly the intention of the Board of the Faculty of Pain Medicine.

What is the relationship of the Faculty of Pain Medicine to the Special Interest Group on Acute Pain?

Since the inception of ANZCA's "Certificate in Pain Management", training programs have been approved on the basis of a strong linkage between the management of acute, chronic and cancer pain. Acute pain has been on the agenda of every ANZCA Pain Management Committee, or Joint Advisory Committee meeting, and subsequently all meetings of the Board of Faculty of Pain Medicine. Dr Pam Macintyre, an acute pain practitioner, was a continuous representative on these bodies and continues to be a member of the Board of Faculty. The intention was to develop appropriate mechanisms to recognise the important contributions of those involved in acute pain management to the development of the field of Pain Medicine in general and to teaching and to research. The new Faculty aims to foster the activities of the SIG rather than to control them; the Board will provide appropriate career opportunities as outlined below. The SIG represents the interests of those who have an interest in acute pain whether they be FANZCA or FFPMANZCA.

Are there career opportunities for acute pain practitioners via the new Faculty?

One of the important implications for ANZCA Fellows of the formation of the new Faculty of Pain Medicine is the development of important new career opportunities. Such opportunities will vary, depending upon the time commitment, degree and depth of contribution, breadth of activity in this field and future aspirations:

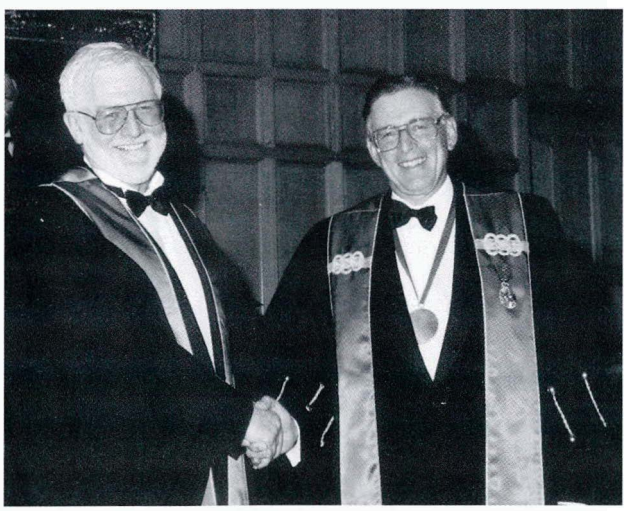
- Some individuals who have made major clinical, teaching and research contributions, of relevance to the whole field of Pain Medicine are currently under assessment for election to the Faculty, following their nomination for election.
- Some further individuals may decide to seek nomination for election, based upon the criteria for election published in this Bulletin.

- Others may decide to expand their activities/knowledge and to link up with an ANZCA approved Multidisciplinary Pain Centre, in order to develop their credentials for potential election to the Faculty. The Faculty's Hospital Accreditation Committee will soon begin inspecting Pain Centres for accreditation for Pain Medicine training. This process will be of assistance, but not the sole criteria, in assessing nominations for election.
- Some may apply for recognition of their prior experience, to enable them to be exempt from further training and to sit the examination for Fellowship, the first of which will take place on November 25-26 this year and admitted to Fellowship of the Faculty by examination.
- However, the majority will continue to work solely in the postoperative pain area, using their entirely appropriate FANZCA qualification. ***It is important to emphasise that such individuals will in no way be disadvantaged by the formation of the new Faculty.*** It is to be hoped that Fellows in this category will decide to expand their teaching activities to trainees in Pain Medicine.

Whichever of the above options apply to Fellows, there is no doubt that the formation of the new Faculty will add to the status of all Fellows who practice in the field of pain medicine. The development of a Faculty in Intensive Care, by acknowledging that there were individuals with specialised knowledge in this particular field, had this effect.

The Acute Pain SIG

The Joint Advisory Committee on Pain Medicine, and subsequently the Board of Faculty, have never envisioned that there would be any change in the relationship of the SIG to ANZCA, ASA and NZSA. Thus the SIG will presumably continue precisely as it has prior to the formation of the Faculty. It would obviously be desirable to have close liaison between the new Faculty and the SIG.



Professor Cousins Founding Dean of the new Faculty of Pain Medicine at the inaugural ceremony in the Bonython Hall, University of Adelaide, May 1999, during the scientific meeting of the Australian and New Zealand College of Anaesthetists. Professor cousins is welcoming expatriate Australian Dr Peter Wilson as a Foundation Fellow.

Dr Wilson has worked for many years at the Mayo Clinic, USA and is currently President of the American Academy of Pain Medicine.

ADMISSION TO FELLOWSHIP BY ELECTION

REGULATION

4.4 *Admission to Fellowship by Election*

4.4.1 Persons who are registered medical specialists in Australia or New Zealand may be elected to Fellowship under the Board Regulations using the following criteria:

4.4.1.1 The candidate must hold Fellowship of a participating College or Faculty or an equivalent specialist qualification relevant to Pain Medicine that is acceptable to the Board.

4.4.1.2 Substantial involvement in multidisciplinary pain centres or equivalent Pain Medicine practice acceptable to the Board. Substantial = commitment equivalent to three sessions weekly (including in and out of hours) in current clinical practice.

4.41.3 Independent confirmation is required by the relevant health care facility of involvement in specialist Pain Medicine practice.

4.4.1.4 Participation in Continuing Medical Education and Quality Assurance in the field of Pain Medicine.

4.4.1.5 Contribution to the field of Pain Medicine by development of professional activity in this field.

4.4.1.6 Contribution to the field of Pain Medicine by:

(i) Regular contributions to undergraduate and/or postgraduate education in this field

and

(ii) Publications in scientific journals and/or contributions to scientific meetings.

4.4.2 The Board of Faculty may elect to Fellowship without examination persons who are not registered medical specialists in Australia or New Zealand and who in the opinion of the Board have made notable and distinguished contributions to the practice and science of Pain Medicine.

4.4.3 Nominations for admission to Fellowship under this Regulation will be made on the prescribed form by two Members of the Board, or one Member of the Board and five other Fellows.

4.4.4 Nominations for election to Fellowship under these Regulations may be considered at any meeting of the Board provided that nominations are submitted to the Faculty Executive Officer at least 30 days prior to the meeting.

4.4.5 Each nomination will be accompanied by a curriculum vitae.

4.4.6 Nominations for election to Fellowship, on the prescribed forms and with supporting documentation, will be sent to each Member of the Board at least fourteen days before the day of the Board Meeting.

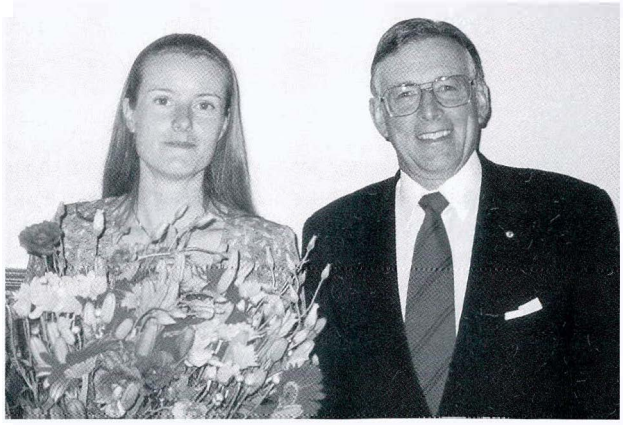
4.4.7 The Board will vote on nominations by secret ballot.

4.4.8 No award of Fellowship will be made at a meeting of the Board unless three quarters of the Members of the Board present vote in favour.

4.4.9 Nominations rejected by the Board may be reconsidered if formally proposed and seconded at a subsequent Meeting of the Board.

4.4.11 Those admitted to Fellowship by election will pay the entrance fee as prescribed by the Board in addition to the annual subscription.

4.4.12 The Board at its discretion may remit the entrance fee and annual subscription of any Fellow admitted under Regulation 4.4.1.



Mrs Janet Devlin's contribution to the Pain Management Committee was acknowledgedby Prof. Michael Cousins at a luncheon following establishment of the Faculty of Pain Medicine

POLICY DOCUMENTS

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

PS38 (1999)

STATEMENT RELATING TO THE RELIEF OF PAIN AND SUFFERING AND END OF LIFE DECISIONS

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

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

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

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

Promulgated (as a Statement): 1997
Revised: 1999
Date of Current Document: June 1999

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

Review TE9 (1999)

QUALITY ASSURANCE

Guidelines for Departments of Anaesthesia

1. INTRODUCTION

1.1 Quality Assurance can be defined as *"an organised process that assesses and evaluates health services to improve practice or quality of care".*

1.2 The objective of Quality Assurance programs is to ensure that high standards of clinical practice are maintained by individuals, Departments, and Hospitals or Institutions through regular assessments. The results of such assessments should be reported to appropriate Departmental meetings for evaluation and action as necessary.

1.3 All Departments of Anaesthesia should participate in Quality Assurance programs. Smaller Departments or anaesthesia services in institutions which do not have formally structured departments, should link their programs with nearby larger Departments.

1.4 All Departments of Anaesthesia should appoint a Quality Assurance Co-ordinator, who will be responsible for the implementation and supervision of the Quality Assurance programs.

1.5 Quality Assurance programs must evaluate clinical care as being consistent with accepted professional standards, including relevant policy documents issued by the College.

2. PROCESS OF QUALITY ASSURANCE PROGRAMS

Steps in a Quality Assurance program can be considered as *Planning, Implementation, Review,* and *Setting Standards*. The steps are repeated continually or at appropriate intervals for on-going Quality Assurance programs.

2.1 *Planning* undertakes careful design and preparation of a project, such as defining the topic to be evaluated and the data to be collected, and methods to collect and analyse data.

2.2 *Implementation* undertakes to collect and analyse data, review results, and determine action to be taken, i.e. to:

2.2.1 Monitor and evaluate the quality and appropriateness of patient care.

2.2.2 Identify areas of deficiency or risk, which is defined as a chance of injury or adverse consequence.

2.2.3 Implement changes where necessary and monitor any changes made, including the safe implementation of new methods of treatment.

2.3 *Review* undertakes to monitor the outcome of changes introduced from 2.2.3 to "close the loop". Showing the outcome or impact of a Quality Assurance program on health care is an important component of the program.

2.4 *Setting Standards* undertakes to write the improvements achieved into new official regulations, guidelines, or standards.

3. QUALITY ASSURANCE PROGRAMS

A number of activities to practise Quality Assurance can be undertaken as Quality Assurance programs.

3.1 Department Structure and Performance: the overall performance and resources of a Department in comparison with accepted criteria (such as ANZCA policies and guidelines) and those of other equivalent Departments in the region. These include:

3.1.1 Staff

3.1.1.1 numbers and qualifications

3.1.1.2 criteria and process of selection and appointment

3.1.1.3 workload, allocation of work and supervision

3.1.2 Physical Facilities

3.1.2.1 equipment, including compliance with standards, maintenance and replacement.

3.1.2.2 department space

3.1.2.3 facilities for teaching, education, and research

3.1.3 Management, including budgets, expenditure, and cost effectiveness.

3.1.4 Educational activities including teaching, research and Quality Assurance.

3.2 Criteria-based audit: performance evaluation according to predetermined criteria (usually reported outcomes of peer groups). In areas without published criteria, new criteria can be established by original study or a consensus of peers. Main criteria-based audit programs are:

3.2.1 ANZCA Clinical Indicators

3.2.2 perioperative mortality

3.2.3 ICU and in-hospital mortality (especially as relates to APACHE II sickness scores)

3.2.4 perioperative morbidity

3.2.5 ICU readmissions

3.2.6 utilisation of operating rooms

3.2.7 ICU bed occupancy

3.3 Clinical Guidelines, Policies, or Protocols: recommended methods of clinical practice. A Department should check for compliance of guidelines, policies, or protocols and if they are regularly reviewed.

3.4 Critical Incidents: voluntary reports by staff on events that led to, or could have led to an adverse outcome in patients or staff members. A program must analyse the incidence, causes, contributing and mitigating factors, and outcome of critical incidents. Strategies for improvement should be recommended. An evaluation of outcome from implementing changes is expected.

3.5 Risk Management: actions to reduce risks to patients and staff in anaesthesia and ICU practice. A Risk Management program undertakes identification of risks (what can go wrong?), assessment of risk factors (what can increase the risk?), and control of risks (what strategies can reduce risk?).

3.6 Peer Reviews: evaluation of clinical performance by peers. Areas to review include communication with patient and relatives, patient selection, anaesthesia techniques, ICU patient assessment, monitoring and investigations used, record keeping, perioperative care, and patient follow up and outcome. Main methods are:

3.6.1 mortality and morbidity meetings

3.6.2 case reviews of randomly selected cases

3.6.3 practice review of an anaesthetist or intensivist in discharging clinical duties by a peer over a period of time.

3.7 Patient Surveys: satisfaction surveys of patients. A program could survey satisfaction with communication, managing relatives, anxiety alleviation, informed consent, pain management, and anaesthesia and ICU procedures rendered. Issues such as confidentiality and patient anonymity should be addressed.

4. AUDIT OF QUALITY ASSURANCE PROGRAMS

Quality Assurance programs should be reviewed extensively by every Department from time to time. Such programs should be consistent with the size and capabilities of the Department. The Department should ensure that remedial steps are taken whenever problems are identified and that continued review should follow.

5. QUALITY ASSURANCE CO-ORDINATOR

5.1 The Department should appoint a Quality Assurance Co-ordinator normally for a period of two years, with eligibility for re-appointment. Appropriate time and secretarial and other support should be allocated to this Co-ordinator.

5.2 The Quality Assurance Co-ordinator should ensure that the above College guidelines are implemented within the limits of the size of the Department.

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

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

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Promulgated: *1983*
Revised: *1987, 1993*
Date of Current Document: *June 1999*

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 Year of Vocational Training in Anaesthesia *Bulletin Nov 96, pg 64*
E3	(1994)	The Supervision of Trainees in Anaesthesia *Bulletin Nov 92, pg 41*
TE4	(1997)	Duties of Regional Education Officers in Anaesthesia *Bulletin Nov 97, pg88*
TE5	(1997)	Supervisors of Training in Anaesthesia *Bulletin Nov 97, pg 89*
E6	(1995)	The Duties of an Anaesthetist *Bulletin Nov 95, pg 70*
E7	(1994)	Secretarial Services to Departments of Anaesthesia *Bulletin Nov 94, pg 43*
TE9	(1993)	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 98, pg 83*
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*
T4	(1994)	Recommended Minimum Facilities for Safe Anaesthetic Practice for Electro-Convulsive Therapy (ECT) *Bulletin Nov 94, pg 59*
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*
P10	(1994)	The Handover of Responsibility During an Anaesthetic *Bulletin Nov 94, pg 44*
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*
P13	(1992)	Protocol for The Use of Autologous Blood *Bulletin Aug 92, pg 49*
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*
P26	(1994)	Guidelines on Providing Information about Anaesthesia *Bulletin Aug 94, pg 61*
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, pg82*
PS31	(1997)	Protocol for Checking the Anaesthetic Machine *Bulletin Nov 97, pg84*
PS36	(1997)	Sedation for Regional Anaesthesia for Ophthalmic Surgery *Bulletin Nov 97, pg93*
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 99, pg 93*
PM1	(1999)	Guidelines for Trainees and Departments seeking College Approval of Posts for Training in Pain Medicine *Bulletin Mar 99, pg73*