ANZCA
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

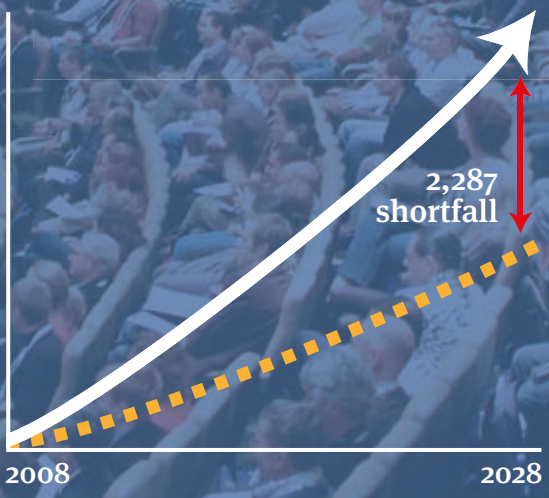
Australian and New Zealand College of Anaesthetists
Joint Faculty of Intensive Care Medicine
Faculty of Pain Medicine

March 2009

The ANZCA Bulletin

EXCLUSIVE REPORT

Australia's looming anaesthetist shortage



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The ANZCA Bulletin

The Australian and New Zealand College of Anaesthetists (ANZCA) is the professional medical body in Australia and New Zealand that conducts education, training and continuing professional development of anaesthetists, intensive care medicine and pain medicine specialists. ANZCA represents more than 5000 Fellows and trainees across Australia and New Zealand and serves the community by ensuring the highest standards of patient safety.

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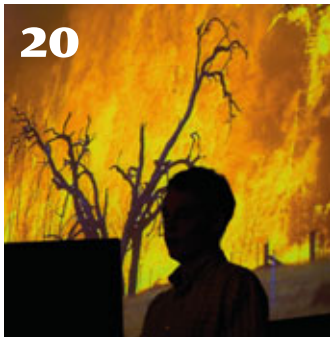
Cover: Plenary session, Australian and New Zealand College of Anaesthetists Annual Scientific Meeting, Sydney, 2008.

Photo: Jason Bull

Looming anaesthetists shortage

ANZCA and ASA workforce study.



Victoria's bushfires

The Alfred Hospital's role in the midst of Victoria's worst natural disaster.

Environment special

Anaesthesia and the environment – how big is your footprint and what can we do?

President's message


Dr Leona Wilson

In this Bulletin, we have a summary of the Australian anaesthesia workforce study "Supply and Demand for Anaesthesia Services" undertaken by Access Economics and commissioned jointly by ANZCA and the ASA. The study examines factors that shape the supply of, and demand for, anaesthesia services and identifies gaps in service provision over the next 20 years. While not underestimating the difficulties involved in conducting such a study, this is an excellent piece of work.

The study was overseen by a joint working group comprising Dr Richard Waldron, Dr Richard Grutzner, Dr Richard Clarke, Professor Barry Baker, Dr Mike Richards, Mr Peter Lawrence, and Mr Ian Collens. Dr Andrew Mulcahy also provided considerable input in refining and interpreting the Medicare and DVA data, and his knowledge and expertise was greatly appreciated. I would also like to thank Mr Michael Douglass for his assistance in putting the Workforce Survey online.

Having practicing anaesthetists in the working group has meant that inaccuracies and gaps in data provided have been detected, estimates have been arrived at where no data is available, and assumptions underlying the methodology have been examined rigorously.

I am very grateful to the committee for their work and enthusiasm in producing this study which will be of considerable benefit to us in our interactions with our governments and other stakeholders. I am also grateful to our Fellows and Trainees who participated in the survey. While I recognise that we may all be suffering from 'survey-itis', there are some data that can only be provided by you. For example, without knowing current and anticipated future average hours worked per week per anaesthetist, our projections on the patterns of workforce would be inaccurate. Having learned from our experiences in conducting the study in Australia, ANZCA will be proceeding with a similar survey in New Zealand this year.

It is vitally important that ANZCA take a central role in assessing the future demand for anaesthesia services and the number of anaesthetists required to meet this demand. If we are not there, others will define these parameters for us. Critical issues such as the proper scope of services provided by anaesthetists, and the appropriate model of care, will be defined by others who may miss out integral parts of our care such as pre-anaesthesia assessment. The negative flow-on from such omissions could include under-staffing of our public hospitals, with consequent implications for trainees' supervision and education, patient safety, and decreased funding for training positions.

With the information contained in the workforce study, ANZCA will be able to take a leading role in the development of public policy with regard to anaesthesia workload and workforce. We have various bodies in the two countries interested in workforce: in Australia, these include the Medical Training Review Panel, and the Australian Consumer and Competition Commission, the Australian Medical Workforce Committee; in New Zealand these include the Clinical Training Agency, District Health Boards New Zealand, and the Medical Training Board.

With recent increases in medical graduate places in universities in both countries, medical workforce has become a major focus of government. The (Australian) National Health and Hospitals Reform Commission, for example, has developed key reform directions that contain implicit workforce issues, such as:

- Ensuring timely access and safe care in hospitals. This focuses on improving access to emergency care, (access to) elective procedures and treatment, and better hospital planning.
- Working for us: a sustainable health workforce for the future. The challenges identified are health professional shortages and unbalanced geographical distribution, predicted increased health needs of the community and professional boundaries.

ANZCA believes it can play a leading role working proactively in partnership with governments to deliver the best surgical outcomes for the community. It is important to stress that the College is not the gatekeeper of numbers of specialist anaesthetists entering the profession. The College does not regulate the numbers of trainees in the system. That is determined by state departments of health / District Health Boards, which fund training positions in hospitals. In Australia, the College already trains more anaesthetists than the Australian Medical Advisory Committee say we should but our position has always been that if state health departments create increased numbers of training posts, we will provide the training. In New Zealand, we have trained more than have been funded by the Clinical Training Agency. This study shows that the demand for anaesthesia services will continue to grow and that governments need to take action now to address a projected shortage in 2028.

The College will periodically review our workforce requirements, modifying assumptions in response to changing demographic and economic factors, as well as government policy. For example, the demand for anaesthesia services may be affected by technological advances, changes in income, or changes in government policy towards such items as waiting lists or accessibility of services in rural areas. Supply can be affected by changes in the age of retirement, pattern of work, and gender balance of the workforce. The model used in the study can be adapted to allow for these changed circumstances, allowing us to identify the impact on workforce/workload and to implement strategies to address these shortfalls.

This is an important body of work that will underpin our forward planning, and is an example of some excellent collaboration between the College and the Societies of Anaesthesia.

Dr Leona Wilson
President

AWARDS

Professor Alan Merry

Professor Alan Merry was recognised in the New Zealand 2009 New Year Honours. Alan Merry was appointed as an Officer of the New Zealand Order of Merit (ONZM). The award is in recognition for services to medicine, in particular anaesthesia.

Alan has been a leader in anaesthesia and medicine in New Zealand and the world, especially in the area of quality improvement of medical services.

Alan was first elected to the New Zealand National Committee of the Australian and New Zealand College of Anaesthetists (ANZCA) in 1990, and served for 12 years until 2002 on that committee. He was the Chair of the Committee from 1996 – 1999. He was then elected to the Council of ANZCA in 2005.

One of the highlights of Alan's service to ANZCA has been his leadership of the campaign to amend the law regarding the conviction for manslaughter of those who owe a special duty of care, such as doctors. His efforts meant that the standard for conviction in New Zealand came into line with that in other similar jurisdictions. In this campaign he led a pan professional group, and worked tirelessly to convince Members of Parliament and others of the need for the law change.

On his election to ANZCA Council, because of his interest and skills in quality assurance, Alan was made the inaugural Chair of the (ANZCA) Quality and Safety Committee. As one of his first actions as Chair, he subsequently set up a tripartite committee with the New Zealand Society of Anaesthetists and the Australian Society of Anaesthetists to gather data required for improving the safety of anaesthesia care. This allowed ANZCA to further develop its focus on maintaining the quality of anaesthesia care for patients in New Zealand and Australia.

In New Zealand he is working with the ANZCA President, Dr Leona Wilson, the Chair of the New Zealand National Committee, Dr Vanessa Beavis, and Ministry of Health officials to establish a National Perioperative Mortality Review Committee.

Alan's interest in quality and safety has been recognised with his chairmanship of the World Federation of Societies of Anaesthetists Safety and Quality Assurance Committee.

In 2007, the then New Zealand Minister of Health appointed Alan to the statutory body, the National Quality Improvement Committee.

Alan has published widely, including a book written with Bill Runciman and Merrilyn Walton, 'Safety and Ethics in Health Care: A Guide to Getting It Right'.

Dr Frank Junius

Photo © Newspix / Sara Nixon

Dr Frank Junius was awarded in the Australia Day Honours List for service to medicine.

Dr Junius, an anaesthetist, devoted his career to cardiopulmonary perfusion. He recognised that this area of work involved high-risk procedures with possible serious complications, but also that it was largely neglected by practicing clinicians.

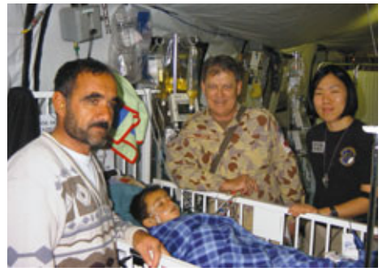
While working at St Vincent's Hospital in Sydney during the 1970s, Dr Junius was very critical of how a potentially damaging procedure was managed. As a result, he spent his career trying to advance the study of cardiopulmonary perfusion with a particular emphasis on research and practical clinical innovations.

Dr Junius' investigations into the side effects of heart-lung machines found 30 to 40 per cent of patients undergoing heart surgery were suffering problems with their brain. These problems included poor memory and concentration, depression, irritability and personality change. Through his work, Dr Junius was able to optimise the parameters to virtually eradicate these side effects.

Dr Junius aimed to be present at all profusion procedures undertaken at the hospital, either as the principal operator or in the role of supervisor. With St Vincent's heavy cardiac surgery load, he was virtually on call 24 hours a day.

While setting high technical standards for the specialty, Dr Junius also established an extensive clinical database to ensure his patients received the best medical care. He kept extensive personal notes on all of his patients, consisting of comprehensive preoperative and postoperative assessments and extended follow-up surveys aimed at detecting any long term problems. This information was carefully audited and used as the basis of innovative changes in his practice.

Brigadier Pezzutti



Brigadier Pezzutti with an Iraqi child, his father and a US army nurse in the US Military Hospital in Iraq in December 2005.

In the 2009 Australia Day Honours List, Brigadier the Hon Brian Pezzutti CSC RFD was awarded the Conspicuous Service Cross 'for outstanding achievement as a specialist anaesthetist and advisor to the Defence Health Service Division'.

Brigadier Pezzutti has served with the Australian Defence Force as a specialist anaesthetist in troubled regions around the world including Rwanda, Bougainville, Iraq, Fiji and East Timor on numerous occasions. He has been a member of the Army Reserve since 1968. He also worked as a civilian volunteer as part of the Australian/NSW Health surgical team in Banda Aceh after the earthquake and tsunami devastated the area in 2005.

Brigadier Pezzutti worked for four years as Assistant Surgeon-General in the Army. In that role he worked to improve Defence capability by improving recruitment of, and conditions of service for, specialist health officers in the Australian Defence Force. He was a member of the Legislative Council of NSW from 1988 to 2003 and was Parliamentary Secretary for Health from 1993 to 1995. He has been in anaesthetic practice in Lismore since 1976 and was Director of Intensive Care there from 1978 to 1988.

People & Events

SA/NT ANZCA and SA/NT RANZCOG joint event

A joint ANZCA and Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) meeting was held in Adelaide on Saturday, February 28, 2009. The topic was 'The Role of Critical Care in Contemporary Obstetrics & Gynaecology – Is It Really Critical?'.

Critical care is an embracing term for intensive care, high dependency care and emergency care and its application to obstetric and gynaecological care is rapidly developing worldwide to counter the continuing morbidity and mortality of women.

This joint meeting of obstetricians and gynaecologists, anaesthetists and intensivists with visiting and local speakers served to reinforce the required nexus between the two specialities to effectively implement critical care. The day was well supported by Fellows and trainees from both colleges and was oversubscribed.

1. Professor John Svigos, Dr Scott Simmons and Dr Kym Osborn.

2. Dr Paul Herreen and Sue Imgraben.

Combined TAS ANZCA/ASA Annual Scientific Meeting

The combined ANZCA/ASA Annual Scientific Meeting in Hobart from February 20–22 attracted 65 registrants and was sponsored by 11 trade companies. The meeting commenced with a registrars workshop conducted by Mary Lawson (Director of Education, ANZCA), and was followed by welcome drinks at Hadleys Hotel on Friday evening. The venue was particularly auspicious as this was the 75th birthday of the ASA and its first meeting was held at Hadleys.

The weekend sessions addressed the theme of the meeting 'What's Up Doc – Anaesthetic implications of new techniques and procedures'. Topics included bariatric surgery, cardiology update, endovascular surgery update and gastrointestinal developments and were delivered by anaesthetists, surgeons, and physicians. Mary Lawson also hosted a concurrent clinical teaching workshop.

Guest speakers, ANZCA President Dr Leona Wilson and ASA President Dr Liz Feeney, addressed the Annual General Meeting on Saturday afternoon.

1. Dr Agata Ancypa and Dr Mimi Darcey.

2. Dr Gabe Shuster, Dr Emily Lee and Dr Wendy Falloon.

3. Dr Deborah Wilson, Dr Mark Reeves and Dr Christopher Wilde.

ANZCA/ASA Combined CME Committee of Queensland

Twelve registrars presented their Formal Projects at the 12th Annual Queensland Registrars Meeting on February 28 at the ANZCA Queensland office, with a diverse range of subjects being covered. The state's hospitals were well represented with presenters travelling from as far as Cairns and Rockhampton.

Three prizes were awarded: the Tess Cramond Prize of $500, The Axxon Health Prize of $350, this year named in honour of Dr Diana Khursandi, and a new prize offered by the ASA, the 'ASA Chairman's Choice' prize of $500. This was the last official engagement for Dr Tess Cramond who retired on 1 March. It was a timely and significant event in what has been a long and outstanding career.

1. Dr Matthew Bryant, Dr Michael Steyn, Dr Di Khursandi, Dr Tess Cramond and Dr Chris Bryant.

2. Dr Paul Suter, Dr David McCormack, Dr John Archdeacon, Dr Mark Gibbs and Dr Matthew Bryant.

Obstetric Anaesthesia Special Interest Group Conference

2020 – A Vision of the Future for Obstetric Anaesthesia

1. Dr Michele Moore, Dr Vicky Volkova (and partner Craig behind), Dr Tim Parris-Piper, Dr Julian Fuller, Dr Jenny Fabling and Dr Michaela Hamschmidt.

2. Dr Graham Sharpe, Wellington Hospital, NZ (left) and Prof Warwick Ngan Kee, Prince of Wales Hospital, Hong Kong.

3. Dr Julian Fuller, North Shore Hospital, NZ.

Blenheim, New Zealand 15–17 October

The Obstetric Anaesthesia SIG satellite meeting of the 2008 ASA/NZSA Combined Scientific Congress was held on October 15–17 2008. Following the success of the 2004 meeting, the meeting returned to the striking backdrop of the Blenheim countryside, at Montana Brancott Winery, Marlborough, New Zealand.

With 150 delegates in attendance, a wide array of local and international speakers including Steve Yentis, Michael Paech and Warwick Ngan Kee gave presentations on evidenced based medicine and clinical audit and the likely developments in clinical practice in the decade to come. There was also a broad coverage on the future of training and simulation and communication skills from Allan Cyna, Alicia Dennis, Suyin Tan and Lara Hopley as well as a perspective on Asia-Pacific practice from Stephen Gatt. Contributions from our obstetric colleagues via Dean Maharaj and a midwifery view from Robyn Maude were also greatly appreciated. It was also the official launch of what is hoped to be the ongoing development of the web-based clinical practice evidence base.

Slides from the presentations are available on the ANZCA website via the Obstetric SIG webpage.

I would like to thank all speakers for donating their time and expertise to make this meeting a great success and the health care industry for their generous support.

Dr Scott Simmons
Convenor

ANZCA Council Meeting report

February 2009

Report following the Council Meeting of the Australian and New Zealand College of Anaesthetists held on 28 February 2009.

Death of Fellows
Council noted with regret the death of the following Fellows:

Dr Lim Say Wan (Malaysia), FFARACS 1974, FANZCA 1992

Dr Brian Donald McKie (VIC), FFARACS 1968, FANZCA 1992

Dr Carlos Parsloe (Brazil), Honorary Fellow, FFARACS 1989, FANZCA 1992

Dr Nalin Rohitha Wijeyesekera (NZ), FFARACS 1984, FANZCA 1992

Honours and Awards
Prof Alan Merry (NZ) was awarded the New Zealand Order of Merit (ONZM) in the New Year's Honours List in recognition of services to medicine, in particular anaesthesia.

Dr Frank Junius was awarded the Medal of the Order of Australia (OAM) in the Australia Day Honours List. This award recognises his service to medicine over a long period of time, and in particular cardiopulmonary perfusion.

Dr Brian Pezzutti (NSW) was awarded the Conspicuous Service Cross (CSC RFD) in the Australia Day Honours List for outstanding achievement as a specialist anaesthetist and advisor to the Defence Health Service Division.

A number of Fellows have been recognised by the New Zealand Society of Anaesthetists with the award of Life Membership: Drs Bob Boas, Mack Holmes and Hugh Spencer. Immediate Past President of ANZCA, Dr Walter Thompson, was awarded Honorary Life Membership of the Society.

Dr Michelle Mulligan was admitted to Fellowship of the Australian Institute of Company Directors (FAICD).

Election of President
Dr Leona Wilson has been elected President for a second term to May 2010.

Quality and Safety

Q&S Editorial Advisory Body (EAB)
The Quality and Safety Committee established a communications and liaison portfolio, chaired by Dr Patricia Mackay. The initial activity involved the provision of a special section of the Bulletin devoted to safety and quality issues. It was always recognised that with the development of the College website, this would be an important medium for such communication. In addition, the College has developed a regular e-newsletter to Fellows and trainees. As a result of these developments, Council has approved the establishment of an informal editorial advisory group to provide advice on all Q&S issues to be published via all three mediums.

In conjunction with the Director of Communications, the EAB will review all Q&S issues for the Bulletin, website and e-newsletter, and will determine the type of information and priorities for each medium to avoid unnecessary duplication.

World Health Organisation – Safe Surgery Checklist
'Safe Surgery Saves Lives' is part of the Second Global Challenge for Patient Safety of the World Health Organisation. One of the initiatives resulting from this project led to the development of a three-phase WHO checklist (the Checklist) for use before the induction of anaesthesia (sign in), before the surgical incision (time out) and at the end of the procedure (sign out). Following the evaluation of a study comparing 4000 patients undergoing surgery over eight sites around the world prior to the introduction of the Checklist with those in 4000 patients after its introduction, mortality and morbidity were substantially and significantly reduced.

In an effort to encourage wide adoption of the Checklist, ANZCA, in conjunction with RACS, will develop and promulgate a suitably modified version as a College Professional Document, indicating those elements they consider essential in Australia and New Zealand. In addition, the College has agreed to work with RACS towards establishing the universal adoption of the Checklist in Australia and New Zealand, with support and input from the ASA and NZSA.

Fellowship Affairs

Annual Scientific Meeting
Council supported the initiative that each member of the ASM Regional Organising Committee be awarded an ASM Certificate in recognition of their contribution to the meeting. The certificates will be presented by the President at the College Dinner.

New Fellows' Conference
This year's NFC will be held at Thala Beach Resort, Port Douglas from 29 April to 1 May. Council ratified ANZCA nominations to attend the Conference as follows:

Dr David Bramley, Vic

Dr Alexandra Douglas, Qld

Dr Bruce Hammonds, Qld

Dr Tomoko Hara, NZ

Dr Mohua Jain, NZ

Dr Kwok Yee Patricia Kam, HK

Dr Irina Kurowski, WA

Dr Irene Ng, Vic

Dr Timothy Porter, SA/NT

Dr Tanya Selak, NSW

Dr Alice Summons, NSW

Dr Michael Thumm, SA/NT

Dr Andrew Watson, ACT

Dr Diana Webster, Qld

Dr Sarah Wyatt, WA

Dr Genevieve Goulding has been appointed Councillor in Residence to the Conference.

It has been agreed that the New Fellow Councillor will attend the NFC in addition to the Councillor in Residence.

Internal Affairs

Resignation from Council
Dr Margaret Cowling has tendered her resignation from Council, effective from 1 May. Dr Cowling's contributions to Council since her election in 2004 were recognised by the President.

Regulations
Regulation 2.7 – Education and Training Committee
This Regulation was amended to include the Chair of Examinations and the Chairs of the Primary Examination Subcommittee, the Final Examination Subcommittee, the Assessments Subcommittee and the Workplace Based Assessment Subcommittee as ex-officio members.

Regulation 16 – Trainee Committee
This Regulation was amended as a result of deliberations by the Trainee Committee. The revisions were designed to emphasise the relationship between the ANZCA Trainee Committee and the Regional/National Trainee Committees, while strengthening the communication between these committees. The updated Regulation appears on the College website.

Professional

Professional Documents
Withdrawal of PS48 – Statement on Clinical Principles for Procedural Sedation
PS48 was promulgated in February 2003 and was due for review in 2008. On review, it was considered that PS48 is less definitive than the new PS9 – *Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical or Surgical Procedures*, has no evidence-based references, and does not adequately address many sedation issues such as staffing, monitoring, medication, training and accreditation. There are also some contradictions generated because of these differences between PS9 and PS48.

As a result, Council agreed to withdraw PS48.

Process for review of Professional Documents
A draft process for the review of College Professional Documents was supported by Council and is to be circulated to the Regional/National Committees for input.

Australian Day Surgery Council
Council has now formally ratified the revised ADSC Charter and will meet the funding request of $1500 for 2009.

ANZCA is currently represented on the ADSC by Dr Anthony Bergin. The revised Charter provides for ANZCA and the ASA to have two representatives each, and the College and Society will confer about the nomination of further representatives to the ADSC.

Australian and New Zealand College of Perfusionists (ANZCP)
The ANZCP has advised of recent revisions to the Constitution of the Australasian Board of Cardiovascular Perfusionists, and that as a result, ANZCA is no longer required to appoint two anaesthetists to serve on the Board. Drs Paul Forrest and Andrew Stewart were long-standing College representatives on the ABCP, and have been thanked for their input over the years by the President.

National Registration and Accreditation Scheme (NRAS) for Australia
The College has provided a submission on arrangements for specialist registration within the NRAS, highlighting the following points:

- Support for a national registration scheme for the health professions.
- Support for a separate specialist register.
- Entry to that specialist register being limited to practitioners with specialist qualifications on advice from the relevant accreditation body. For medical practitioners, this is the AMC acting on the advice for the Medical Colleges.
- Support for independence of any accreditation processes.
- Support for a name change from 'continuing competence' to 'continuing professional development'.
- Concerns about the proposed powers of the Ministerial Council. ANZCA considers that Government should set legislation, and independent statutory bodies should be responsible for its implementation.

International Medical Graduate Specialists
The IMGS Assessment Process was introduced, and Regulation 23 updated from 1 January 2009 for the assessment of IMGS via the AMC process. Some Partially Comparable applicants have sought to have their pre-2009 requirements 'reconsidered' under the new rules.

Following receipt of legal advice, it has been clarified that applicants assessed under the pre-2009 Regulations may not be 'reconsidered' under Regulation 30 – Reconsideration and Review, but rather, should be invited to submit a new application. As a result of this advice, Council approved a new application fee of $1000 to cover the associated administrative costs.

Dr Leona Wilson
President

A/Prof Kate Leslie
Vice-President

ANZCA Council Meeting report 2

December 2008

Report following the Council Meeting of the Australian and New Zealand College of Anaesthetists held on 13 December 2008

Death of Fellow
Council noted with regret the death of the following Fellows:

Dr John Martin Rutherford Bruner FFARACS 1985, FANZCA 1992.

Dr Russell Geoffrey Cole (Vic), FFARACS 1956, FANZCA 1992.

Dr John B McCarthy (Qld) FFARACS 1984, FANZCA 1992, FJFICM 2002.

Honours and Awards
Dr Phoebe Mainland has been awarded Fellowship of the Australian College of Legal Medicine (FACLM). ANZCA CEO, Dr Mike Richards, recently gained Fellowship of the Australian Institute of Management (FAIM).

Education and Training

Clinical Teaching Workshops
Council supported the concept of expanding the provision of CTC workshops to include Malaysia and Singapore. As a result, face-to-face workshops have been budgeted to be convened in these regions in 2009.

Curriculum Review and Development
At the first meeting of the Curriculum Review Working Group (CRWG) held in August, it was agreed to adopt the CanMEDS framework for the revision of the training curriculum. Invitations have been sent to key stakeholders to provide input to the review process.

Formal Project Officers
The requirement for increased support to Formal Project Officers (FPOs) has been raised, along with issues such as the need for standardisation of project submissions, assessment between the regions, and development of quality assurance processes. As a result, it has been agreed that the Deputy Chair of the Education and Training Committee will conduct regular meetings with the FPOs. This arrangement will be reviewed at the time of implementation of the outcomes of the current curriculum review process.

Final Examination Lecture Series
This initiative is aimed at meeting the needs of advanced trainees in rural settings by developing a series of online materials for delivery via the ANZCA website. The rationale behind the project is that rural trainees may not have access to the range of training activities and resources that may be available in metropolitan settings. To this end, an Online Learning Working Group has been established.

Dr Ray Hader Trainee Award for Compassion
This award was established to recognise Trainees or Fellows within three years of admission to Fellowship by Examination who have made a significant contribution to the welfare of an individual, a group or a system that promotes welfare and compassion. The award of $2000 per annum for five years has been donated by Dr Brandon Carp.

The inaugural award was made to Dr Amanda Young (Vic), and was presented to her by Dr Carp at a function hosted by the President at ANZCA House on 12th December.

Finance

Annual Subscription and Fees for 2009
Council approved the 2009 budget and the following fees were set for the coming year. The table of fees can be found at *www.anzca.edu.au* in the News section under Council Reports.

Establishment of Regulation 2.17 – Investment Committee
As the Investment Committee reports regularly to Council with updates on the performance of the Investment Portfolio, it has been agreed to formalise its functions in the College Regulations with the promulgation of Regulation 2.17.

Membership of the Committee includes the President, the Honorary Treasurer, the CEO and the Director of Finance. In addition, Council may co-opt members who have high levels of financial literacy and are not Fellows of the College. The Committee is responsible for developing and reviewing investment strategies regarding the Investment Portfolio for approval by Council, and reviewing and reporting to Council on the performance of the Investment Portfolio.

Fellowship Affairs

Annual Scientific Meeting – Cairns 2009
Organisation of the ASM is progressing appropriately and registration brochures will be circulated early in the new year.

Continuing Professional Development

Mandation of CPD Program
Information is being provided to Fellows via the Bulletin, website and letter reminding them of Council's decision in October 2007 to mandate participation in a 'formal CPD program' effective from January 2009.

International Medical Graduate Specialists (IMGS)

IMGS Assessment Process
In April 2006, Council resolved that Specialist Anaesthetists with Fellowship of the RCoA or CARCSI by training and examination with CCT, recency of practice and participation in CPD, after six months in Australia or New Zealand would be granted recommendation for specialist recognition. After a further six months' practice in Australia or New Zealand together with a pass in the Final Examination or the OTS Performance Assessment, they were eligible to apply for FANZCA.

The OTS Committee was given until December 2008 to recommend a new process for IMGS, based on AMC requirements, taking into account New Zealand requirements, and guided by initial documents prepared by Prof Teik Oh. As a result, the following resolutions were passed by Council:

1. That the criteria for Advanced Standing towards Substantial Comparability, Partially Comparable and Non-Comparable IMGS be accepted.
2. That the "Workplace Based Assessment" process and form be accepted.
3. That those UK and Irish Fellows recommended for Specialist Recognition between April 2006 and December 2008 be advised that in order to be eligible to apply for Fellowship, they must either pass an examination, or undergo a Workplace Based Assessment.
4. That those OTS previously assessed as Partially Comparable be advised of the new IMGS process.
5. That the new IMGS process be implemented from 1 January 2009 and evaluated once fully implemented for two years.

Internal Affairs

New Zealand Resuscitation Council
Dr Malcolm Stuart has been nominated as ANZCA representative to the New Zealand Resuscitation Council.

Regulation 6 – Admission to Fellowship of the College
Council suspended parts of Regulation 6.3.1 (Election to Fellowship) in February 2008, pending review and formalisation of the IMGS Assessment Process. As the new process has now been approved for commencement on 1 January 2009, appropriate changes to the Regulations governing Election and Admission to Fellowship have been approved and appear on the College website.

Research

Lennard Travers and Douglas Joseph Professorships – Deadline for Applications
To bring the timing of the Lennard Travers and Douglas Joseph Professorships into line with other research awards, the submission date for each has been amended from 1 March to 1 April. The Regulations pertaining to these Professorships have been amended accordingly.

New Programs Committee

Royal Hobart Diving and Hyperbaric Medicine Unit
This unit has been accredited for training towards the ANZCA Certificate in Diving and Hyperbaric Medicine for a further period of five years.

Christchurch Hyperbaric Medicine Unit
Following review in February, it has been confirmed that the Hyperbaric Medicine Unit at Christchurch Hospital is accredited for training towards the ANZCA Certificate in Diving and Hyperbaric Medicine for six months of the 12 months required in an ANZCA-approved unit.

College Award

Orton Medal
The Orton Medal was established in 1967 by the Faculty of Anaesthetists, RACS and is the highest award the College can bestow on one of its Fellows, the sole criterion being distinguished service to Anaesthesia. Council has awarded an Orton Medal to Professor Michael Cousins (NSW) in recognition of his outstanding contributions over many years to anaesthesia and pain medicine research, to clinical practice in pain medicine, the establishment of the Faculty of Pain Medicine, to the College as an examiner and Committee member, and as President from 2004 to 2006.

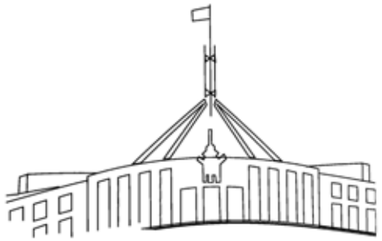
The Medal will be presented to Professor Cousins by the President at the Annual Scientific Meeting in Cairns in 2009.

An attachment on 'Regulation 6 – Admission to Fellowship of the College' can be found at *www.anzca.edu.au* in the News section under Council Reports.

Dr Leona Wilson
President

A/Prof Kate Leslie
Vice-President

ANZCA responds to National Health and Hospitals Reform Commission (NHHRC) Interim Report



The NHHRC recently released its interim report after more than 500 submissions and countless consultations across the country. ANZCA contributed a 35-page submission to the Commission with a list of 22 recommendations covering the health service system, education and training in relation to the health workforce, and rural health. The final report is due for completion by the end of June 2009.

ANZCA congratulates the NHHRC on the interim report that outlines a comprehensive suite of mainly sensible reform directions. ANZCA is preparing a follow up submission.

Ensuring timely access and safe care in hospitals

In our earlier submission we recommended special arrangements for emergency surgery to improve patient throughput and safety and prevent "bed-block" of inpatient beds. It is pleasing to see acknowledgement of this serious issue and the recommendation that consideration be given to separate "planned" procedures from "emergency" procedures by ensuring dedicated planned procedure units are established as separate facilities. This also has the added advantage, if properly planned, of improving clinical training and supervision. We concur with the need for greater support for teaching. However, we do have concerns about centralising all clinical placements at a national level.

Delivering better health outcomes for remote and rural communities

ANZCA endorses the directions for rural and remote health, in particular improved access to care, including specialist health care that is often hard to reach by these communities. ANZCA has direct experience through its Fellows of the difficulties faced by these communities and supports calls for improvement to distance learning opportunities and continuous professional development for practitioners. These are of direct relevance to anaesthesia trainees as well as specialist anaesthetists who need to access educational support, as well as locum relief.

To demonstrate its commitment ANZCA has recently been directly involved in a feasibility project funded by the Department of Health and Ageing (DoHA) and led by the Australian Society of Anaesthetists to explore the demand/supply and suitable models for locum support for GP anaesthetists, which should also be extended to other health professionals including specialists. We also are running another project funded by the Rural Advanced Specialist Trainee Scheme from DoHA which is looking at improved distance education facilities through use of the web and video conferencing. ANZCA also actively supports the Support Scheme for Rural Specialists.

Strengthening the governance of health and health care

As discussed in our original submission, ANZCA is concerned about the fragmentation of health care and the need for a better-integrated and coordinated system. Our preference is for Option A in the interim report – continued shared responsibility between governments, with clearer accountability and more direct Commonwealth involvement. This proposal is less ambitious and therefore less disruptive than the other two and much more realistic as it streamlines accountabilities under the umbrella of a national health strategy. It retains both local state/territory and national federal control, allowing the states/territories to retain local level control which is usually their overwhelming preference.

Working for us: a sustainable health workforce for the future

ANZCA favours a team-based approach to care. Anaesthetists have been at the forefront in utilising nurses as assistants as part of the anaesthesia health care team. There may be roles, and reference is made to the scarcity of workers in rural and regional areas, which anesthetists feel are appropriate for delegation to others. However, the composition of any team, and their specific roles, should be applicable to the Australian context, especially with consideration of workforce projections for all healthcare workers, and must be of proven benefit. The current pilots in Victoria and Queensland on nurse clinicians and physician assistants will provide valuable guidance on some of these alternative roles.

The establishment of a National Clinical Education and Training Agency while perhaps superficially attractive is not proven in practice. A key consideration is that the separation of the costs of training from service provision is not an exact science. Also, another layer of bureaucracy would need to be funded at taxpayer's expense.

National Health and Hospitals Reform Commission – Interim Report – Key points

- Acknowledgement of access to universal health care
- Establishing a national health promotion and prevention agency to improve community health and well-being
- Safe and timely access to hospitals
- Universal dental care (Denticare Australia)
- Commonwealth assuming responsibility for all primary health care policy and funding
- Reshaping hospital roles (greater delineation such as separating planned and emergency services) and reflecting this in the use of activity-based funding for private and public hospitals
- Establishment of Comprehensive Primary Health Care Centres
- Prioritising and investing in sub-acute services
- National Access Guarantees and Targets for hospitals
- Remote and rural health – equitable and flexible funding, innovative workforce models (including allowing appropriately trained nurse practitioners and other registered health professionals to order diagnostic tests and make specialist referrals covered by Medicare
- New educational framework consisting of a competency-based approach
- National Indigenous Health Authority
- National registration of health professions
- Three options for governance

Maternity services report silent on analgesic and anaesthetic services, high-risk pregnancy and critical care

Mike Paech

In the previous issue of the ANZCA Bulletin (December 2008) key points made in ANZCA's submission to the federal Government's Maternity Services Review Discussion Paper were highlighted. The report of the Maternity Services in Australia Review has recently been released and presumably establishes a blueprint for possible reforms and priorities in the development of a national maternity services plan. So does the report address any of the key points made by the College?

Many people will have seen media comment on the report, which focused on recommendations to expand choice and the availability of models of maternity care, with an expanded role for midwives. Pleasingly, three important components of the ANZCA submission in relation to quality and safety of care appear to have been well supported by the report.

First, there are recommendations to develop national cross-professional best practice guidelines to support multidisciplinary care and to improve national data collection and targeted research. The Obstetric Anaesthesia Special Interest Group scientific evidence guidelines now available on the ANZCA website are an example of a suitable resource that we have already developed. Second, as a member of the National Advisory Committee on Maternal Mortality, representing the College, I have been acutely aware of the current deficiencies in state-based mortality reporting and the need to introduce national serious morbidity reporting in some form. It is therefore most welcome to see a recommendation that the Australian government, in consultation with states and territories, implement arrangements for comprehensive national data collection, monitoring and review of maternal and perinatal morbidity and mortality. Third, a recommendation to support collaborative care, especially in rural and remote areas (where maternal mortality is higher), including targeting retention of GP anaesthetists, also fits well with ANZCA's policy of enhanced specialist back-up and increased education and training for all local rural anaesthetists. Many Fellows are already involved in such initiatives and this role may expand in future.

Nevertheless, a number of the suggestions made in the ANZCA submission received little or no attention. The important role of the anaesthetist, chronic pain management services, multi-disciplinary team training to optimise safety standards, and the issues related to public hospitals delivering maternity services, all failed to receive mention.

The Report made repeated mention of the need to support procedural rural GP anaesthetists, but was silent about rural specialist anaesthetists. In relation to the pressure on the maternity workforce and the need to attract and retain health professionals, specialist anaesthetists were not mentioned. For those anaesthetists involved in maternity services, one recommendation that may affect you is the responsibility of 'professional bodies' to ensure that all staff involved in delivery maternity services receive cultural awareness training.

While no-one would dispute the value of a recommendation to improve information available to Australian women (an area in which Fellows are also active), a key remit of the report was to consider quality and safety. From my perspective, the report is striking for the total absence of reference to analgesic and anaesthetic services, high-risk pregnancy, tertiary and critical care services. This seems a serious omission. The report acknowledged the excellent safety record of obstetric care in Australia and the fact that 85% of the population is delivered in public and hospitals and by private obstetricians, with the current caesarean section rate (more than 30%), not surprisingly, receiving some attention. Perhaps we can assume that obstetric anaesthetic services are so good that they do not need to be changed or improved? The College was represented at a round table forum on this topic, but it is not clear to me whether the discussions there will have any impact on the final national plan. It remains important that ANZCA continues to participate in the process of developing this plan, and that we as a profession do not remain a highly effective but inadequately acknowledged health care provider.

Professor Mike Paech
King Edward Memorial Hospital for Women, Perth

Maternity services report

The Federal Government's Maternity Services report was released on February 21. The report followed a review led by Chief Nurse and Midwifery Officer Rosemary Bryant. The report focuses on the need to improve the choices available to pregnant women, access to high quality maternity services, and support for the maternity services workforce. The review received more than 900 submissions.

Summary of findings and recommendations

- Australia remains one of the safest countries in the world in which to give birth
- In 2006, 277,436 women gave birth to 282,169 babies in Australia – the highest number of births since 1971
- Over 60 per cent of births take place in public hospitals
- Improving choice for Australian women by supporting an expanded role for midwives
- Consideration of the expansion of access to Medicare and the PBS for midwives – but only if accompanied by stringent professional requirements for midwives
- Consideration of support for professional indemnity insurance for midwives
- The development of new national cross-professional guidelines to support collaborative multidisciplinary care in line with best practice
- Consideration of the establishment of a single integrated pregnancy-related telephone support line
- Improved data collection and analysis, and further research
- Providing increased support for the maternity workforce, particularly in rural Australia
- National Maternity Services Plan to be developed

Australia's looming anaesthetist shortage: ANZCA and ASA combined workforce study

With the issue of medical workforce a major focus for government and policy makers, Australia and New Zealand's medical colleges have a central role to play in ensuring the community has a well-trained highly skilled workforce available into the future. Rather than leave this important work to others, ANZCA and the Australian Society of Anaesthetists decided to commission an independent workforce study on the likely future demand and supply for Australian anaesthesia services which will continue to underpin modern surgery.

THIS FEATURE CONTAINS THE KEY RESULTS of the first joint ANZCA/ASA Australian Workforce study "Supply and Demand for Anaesthesia Services". The study was undertaken by Access Economics who not only assessed the numbers of anaesthetists, and their participation, in the workforce (i.e., the supply side of the workforce), but also the demand for anaesthesia services. Access Economics were also asked to make 20-year projections (to 2028) regarding probable future trends, based on current modelling.

Anaesthetists in Australia are only too aware of statements made about the adequacy of numbers of anaesthetists. Some reports in the media often refer to the lack of anaesthetists in the Australian workforce and cite this scarcity as one reason for the lengthy surgical waiting lists.

Since the mid-1990s, ANZCA has been surveying its Fellows regarding workforce participation on a roughly triennial basis. The information gathered from these surveys has been used by ANZCA to respond to enquiries from various government bodies, particularly the Medical Training Review Panel (MTRP), the Australian Medical Council (AMC) and most notably the two Australian Medical Workforce Advisory Committee (AMWAC) review reports of 1996 and 2001.

The 2001 AMWAC report noted that there were 369 specialist anaesthesia training positions in 1995. It identified the need for 512 trainees by 2003 in order to maintain adequate numbers of anaesthetists in the workforce (on the assumption of a 2.1% growth in demand for anaesthesia services).

In 2003, the Australian Institute of Health & Welfare (AIHW) Medical Labour Force Survey 2003 revealed that there were 763 anaesthesia trainees that year with a further 67 trainees classified as intensive care trainees. This was 50% more than recommended by the AMWAC report of 2001. ANZCA is currently experiencing significant growth in candidates presenting for examination. The ANZCA Final Examination to be held early this year has a record 220 candidates presenting. This is the first of two such exams which will be held this year.

What is the ideal number of anaesthetists to meet the demand for anaesthesia services? Early attempts looked at the Specialist Anaesthetist to Population ratio (SPR). In 1995, the SPR was about 1:10,000. By way of comparison, Canada in 1996 had an SPR 1:13,583. However, according to the 2004 Medical Workforce Survey of Victoria, there were 17 Specialist Anaesthetists per 100,000 population or a SPR of 1:5,882 (note that AMWAC 2001 stated that South Australia had the highest SPR of 1:7,290 and the Northern Territory has lowest at 1:20,470).

The above data is obviously incomplete. The ANZCA data only contains information about Fellows of ANZCA. Other providers of anaesthesia not included in the ANZCA figures include some members of the ASA, GP Anaesthetists, some International Medical Graduate Specialists (IMGS), and doctors working in Area of Need (AON) locations. Similarly, the Australian Institute of Health & Welfare (AIHW) has incomplete data as their information relies on a re-registration census-type process. Thus, international medical graduates who work for less than 12 months are not captured. Also, they do not necessarily catch all GP anaesthetists in their data.

With the above in mind, a joint working group was established between ANZCA and the ASA co-chaired by myself and Dr Richard Grutzner. The Workforce Working Group also comprised both ANZCA and ASA Presidents and CEOs, Professor AB Baker and Mr Ian Collens, ANZCA Director of Strategy & Operations. Dr Andrew Mulcahy also provided considerable input in refining and interpreting the Medicare and DVA data. It was agreed that a joint survey (distributed in October 2007) should be undertaken to provide a "snapshot" of the Australian workforce's characteristics. In addition, Access Economics were also asked to develop a model that could be used to conduct future surveys in Australia and New Zealand.

I would encourage all Fellows and Trainees of ANZCA and members of the ASA to take the opportunity to read the summary report which is available on the ANZCA website. Although there were many difficulties in gathering accurate data, and several key assumptions had to be made based on the experience and knowledge of Working Group's members and scanty information, the report nonetheless clearly identifies the disparate growth in demand and supply of anaesthesia services over the next 20 years, and makes use of various scenarios to identify potential strategies and will be of considerable use in future workforce planning.

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Dr Richard Waldron
Co-Chair, Combined ANZCA/ASA Workforce Working Group

'In the base case, the projections suggest a widening gap between demand and supply, rising from a very small shortage of four FTE anaesthetists in 2008 to 2287 in 2028.'

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'By 2028 shortages, under the base case scenario, are predicted in both urban and rural areas. The projected workforce of anaesthetists in 2028 should reach 6312 FTEs, compared to a demand for 8599 FTEs – a total potential gap of 2287 FTE anaesthetists.'

Key findings

THERE ARE CONSIDERABLE PROBLEMS in undertaking medical workforce studies, in particular accessing robust, up-to-date and consistent data on which to build projections.

Access Economics developed a model split into two modules:

— a demand module, reflecting the use of anaesthesia services and

— a supply module reflecting the capacity of the workforce to provide anaesthesia services.

The latter was informed by a survey of anaesthetists conducted in October 2007. In addition, a Working Group of ANZCA and ASA members provided guidance on the project.

The methodology involved four stages (Box 1).

Box 1 Methodology

Stage 1: Demand projections of anaesthesia services based on: age and gender of population, region, prices of services influenced by public/private split, bulk billing rates, private health insurance and rebate levels, patients' income and technology and patient expectations.

Stage 2: Supply projections of full-time equivalent (FTE) anaesthetists based on: age and gender of the workforce, average hours worked, number of new trainees entering the workforce, remuneration, net overseas migration, retirements/deaths, temporary movements in and out of the workforce, substitution between specialist anaesthetists and other service providers, and employment status (e.g., major settings including public/private).

Stage 3: Gap analysis involving a comparison of the demand and supply projections of FTE anaesthetists for the period 2008-28. Gap estimates were also made for urban and regional areas to identify any geographic imbalances in service provision.

Stage 4: Scenario analysis of various policy options to remedy imbalances.

Utilisation in 2006-07
Existing data sources indicated that close to 5.5 million anaesthesia services were provided to Australians within a twelve-month period in 2006–07. The bulk of these services were provided under Medicare and to public in-patients. Some 450,000 services were provided to Department of Veterans Affairs (DVA) patients, as well as for intensive care, pain management and hyperbaric services. These are conservative estimates as the services provided to public in-patients are likely to be understated owing to data limitations.

Converting the number of anaesthesia services used to hours, around five million hours would be required – an average of 55 minutes per service. Dividing by clinical hours per FTE (1176 hours per year) suggests that in 2006-07 there was a requirement for 4286 FTE anaesthetists.

Demand Projections
Demand projections of anaesthetists, including a split by urban and rural areas, are presented in Table 1. The urban population share used in the study was based on 2006 census data and Access Economics' estimates, and held constant for the projected timeframe. The number of FTE anaesthetists required was forecast to nearly double from 4437 to 8599 in the 20 years to 2028, representing an average increase of 208 FTEs per annum. Nearly half of the expected increase in demand can be attributed to demographic change, including ageing of the population. The balance can be largely attributed to rising incomes and raised community expectations.

The base case results reflect a number of assumptions (e.g., no net effect on demand from advances in medical technology, a public patient complexity factor of 1.3[1] , income elasticity of demand[2] of 1 and 80 per cent of clinical time captured by Medicare data). Alternative scenarios were also modelled and found to be most sensitive to the assumptions regarding income elasticity of demand and technological change.

1. The public patient complexity factor was applied to Medicare T10 data to allow for the greater time associated with the more complex care generally required of public patients.
2. The income elasticity of demand measures the relative responsiveness of demand (in this case for anaesthesia services) to a change in consumer income.

Key findings

Continued

Table 1 Demand Projections for FTE Anaesthetists to 2028

Year	*Urban*	*Rural*	*Total*
2008	3242	1195	4437
2028	6261	2388	8599
Average annual increase of FTEs from 2008	151	57	208

Table 2 Base Case Projections of Supply (FTEs)

	Total	*Anaesthetist Fellows and Trainees**	*GP Anaesthetists**	*Non-Fellows**
2008	4,433	4,063	118	252
2028	6,312	5,786	168	358
Growth	42%			

** These numbers vary from the headcount numbers given earlier being estimates of full-time equivalent positions.*

Estimate of Current Supply

ANZCA headcount data in 2007 recorded 2963 active Fellows and 1084 Trainees. Data from the ASA and the Joint Consultative Committee on Anaesthesia (JCCA) suggested a further 564 non-Fellows and 460 GP anaesthetists. Medicare data indicated that GP anaesthetists tend to work in rural areas and provide approximately 2.7 per cent of anaesthesia services overall. Trainees tend to be located in public hospitals in urban areas.

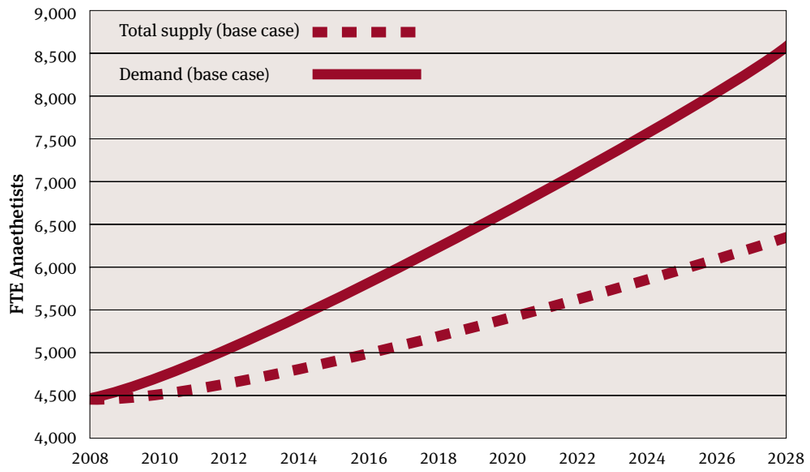
Based on headcounts of anaesthetists and an estimated average clinical time of 1176 hours per year, the model suggested that in 2008 there were 4433 FTE anaesthetists in Australia. Over 90% of these were ANZCA Fellows and Trainees.

Supply Projections

The number of FTE anaesthetists working in Australia was projected to increase by 42% to 6312 by 2028 (Table 2).

Again, the base case applied a number of assumptions (e.g., net migration inflow of 40 FTEs per annum, 33 per cent female trainee completions, constant real remuneration, 1.9 per cent per annum growth in new Fellows). Several alternative supply scenarios were also modelled (Table 3).

Figure 1 Growing Shortage of FTE Anaesthetists



Comparing Supply and Demand

In the base case, the projections suggest a widening gap between demand and supply, rising from a very small shortage of four FTE anaesthetists in 2008 to 2287 in 2028 (Figure 1).

The results also indicated a significant maldistribution of FTE anaesthetists between urban and rural areas. They revealed a current shortage in rural areas and an oversupply in urban areas.

By 2028 shortages, under the base case scenario, are predicted in both urban and rural areas. The projected workforce of anaesthetists in 2028 should reach 6312 FTEs, compared to a demand for 8599 FTEs – a total potential gap of 2287 FTE anaesthetists (i.e., there will be a requirement for 36 per cent more anaesthetists).

Table 3 shows the impact on the supply/demand gap of implementing a range of initiatives to increase supply. It also shows the potential impact of increasing feminisation of the anaesthesia workforce.

Table 3 Alternative Supply Scenarios

Scenario	Description	Percent Increase in FTEs (2008–28)	Projected FTE Supply Gap (2028)
Base case		42%	2287
Scenario 1	Training completions grow 4.4% pa (historical trend)	74%	883
Scenario 2	Increase feminisation (33% in 2008 to 40% in 2028)	41%	2338
Scenario 3	Net migration inflow of 60 p.a.	50%	1875
Scenario 4	Later retirement	55%	1522
Scenario 5	Increase in real remuneration by 20% in 2010	61%	1466

Conclusions

The study projections indicated that a significant shortage in anaesthetists could occur by 2028. This result reflects pressures on both the demand and supply sides, resulting from a growing and ageing population, higher income levels, and a workforce whose average age is increasing as specialists retire.

Questions arise as to how 'real' these expected shortages are. Sensitivity analysis indicated that the results can be sensitive to the assumptions used. Similarly the application of alternative scenarios on both the demand and supply sides produced markedly different outcomes. The choice of assumptions can have opposing effects on the gap. For example, using actual utilisation in 2006–07 as a proxy for demand would underestimate the projected gap given the current level of unmet demand for elective surgery in the public sector.

The results are also sensitive to the assumption regarding technological change. Technological advances could influence the future practice of medicine significantly and, as a result, surgical and anaesthetic practices, both directly and indirectly. On balance the overall impact of technological change is uncertain and needs to be monitored.

This study assumed no changes in government policy, but it is reasonable to assume that over a 20-year period there could be significant changes at both Commonwealth and State levels that could affect both the demand and supply sides.

Meanwhile the supply scenarios tested indicated that the projected supply gap could be reduced by introducing one of a number of initiatives, such as maintaining training completions at recent trend levels, increasing financial incentives, or increasing the net migration flow. Introducing a combination of such measures could serve to meet the future demands for anaesthesia services.

Survey results

A KEY PART OF THE ANZCA/ASA joint workforce study, was a survey that covered both qualitative and quantitative aspects of the work environment.

A total of 1,368 responses were received, of which 75% were current anaesthesia service providers, 17% were in training and the remainder had not provided anaesthesia services in the last month. The response represented approximately one quarter of total potential respondents.

	All ANZCA Fellows		**Survey Sample**	
	Male	Female	Male	Female
Average Age	51.6	46.6	51.4	48.8

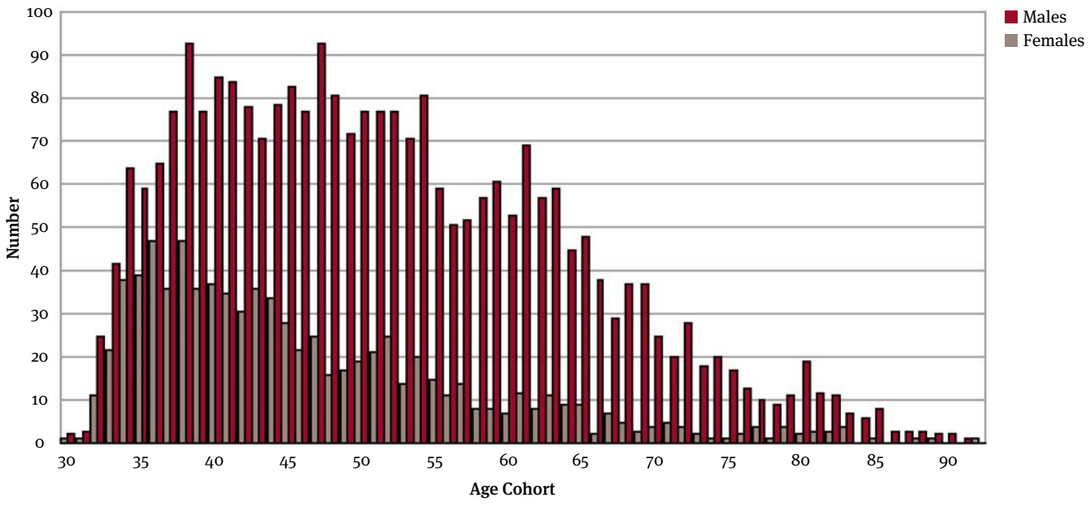
Age and Gender

The average age of respondents to the survey was 51.4 years for men and 48.8 years for women. This was not too different from the current age distribution of Australian-based Fellows which is 51.6 for men and 46.6 for women.

Survey results

Continued

Distribution of Australian FANZCA by age and gender



A chart of the distribution of current Fellows (including those who have retired) by Age and Gender, shows the population to be a relatively young one with the majority of Fellows lying between the ages of 38 and 54.

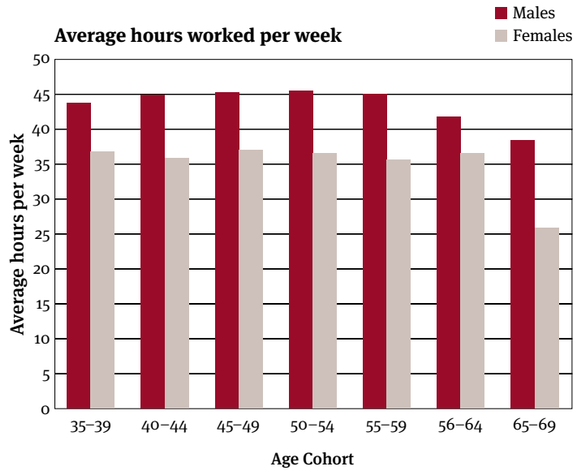
While women make up 28% of the total current workforce, the average percentage of women Fellows in the last five years has been approximately 33% of total new Fellows. The Workforce Model assumes this percentage of women will enter the profession in future years, and explores the scenario where this percentage increases to 40% in the next 20 years.

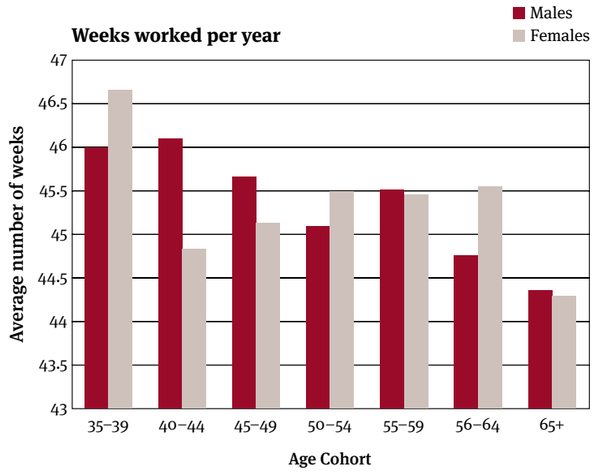
Years as a Fellow

The table to the right shows the distribution of FANZCA by Gender and Years since qualifying as a Fellow of the College. While the proportion of women entering the profession fluctuates each year, over the past five years, 33% of all Fellows have been women (288 of 880 new Fellows).

This 'feminisation' of the anaesthesia workforce has small but important implications for the future supply of services.

Years	Female	Male	Total	Percent
Founding Members	**142**	**710**	**852**	17%
Less than 17 years	104	555	659	16%
16	15	63	78	19%
15	20	54	74	27%
14	24	67	91	26%
13	14	62	76	18%
12	15	68	83	18%
11	28	80	108	26%
10	32	87	119	27%
9	31	89	120	26%
8	45	83	128	35%
7	28	73	101	28%
6	46	115	161	29%
5	54	115	169	32%
4	63	111	174	36%
3	63	101	164	38%
2	55	123	178	31%
1	53	142	195	27%
Sub-totals	832	2698	3530	24%





Duration of Work

Survey respondents worked an average of 41.7 hours a week, 38.2 hours of which were spent in direct contact with patients. Of this, an average of 12.1 hours per week was spent on call, but not providing services.

In general, women worked fewer hours then men (36.0 hours per week compared to 43.8 hours). Both sexes worked a little over 45 weeks per year.

Hours worked per week were relatively constant over age groups, but began to fall at aged 60 and over as anaesthetists approached retirement.

Time Spent in Private and Public Hospitals

Survey respondents who were Fellows of the College spent approximately 45% of time in Public Hospitals caring for 'public' patients, and a further 5% caring for 'private' patients. The remaining 50% of the time was spent in private practice.

The four main reasons listed by anaesthetists for preferring the private system were (in decreasing order of importance):

- Remuneration
- Greater control over time
- Surgeon/anaesthetist relationship
- Ability of institution to provide a pleasant working environment

Specialisation and Country of Training

Over 85% of survey respondents had completed their anaesthesia training in Australia. Of the remaining 15% of respondents trained overseas, most came from the United Kingdom, followed by New Zealand and Europe. A higher-than-average proportion of anaesthetists who trained in the UK, Europe, South Africa and Ireland and India worked in regional and rural areas.

Determining Factors in Practice Location

Respondents were asked to weight the top three factors they would take into account when deciding to move from their current practice location to a rural location. The six leading factors in descending order of importance were:

1. Locality/lifestyle preferences
2. Family Issues – Children
3. Family Issues – Partner
4. Remuneration
5. Professional development/educational opportunities
6. Access to high-quality hospitals/prestige of appointment

The top three factors were nominated by far greater numbers than the final three factors in the above list. Significantly, all three reasons for choice of practice location are factors that cannot be altered by policy incentives. The fourth and fifth reasons, while appealing to a significantly smaller number, provide possible incentives to encourage a subset of anaesthetists to practice in rural locations.

Levels of Adequacy of Service Provision

Survey respondents were asked to describe the general level of adequacy of the anaesthesia workforce in meeting current demand for anaesthesia services. Only 7% of respondents thought that supply was more than adequate, with a large portion of these responses from anaesthetists in private medical facilities. About half of respondents (55%) thought the number of anaesthetists adequate, and the remainder, just over a third (38%) thought there was a shortage.

The top recurring areas in which gaps were thought to exist were:

- Country or rural regions (18.1%)
- Emergency and ICU (6.8%), and
- Obstetrics (4.9%).

Summary

While the survey results in themselves are of interest, their main value from a strategic perspective lies in the qualitative and quantitative insights they provide to the Workforce Model. Survey input provides critical demographic data that facilitates cross-tabulation analysis and provides estimates of parameters for use in the Workforce Model, e.g. working hours, elasticity of workforce supply.

The experience gained in the process, and the careful scrutiny and analysis of data, will allow the College to further refine the model in future years, and provide valuable input into developing strategies that can be used by the College to address future needs of the profession.

Ian D Collens
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ANZCA

Access Economics study
The Access Economics' workforce study monograph "Supply and Demand for Anaesthesia Services" is available on ANZCA's website *www.anzca.edu.au*

Australia's worst bushfire disaster: the medical response on Victoria's Black Saturday

The worst bushfires in Australia's history occurred on Saturday, February 7, 2009 in Victoria. More than 210 people were killed, 30 people are still missing, hundreds were injured and whole communities were destroyed. We spoke with Dr John Moloney, Head of Trauma Anaesthesia, at The Alfred Hospital and some of his colleagues in Melbourne where all the major adult burns victims received their definitive care following Black Saturday.

South-eastern Australia is one of the most bushfire prone areas in the world. Wet winters, long dry summers and eucalyptus-based bush make fire a part of the natural landscape. Previous disastrous fires occurred in 1939 (Black Friday, with 71 deaths) and 1983 (Ash Wednesday, 75 deaths).

The summer of 2008-9 was particularly hot. In the last week of January, land surface temperatures in Victoria and South Australia were well above recent summer averages. Melbourne had three consecutive days with temperatures above 43 degrees, South Australia had four. Tasmania broke temperature records on two consecutive days.

In the days leading up to what has become known as Black Saturday (February 7, 2009), meteorologists and politicians were warning of major bushfire threats. The Premier, John Brumby, said: "The conditions look set to be the worst in Victoria's history". The following day, the Premier added: "It's just going to be probably by a long way the worst day ever in the history of the state in terms of temperature and winds."

On Saturday morning, 107 fires were still burning across the state. Record temperatures, up to 49 C, extremely low humidity and hot gale force northerly winds set the stage for what was to follow.

Townships were razed and many lives were lost when bushfires on a scale never before seen tore through many areas of Victoria. Townships like Marysville, Kinglake and Flowerdale almost ceased to exist. The current death toll is 210, with 30 people still missing. Forensic teams are still searching for human remains in some townships a month later, such was the extent of the destruction.

The Alfred Hospital in Melbourne is home to the State's adult burns centre. Together with the Royal Children's Hospital they took 24 patients, including the most severely burnt victims.

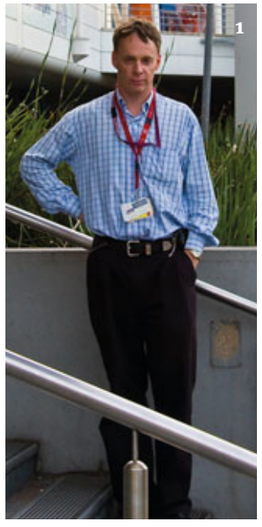
Over the ensuing hours, days and weeks, Fellows and trainees of the College have been involved in their care. Initially this included pre-hospital triage and emergency department airway management and resuscitation. Operative management and intensive care are obvious sequelae. Less obvious was the ongoing need for anaesthesia for burns dressings and the significant pain management issues, made more difficult by complex psychosocial issues.

With the Alfred on ambulance bypass for everything except burns, other hospitals in Melbourne took on additional patient loads.

Dr Moloney first heard about the fires mid-afternoon on Saturday when he was coordinating for Adult Retrieval Victoria (ARV). He was asked by Hamilton Hospital in western Victoria to move a patient who suffered 50 per cent burns, having been caught in a fire in his shorts and t-shirt. ARV was involved in another incident around 7pm. Dr Moloney was on the phone to Bendigo Hospital and heard the bushfires were two kilometers away from the hospital.

Soon after, he received a text message asking him to contact the Field Emergency Medical Coordinator from the Field Emergency Medical Officer (FEMO) Program, a component of the State Health Emergency Response Plan.

'I was requested to proceed to Diamond Creek where they were setting up a Casualty Collecting Post at the combined Country Fire Authority/ Ambulance headquarters. People were being brought down from the hills by police, ambulance or private vehicles, being assessed, treated as needed and then transferred to appropriate hospitals,' Dr Moloney said.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1. Dr John Moloney, Head of Trauma Anaesthesia at the Alfred Hospital.
2. A slide from Dr John Moloney's presentation to colleagues at the Alfred Hospital on the bushfires.
3. Doctors from the Alfred Hospital who worked over the weekend of Black Saturday: Back row – Dr John Moloney, Dr Alex Konstantatos, Dr Sarah McLeod, Dr Carolyn Arnold, Dr Joel Symons, Dr Hugh Anderson. Front row – Dr Wai Tam and Dr Cong Choong Tang.

'The sheer volume of patients was overwhelming and we were stretched to our limits but what came through was extraordinary teamwork between anaesthetists, intensivists, pain specialists and the burns department.'

Dr Kerry Thompson, Pain Medicine registrar, The Alfred Hospital.

"As I was driving up to Diamond Creek, I rang the anaesthetic consultant on duty at The Alfred and said 'this is going to be bad, you'd best find out who's around town'."

The FEMO Program mobilised six specialists with experience in emergency and disaster medicine. Dr Moloney and the team at the Casualty Collecting Post saw about a dozen patients. One was dead on arrival. There were also numerous patients with minor injuries such as smoke inhalation and minor burns who were sent to Box Hill Hospital, in order to take the pressure off the hospitals closest to the fires.

'It later became obvious that where we were stationed wasn't where the majority of patients were coming to, so our convoy of more than seven vehicles moved up to Whittlesea. We arrived there at around 1:40am.'

The Alfred didn't have any information on how many burns patients would be transported to them, so the plan was to accept all patients with more than 30 percent burns and other patients with less severe burns were to be sent to one of the other major hospitals in Melbourne. The potential Victorian burns capacity was also expanded by arranging for the intensive care unit at the Royal Melbourne Hospital to be able to accommodate up to four major burns patients.

Dr Moloney believes The Alfred Hospital staff coped well with the burns patient load.

'Additional anaesthetic staff were called in during the early hours of Sunday morning so that instead of having only one consultant in the hospital we had four. We ran two burns theatres all day on the following Sunday, Monday and Tuesday and then ran one burns theatre for the rest of the week. Normally we would have one burns theatre running for less than three half days a week,' he said.

'We put 10 burns patients through the ICU and another 10 into the burns ward. By Monday morning we were able to accept other patients into ICU. Within 36 hours, despite the influx of major burns patients, we were able to take 'normal' ICU patients, which astounded me.

'The Burns Unit managed its staff better than we did after the Bali bombings. We paced ourselves a bit more so we didn't run ourselves into the ground. Everyone was willing to help. Every department went out of its way to work well together and show good will.'

On Monday, February 9, Dr Moloney was the anaesthetist for a burns list at The Alfred and anaesthetised two of the severely burnt ICU patients.

FEATURE

Australia's worst bushfire disaster: the medical response on Victoria's Black Saturday

Continued

The toll:
210 lives lost
2,029 properties destroyed
78 townships affected
400,000+ hectares burnt
500+ incidents responded to

1. **Dr Joel Symons, an anaesthetist, at work at the Alfred Hospital.**
2. **A slide from Dr John Moloney's presentation to colleagues at the Alfred Hospital on the bushfires.**

'The cooperation was exceptional on Saturday night and Sunday. Administration asked what we needed and did as we asked; this meant no bed block so that there was smooth transition between resuscitation of patients in the emergency department and admission to ICU or operating theatre and then again back to ICU. Surgeons operated in emergency department, ICU and OR. Anesthetists and intensivists did what was required for optimal patient care. Theatre sterilized ICU bronchoscopes, without delay.'

Associate Professor Warwick Butt, intensivist, The Alfred Hospital

'The bushfire patients were badly burnt, but their burns were comparable to a house fire, a motor vehicle or industrial burns. Their burns and injuries were less severe than the survivors of the Bali bombings. Some of the bushfire burns patients suffered from being stuck in dams (severe infection) and experienced delayed fluid resuscitation,' he said.

Dr Moloney says it's the psychological component that makes this burns crisis different from others he's seen during his career.

'If someone's in a car crash and gets burnt (or even some of their family members have been killed or hurt as well), they still have a house and family to come home to, friends and next-door neighbours. The bushfire patients may have lost everything,' he said.

There are approximately 15 burns patients still being treated at The Alfred and the severe ones in intensive care will need further surgery over the coming weeks, months and, potentially, years.

'Two or three years ago I re-anaesthetised one of the Bali bombing patients and that tragedy was six and a half years ago,' Dr Moloney said.

On the Monday following the fires, Dr Moloney also visited Kinglake as a FEMO to assist relief and recovery. A week later, he was asked to undertake a tour of the bushfire sites to assess further health needs. Doctors and nurses had been organised to support many communities including Kinglake, Alexandra, Eildon, Flowerdale, Buxton and Narbethong. The Department of Human Services (DHS) facilitated the placement of GPs utilising the Rural Workforce Agency Victoria, and similarly utilised Royal District Nursing Service to supply nurses.

In addition, medical staff and nurses were drawn from the Royal Melbourne, St. Vincent's, the Austin, the Western, Ballarat, Maroondah and Bendigo Hospitals, forming Victorian Medical Assistance Teams (VMAT).

'I visited Alexandra Hospital and met with the administrator on-call about the medical and nursing support that DHS and the FEMO Program were facilitating, and to establish how best to provide ongoing support. Supporting the business continuity of small GP-dependant hospitals becomes unsustainable in the long-term without separate identifiable funding,' Dr Moloney said.

Overall, Dr Moloney believes the acute health response worked well.

'As is frequently the case in emergency response (disaster medicine) we had to manage initially with limited information, which in this instance was related to the speed of the fires. However, years of planning, training and exercising paid off,' he said.

Dr Moloney says some aspects of the extended response weren't anticipated.

'If there was a need it was met, but some of it wasn't explicitly planned for. There has been discussion in the past about how to support isolated communities but support for maintaining primary care and the business continuity of small hospitals on the periphery of Victoria's urban conurbations had not previously been required,' he said.

'To have so many people affected and the destruction of infrastructure over such a large area was unimaginable. For example, the general practice in Marysville was burnt out and the whole town was inaccessible. The pharmacist in Yea was busy defending his house and in Alexandra, one of the GPs was defending his house while another was missing for a period of time.'

Dr Moloney says the best way of assisting the communities affected by the bushfires is by making a donation through the Red Cross or by supporting the local economies. Once the towns are eventually up and running again, getting tourists in to spend some money will really help the recovery process.

'From a medical point of view, I would suggest having an awareness of disaster medicine and the principles around it would also help because one never knows what's going to happen and where,' he said.

Dr Moloney says Black Saturday wasn't specifically a burns response but a mass casualty incident with multiple victims that needed health and recovery personnel with expertise and experience in dealing with multiple patients. The Alfred and Royal Children's Hospital treated most of the patients with major burns but many other hospitals in Melbourne and the rest of Victoria also treated victims of the bushfires.

Black Saturday was a 'super fire'. The heat energy was unprecedented because of the extremely dry conditions, low humidity, record temperatures and strong winds.

'People were injured from 200 meters away from the flames (compared to normal fires – 50 meters away) and there were embers the size of forearms,' Dr Moloney said.

'Most anaesthetists would be able to deal with one of these burns patients. The question is how you best organise the system to deal with five, 10, 50 or 100. That's the challenge and my area of interest.

'Black Saturday was worse than anyone could imagine.'

'There were many generous offers from other anaesthetists, including VMOs, full-time staff, trainees, and other non-Alfred anaesthetists in Melbourne and interstate, to assist in the management of the burns victims.'

Dr Hugh Anderson, anaesthetist, The Alfred Hospital

Judith Killen: Living and working in rural New South Wales

After a morning working on an eye list (one baby and five patients over 80), then an afternoon of endoscopies, Wagga Wagga anaesthetist Dr Judith Killen is sitting in her garden looking across 100 acres that include a soccer field and a small orchard. This is the lifestyle that Dr Killen wants anaesthetists and trainees to know about: the combination of rewarding and varied work with a great family lifestyle.

Although Dr Killen's training was in Sydney, based at St Vincent's, Darlinghurst, with secondments to St George Hospital, St Margaret's and the Royal Alexandria Hospital for Children, she always wanted to end up in a regional setting. After her training finished in 1986, she moved to Wagga Wagga. "I was born in the Riverina and I always wanted to go into rural practice. When I first started medicine, I assumed that I'd be a general practitioner, but quickly decided that wasn't for me and developed an interest in anaesthesia. I did an anaesthetic term as a resident in Wagga; also an emergency and a surgical term. I really liked the range of work that was available. You don't get stuck in a subspeciality."

"I do a lot of intensive care. While I didn't particularly enjoy intensive care during my training in Sydney, when I came to Wagga the intensive care unit was run by anaesthetists and they asked me to participate in this. My interest gradually increased – I think we had younger patients and I could see their progress over time. I'm now somewhat of a dinosaur, as I'm the only consultant in our unit who does not have a dual fellowship. I'm very conscious of this and always consult a colleague if I have any doubts. I have very supportive colleagues, so this is a very rewarding part of my practice. I do roughly every fourth week in ICU, and all my on-call is for intensive care."

"My regular lists include paediatrics, O&G, urology and colorectal surgery. Wagga is unique in rural areas in having a fully equipped ICU in both the public and private hospitals, so we can feel comfortable anaesthetising the frail and elderly in both locations."

Dr Killen has long been interested in the issue of rural workforce shortages. The increasing problems became very apparent during the 1990s and have been at crisis point this century. There are 14 anaesthetists based in Wagga Wagga, three of whom cover Intensive Care. There is a need for about 20, and the shortfall is made up with locums. Not all anaesthetists are suited to rural locum work. They need to be confident anaesthetising the extremes of age, obstetric patients, trauma, often with unfamiliar equipment and without the luxury of knowing the staff's strengths and weaknesses. "A lot of new Fellows aren't very happy anaesthetising small children, but in a rural area we can't send off every three-year-old with a broken arm," Dr Killen says.

"The College has responded to this situation by increasing trainee numbers and the Federal Government has increased medical student numbers. In the next decade, more anaesthetists will be trained, but they need to realise that much of the available work is in the large regional centres. This is varied and rewarding work.

"Such centres are good places to live. They have vibrant communities with good educational, cultural and sporting facilities. There are rural clinical schools so clinicians can follow up interests in education and research," she says.

Dr Killen says ongoing professional development is essential. "We are big enough to have regular sessions, hopefully on topics identified as of interest to everyone. Recent topics have included Diabetes and Anaesthesia, Anticoagulants and Eye Blocks, Regional Anaesthesia, Anaesthesia for Radical Prostatectomy and the next will be on Major Haemorrhage. We occasionally have visiting speakers – for instance A/Prof David Baines from Westmead Children's came down to speak on Paediatric Adenotonsillectomy and Obstructive sleep apnoea, and Dr Cliff Peady from Canberra on Fascia Iliacus Blocks."

"However, we also have very regular flights to Sydney and Melbourne and are only two-and-a-half hours from Canberra. Thus, weekend meetings are easy to attend.

Having said that, we all enjoyed the video conferences available a few years ago – this gave us access to mid-week city meetings and weekend ones when we had family commitments near home."

"Modern communications have transformed rural practice. There is no need to feel isolated or unable to get support. The hospitals have quick dials to all the major Sydney hospitals. The internet gives us the ability to access information quickly and sites such as CIAP and the College website are great sources. Many senior consultants are happy to be emailed with particular clinical issues – two outstanding examples would be Dr Andrew Ross in Melbourne and Dr Stephen Katz in Sydney, who are unfailingly courteous and helpful with obstetric anaesthetic issues."

"Such professional support is two-way. Once a fortnight, I visit one of the smaller hospitals in the area health service, Tumut. I'm the only specialist anaesthetist going there and can give advice on standards and education. My support there allows them to continue an obstetric service – they have around 150 deliveries there per year, and the alternative is travelling to the overstretched service in Wagga Wagga. It's good for patients and the community," Dr Killen says.

A new direction for Dr Killen is involvement in writing a paper. This is on Type 1 Diabetes and Anaesthesia. Dr Killen's interest in writing on diabetes is personal: her younger son, now 17, developed Type 1 Diabetes when he was three. This has been a huge focus for her family since then – they have an annual fireworks display on the June long weekend which has raised over $100,000 over the years for research into Type 1 Diabetes. Dr Killen has also had her garden on display as part of the Australian Open Garden Scheme, with proceeds going to research into diabetes.

Dr Killen's experience with a child with Type 1 Diabetes has impacted on her clinical life. "During the late 1990s, I realised in-hospital management of diabetes was appalling, particularly in Intensive Care. Very few people understood the duration of action of the various insulin preparations. I did introduce the use of longer acting insulins in our ICU, particularly for patients on total parenteral nutrition, but we were still failing to treat high blood glucose levels effectively."

"Then in 2001, I was at the World Congress of ICU in Sydney. There was a seminal paper on tight glycaemic control in Intensive Care units. It transformed our management practices worldwide virtually overnight. We changed from intermittent injections to insulin infusions, with specific glycaemic targets. This made me think about management of diabetic patients in other wards, and undergoing anaesthesia. We do not measure the blood glucose level often enough in hospitals, including in the theatre setting in most cases. This is particularly troubling in a speciality that bases decisions on frequent measurements of other parameters, such as oxygen levels, heart rate, blood pressure, gas exchange..."

"Management of Type 1 Diabetes has changed enormously in the past decade. When my son was first diagnosed, we tried to minimise the number of needles. This meant guessing what a toddler might eat for the day, and giving this amount of insulin. I remember one weekend in Sydney when he refused to eat until I had to let him have chips and doughnuts. Now the insulin is given as "basal and bolus", with mealtime insulin matched to the food eaten. Insulin may be given by an insulin pump – my son has had a pump for the past 18 months and loves it. There are many new insulins being used. However, there have been very few updates in the anaesthetic literature on managing diabetic patients, and the potential of the emerging technology."

"Within the next decade, there will be continuous glucose monitors, so diabetic patients will have a continual display of their blood sugar, right by the oximetry and end tidal CO_2," Dr Killen says.

'I was born in the Riverina and I always wanted to go into rural practice. When I first started medicine, I assumed that I'd be a general practitioner, but quickly decided that wasn't for me and developed an interest in anaesthesia. I did an anaesthetic term as a resident in Wagga; also an emergency and a surgical term. I really liked the range of work that was available. You don't get stuck in a subspeciality.'

The cool side of medicine


Mawson station

Antarctica is a fascinating place and somewhere that I had always wanted to visit. My opportunity came in 2006 and 2007, when I was employed as the Expedition Medical Officer for Mawson Station, with a contract lasting 18 months.

Both of my brothers had worked "down south" in the 1990s, one as a biologist and the other as the Station Leader, so I thought that I had some idea as to what would be in store. I certainly knew that it was not all a bed of roses. The job consisted of several months of training, a long ship journey through the infamous southern seas, followed by 12 months at the station.

The position of medical officer with the Antarctic Division (AAD) is essentially that of a solo practice general practitioner. Australia has three stations on the Antarctic continent: Davis, Casey and Mawson. All these bases are very isolated: over the summer, it may take weeks to evacuate a patient, whereas over the winter (which lasts from March to November), there is no possibility of external assistance, for the bases are thousands of kilometres away from any cities, and it is far too dangerous and costly to try to reach them at this time of year. Thus, all bases need to be self-sufficient, which also means that all expeditioners must be able to handle their area of expertise, whether it is the doctor treating appendicitis or the diesel mechanic handling a generator malfunction. Luckily for the doctor, major problems rarely occur (whereas the mechanic isn't quite so fortunate!).

Thus, to fulfil the criteria for the position, both my employers and I had to be happy that I could deal with any contingencies. My main concern was surgery, so I used my contacts among obliging surgeons at my hospital base to do some surgical assisting. It was fun to be on the other side of the "blood-brain" barrier, and my surgical colleagues were extremely helpful and encouraging. Another requirement for the wintering doctor is that they must have had an appendicectomy before going down, so I dutifully had this performed. The theory behind this is that appendicitis is still the most common surgical emergency, and it would be rather difficult for the doctor to do an appendicectomy on themselves. Mind you – it has been done, unsurprisingly by a Russian doctor, using local anaesthetic, mirrors and vodka.

There are a variety of doctors that are employed by the AAD. Classically, it was the rural GP, who could turn their hand to anything. This individual is becoming harder to find, so the doctors now have a diverse background, with emergency physicians, surgeons and anaesthetists now also often being employed. I think that anaesthetists have a valuable role to play. They are used to dealing with emergencies, plus have a good grounding in medicine and surgery.

Other training required was provided by the AAD, based in Hobart, and it was great fun. "How to do dentistry" took eight days at the Dental Hospital in Melbourne, and was incredibly useful as that is one of the major workloads. Other parts of the training included "do-it-yourself" haematology, biochemistry, radiology, microbiology, sterilisation and others. Although this sounds daunting, they were just guidelines. When we needed to do things at the bases, there were plenty of guides that could be followed or advice obtained over the phone or the internet. Also, the equipment provided was generally excellent, with a fully functional theatre including anaesthetic machine and ventilator, diathermy, and a dedicated scrubbing area. There was also Antarctic training – including navigation, survival in the cold and basic rock-climbing to name a few. Part of my training including gaining a forklift licence, although I am not sure that my skills were quite up to scratch! Fire training was essential for the whole community, as fire remains one of the real problems in Antarctic – though cold, it is a very dry place, and fires are not uncommon.

The main activity of the station is over the summer, which lasts from late November until late February, and the numbers at the stations during this period are at their largest – anywhere from 30 to 70 people. When they leave, there remains a core group which are mostly involved with maintenance of the stations, and the numbers drop dramatically. At Mawson in my year, there were only 14 winterers, most of whom are tradesmen.

Like all things, working in Antarctica had its highs and lows. Everyone has different experiences, but for me the good certainly outweighed the bad. Medically, fortunately it was pretty mundane, with minor musculoskeletal complaints being the main problems, though the odd dental issue also raised its ugly head. I really enjoyed doing some minor dentistry. The isolation can be very hard, and that tends to cause the most troublesome medical issues, with somatisation of stress being a common problem, and very hard to treat. This tends to become more of a problem in the winter, as it becomes colder and, of course, darker so there is less inclination to spend time outside.

The equipment at the base was really good, and generally we had everything that we could possibly need in case of emergencies, from obstetric forceps and neonatal incubator (luckily they have never been needed), to craniotomy or rigid bronchoscopy instruments. There have been some major incidents, though only rarely. The commonest major injury is broken limbs – there were a couple of fractures the year I was down there – one broken ankle and a fractured humerus. Both were treated conservatively, as we had no other treatment available. About every 10 years someone has an appendicectomy – my predecessor performed this surgery on the ship on the way down to the surgery. Luckily, on the ship there are usually a lot of useful people around – other doctors, vets, nurses, so there is help. His patient did so well that she recovered quickly and went back to work within days. There have been some major traumas – the last was about 10 years ago, when an expeditioner was crushed by her quad bike as it fell through a crevasse. She sustained abdominal trauma, requiring several returns to theatre both in Antarctica and also once we returned to Australia. Let me stress, however, these incidents are rare, and most doctors have nothing more exciting happen than losing a filling. And as it is such an isolated environment, over the winter, expeditioners do not even get the common cold, as there is no exposure to any new viruses. However, that soon changes once the summer arrives and the viruses are brought in with the next crew!

As all expeditioners should be fit and healthy, there is often not a lot for the doctor to do. We do have other responsibilities, such as maintaining all our equipment (each base effectively has a mini hospital!), stocktaking all items and reordering for the following year plus also checking the quality of the drinking water every month. As it is such a small community, there are numerous other jobs that need to be performed – my main job was looking after hydroponics, which was situated in its own building, and a wonderful source of vegetables and herbs and warmth and light. It provided a nice change from the inevitable frozen or dried produce.

There were so many incredible experiences. The highlights for me were the wildlife – Emperor penguins, Adelie penguins, seals and sea birds. All of the Australian bases are close to Adelie penguin rookeries, but Mawson is the only one that is close to an Emperor penguin rookery.

The rookeries are usually on sea-ice, in areas that are protected by ice-bergs, so both the scenery and the colonies are spectacular. Since the birds start their nesting in winter when the sea-ice is firm, there were many trips over the dark months to visit these superb creatures. To my surprise, I really enjoyed the winter, not only because we could visit the penguin colonies, but also seeing the incredible colours of the twilight, with regular viewings of the extraordinary aurora australis.

A year such is this is not one that is easily forgotten. Each base has its own magic, every year its own experiences. I think these challenges need to be taken up occasionally, as they are rarely regretted. Will I go down again? Not this year, but who knows what the future will bring?


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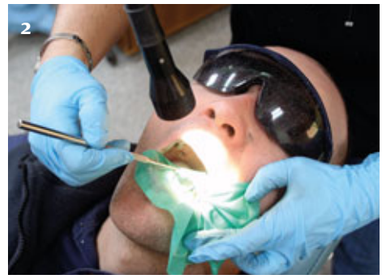
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1. Adelie Penguins.
2. Dr Jo Melick doing some minor dentistry work in Antarctica.
3. Dr Jo Melick.
4. Emperor Penguin rookery.

Dr Jo Melick

Dr Jo Melick is originally from Melbourne, starting her anaesthetics training in North Wales but finished it based at The Alfred in Melbourne, gaining her FANZCA in 1998. Originally she worked at Dandenong, but moved to Adelaide in 2004, where she remains – working at the Repatriation General Hospital. Since she has been a consultant, she has spent two weeks most years in Vanuatu, with the Pacific Island Project, with an orthopaedic team.

Doctors for the Environment Australia


Forbes McGain and Eugenie Kayak

Doctors for the Environment Australia (DEA) is a voluntary organisation of medical doctors and students. It was formed in 2001 as a branch of the Swiss-based International Society of Doctors for the Environment (ISDE), a group that has had significant achievements in Europe. Climate change is a priority for DEA because we recognise its major health impacts and its overwhelming threat to humanity.[1]

DEA aims to educate and inform policy makers, industry, colleagues and the public about the health and humanity implications resulting from green house gas emissions and environmental degradation. Members are supported by a scientific committee comprised of renowned international leaders and pioneers in research and medicine, including Sir Gustav Nossal, Professor Peter Doherty, Professor Fiona Stanley and Professor Tony McMichael. The present Chair of DEA is Professor Michael Kidd, past President of the RACGP.

DEA has developed policies, comprehensive reports and supported recent initiatives such as Green Clinic[2], Bike Doctor[3] and a Green Hospitals group. Policy documents include the topics of climate change, energy production, public transport and forests (*www.dea.org.au*). "Climate Change Health Check 2020" is a report prepared by members for the Climate Institute of Australia in relation to World Health Day 2008 for which the WHO's theme was 'Protecting Health from Climate Change'[1]. The report outlines and quantifies the direct effects of climate change on health, including heat stress and related deaths, trauma from extreme weather events, increases in allergic symptoms, respiratory problems, mental illness, post-traumatic stress disorders, infectious diseases and changes to the distribution of mosquito-transmitted diseases. DEA has also developed a range of educational material including pamphlets and posters.

Medical doctors are in a unique position to promote the need for action concerning our environment. We are well positioned professionally and in society to be heard and help influence others. Politicians have shown a willingness to listen to DEA members. The organisation actively engages politicians on both sides of politics, recently writing to all federal members and senators on the issues of renewable energy and the Carbon Pollution Reduction Scheme.

Health professionals have a proud history of service to the community and have been instrumental in encouraging policy development to improve the health of present and future generations. This is evident with tobacco legislation and various road trauma initiatives (seat belts, blood alcohol levels, speed limits). DEA now builds on this foundation of service by addressing the global health implications of our lifestyle.

Fellows of our College are ideally placed to alter the environmental impact of our operating theatres and intensive care units – some of the highest energy-consuming waste-producing areas in hospitals. We are also well placed, as a core group of senior clinicians, to encourage sustainable practices throughout our hospitals.

The Australian Medical Association has recently updated their position statement on climate change and DEA encourages and supports all Colleges to do the same.[4] Our College has taken the initiative and formed the ANZCA "Green Committee" to encourage and promote sustainable practices within ANZCA House. The committee has been running for more than a year and have been active in promoting increased awareness of sustainable practices among College staff. Some of the initiatives undertaken by ANZCA include the installation of water tanks, drip fed irrigation, recycling and energy conservation practices. Energy conservation measures have led to decreases of up to 10% in electricity usage by the College.

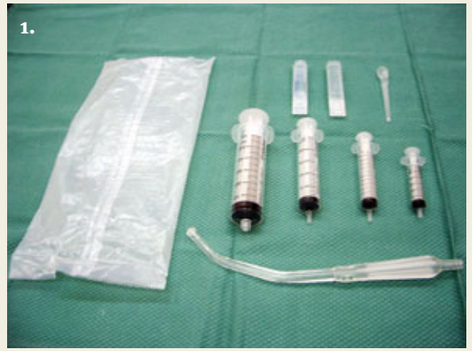
Australia is an affluent, secure country that should be showing leadership in abating greenhouse gas emissions, rather than waiting for countries with millions of people living below the poverty line to act first. Per capita we are the highest greenhouse gas emitters in the world. The Australian government recently acknowledged the adverse health consequences of climate change with their allocation of $10 million into researching the health implications of climate change.[5]

The United Nations Secretary-General Ban Ki-moon has recently stated that climate change is the "one true existential threat to the planet" even in today's current of multiple crises. He has called for a positive outcome in the Copenhagen Climate Conference and emphasised that "climate change threatens all our goals for development and social progress".[6]

Continued on page 30

Personal experience: Initiating operating theatre plastic recycling programs

By Forbes McGain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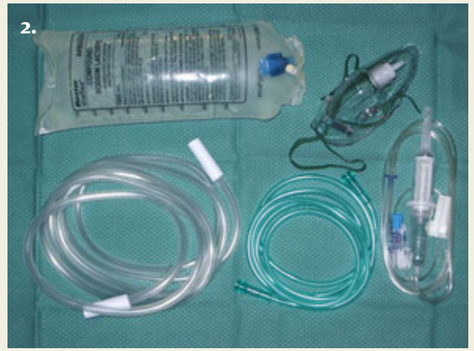
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1. **Proportion of products recycled in Case 1.**
2. **PVC products being recycled in Case 2.**

After reading Dr Rod Westhorpe's "Letter from the editor: Agents of change", ANZCA Bulletin, March 2007, I was motivated to investigate and quantify what our individual effect of using N_2O on greenhouse gas emissions is. As Dr Westhorpe states in his article N_2O contributes about 5% to the total greenhouse gas effect. Although medical use is a minimal producer of greenhouse gases, relative to release from fossil fuel burning and farming, Dr Westhorpe questions whether using low-flow closed-circuit anaesthetic delivery systems is adequate or whether Fellows of ANZCA should consider phasing out N_2O (and volatile anaesthetic agents)? My research astounded me: **you are likely to be emitting far more greenhouse gas administering a 30-minute 1 l/min N_2O anaesthetic than driving to and from work** (1 min of 0.5 l/min N_2O is equivalent to driving an average car 1 km)[1].

This initial research lead me to consider other questions concerning the sustainability of our practice e.g. total carbon footprint of disposable vs. reusable trays. It also gave me added motivation to initiate what changes I could within my current work places to improve their carbon footprints.

We formed a hospital environmental committee at Western Health with a strong theatre presence, inviting members of the environmental services, engineering, infection control and clinical staff to become involved. The committee decided to focus on waste management initially because energy and water issues, while integral, would involve an initial outlay of finances.

Case 1

The Williamstown Hospital operating suite already had successful recycling of cardboard, paper and most plastic bottles, however the theatre staff were keen to do more. It was readily apparent that the major recyclable material heading into the waste bin was plastic.

Firstly, we needed to determine the types of plastics in our operating theatre rubbish. These plastics are often not labeled, unlike the plastics that we use at home. A laborious process, which involved contacting all the manufacturers of the medical plastic products, was undertaken.[4]

Secondly, an appropriate recycler needed to be found. Limitations were soon discovered upon contacting possible recyclers i.e. volume was not considered to be large enough for the big recyclers, several recyclers would only take compacted material (smaller hospitals tend not to have compacters), other recyclers would only accept certain types of plastics (made by companies with whom they had contractual arrangements). Fortunately, *Thermoplastics Recyclers,* a local Melbourne company was happy to take as much plastic as possible from the operating suite. Products recycled by this company into plastic wrap for flooring include: saline and water ampoules, intravenous fluid bag wraps, disposable warming blankets and wraps, syringes, intravenous cannula covers, suckers and surgical wraps (polypropylene and polyethylene types).

We are now recycling about 200kg per week of plastic products in a cost-negative exercise from the operating theatres at Williamstown Hospital.

Case 2

At the Western Hospital, we have embarked on a pilot project to recycle polyvinylchloride (PVC) plastic only. PVC forms about 25% of all operating suite and intensive care plastic. This recycling project is converting oxygen masks, oxygen tubing, intravenous fluid bags and giving sets and suction tubing into PVC pipes. Thus far, the trial is performing well and we are in communication with various medical PVC recyclers to expand the program beyond the pilot stage.

Change is required and we as doctors should be leaders in advocating for sustainable practices within our hospitals. Anaesthetists are ideally placed to make changes, particularly within our theatres. Some practical measure are detailed in Table 1. Researching the sustainability of our practice is no less important than other areas of medical research, indeed one could argue that it is of utmost importance.

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FEATURE

Doctors for the Environment Australia

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As medical professionals we understand that "prevention is better than cure", as anaesthetists and intensivists we are trained to pre-empt and avert potential disasters in our daily practices. Now is the time to advocate for the mitigation of green house gas emissions and environmental degradation, pre-empting and averting a truly global disaster that will affect us and future generations. Now is the time to reflect on how we can alter our personal and work practices for a lower carbon footprint. Now is the time to join an organization, such as DEA, empowering them with numbers and contributing as much or as little as you wish. If nothing else, now is the time to seek us out at the next Annual Scientific Meeting in Cairns. DEA will have a display area and welcomes delegates to come and discuss environmental issues globally, in our hospitals and within anaesthetics.

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Dr Forbes McGain
Staff Anaesthetist and Intensivist
Western Health, Melbourne

To join Doctors for the Environment Australia
Visit ***www.dea.org.au*** and follow the links. Or contact David Sherman, Honourary Secretary for Doctors for the Environment Australia, via email: mountlofty@ozemail.com.au

Personal experience: Initiating operating theatre plastic recycling programs

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Table 1. Practical steps towards sustainability for the anaesthetist

- *Alter your gases!* Stop using Nitrous Oxide. For every minute of 0.5L/min. N_2O you've driven the equivalent of 1km in an average car.[1]
- *Conserve your gases!* Use low flow anaesthesia (sevoflurane nephrotoxicity in humans has been shown not to occur at low flows).[2,3]
- *Reduce.* Are two disposable anaesthetic trays per patient necessary?
- *Re-use.* Disposables routinely use more energy and water to produce than re-usables. Re-usable plastic drug trays require around 1/3 the energy and 1/10 the water to reprocess compared with similar disposable plastic trays (unpublished research by author).
- *Recycle.* Twenty five per cent of theatre waste is of anaesthetic origin (paper submitted for publication). More than 40% of all anaesthetic waste is recyclable, mostly plastic. Recyclable medical plastics are referenced.[4]
- *Procure more sustainable products.* Fifty per cent recycled paper is a start.
- *Form / join a Theatre/Hospital Environment Committee.* Theatre produces anywhere between 5–20% of all hospital waste.
- *Minimise lighting costs* with timers and energy efficient fluorescent lamps.
- *Turn off* the theatre ventilation and air conditioning when not in use, with hospital engineering invovement.[5]
- *On your bike!* If ever there was a medical profession that was sartorially suited to lycra and blues it's anaesthesia! Facilitate bike use by advocating for bike parking and form a BUG (bicycle users' group).
- *Advocate for the environment.* Join DEA (Doctors for the Environment Australia).

Useful links:

www.dea.org.au
(Doctors for the Environment),

www.ihea.org.au
(Institute of Hospital Engineers of Australia),

www.ecobuy.org.au
(for more sustainable procurement),

www.corporatecitizen.nhs.uk/index.html
(NHS sustainable website),

www.gghc.org
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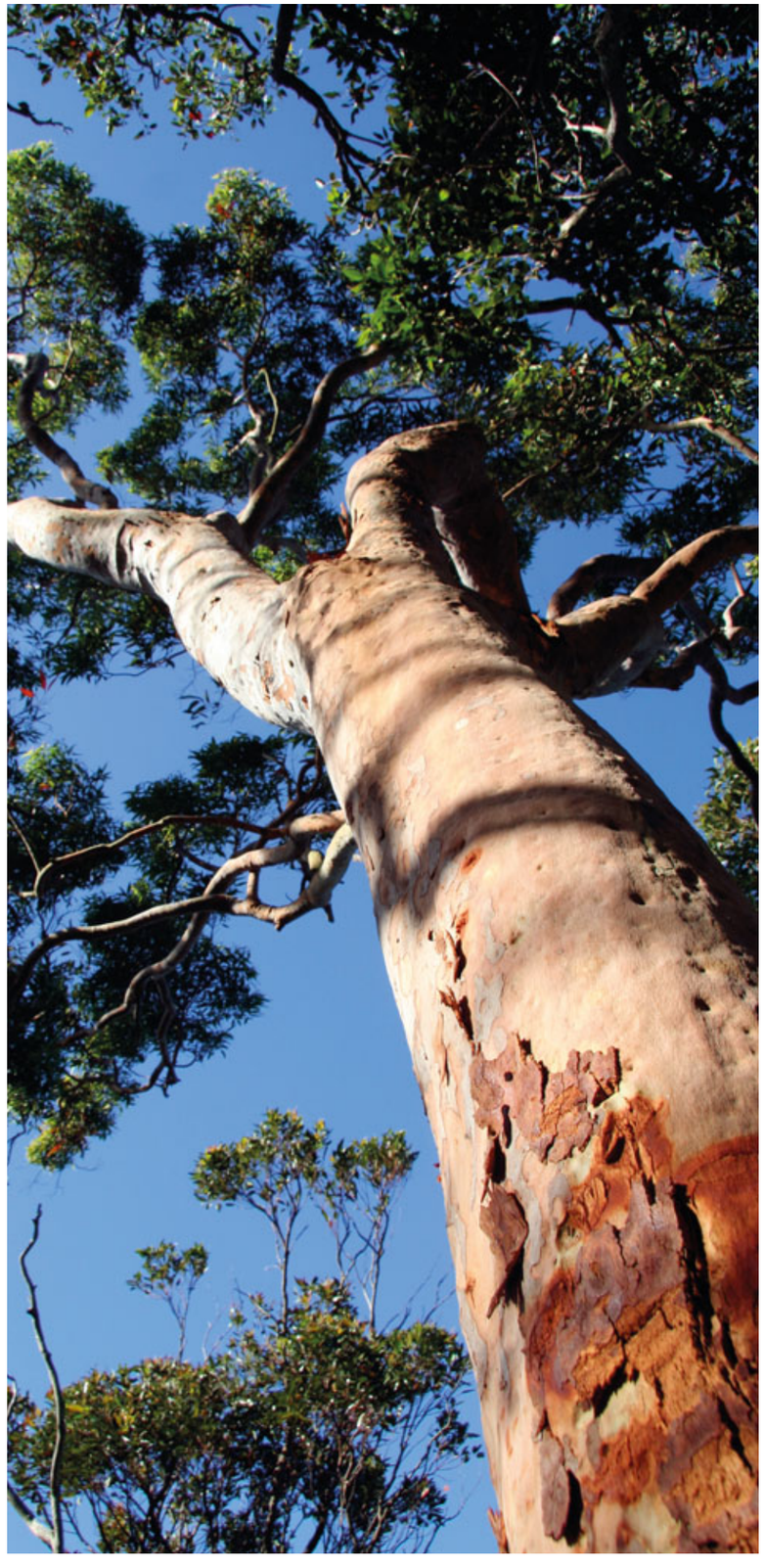

ANZCA Green Committee

A Green Committee was established at ANZCA House in November 2007 to promote and support the development of a range of initiatives that encourage environmentally sustainable practices across the national and regional offices of the College.

The principles of the committee are:

- To take greater care of our environment for current and future generations by reducing the College's consumption of energy and other consumables.
- To ensure all staff (including regions) are involved and committed by promoting enthusiasm and education.
- Promote sustainable cultural change via management and from the ground up.
- Be seen as a leader in environmental sustainable practices.
- Ensure short-term and longer-term actions are implemented with clear deliverables.

The committee meets monthly and comprises members from ANZCA management, administration, and Council, including A/Prof Kate Leslie.

So far the Green Committee has:

- Reduced electricity usage by 10% (via the "switch off lights" campaign).
- Installed water tanks and drip feed irrigation.
- Improved recycling of glass, plastics, and other recyclables.
- Begun composting food materials.
- Reduced paper usage by Council and increased the use of electronic means to access documents.
- Reduced paper usage by ANZCA staff and priority given to double-sided copies.
- Explored the use of solar power installation and the option of switching to renewable energy.
- Increased awareness by staff of environmentally sustainable practices.

Anaesthesia and the environment: How big is our footprint?


Dr Stephen Lightfoot

SINCE SEPTEMBER LAST YEAR, the media, politicians and the public have been obsessed with the global financial crisis (GFC). Unfortunately this has diverted their collective attentions from a crisis of equal, and I would argue greater, long-term gravity that has been brewing since the industrial revolution. This is what I call the global environmental crisis (GEC) and just because it is no longer centre stage doesn't mean the crisis is over.

Sustainability

The GEC is a crisis of sustainability. Sustainability refers to an economic and social way of life that can be continued ad infinitum without degrading ecological systems and thereby compromising the ability of future generations to meet their needs.

In short, it is about the Earth's capacity to cope with our way of life and it is becoming increasingly clear that the human race is living beyond the Earth's means. The evidence is undeniable. Issues such as peak oil, climate change, rising food prices, and the collapse of entire ecosystems such as the Murray-Darling basin are just a few of the obvious symptoms of the GEC. The continuing rapid growth of the world's population, combined with the industrialisation of the world's most populous nations, means that the GEC is only going to get worse.

Climate change is, in essence, a sustainability problem. It is caused by the unsustainable use of fossil fuels and unsustainable land use practices. It is a problem that requires urgent attention.

So who cares about healthy functioning ecosystems anyway? We all should. We need a healthy environment to sustain our way of life. We need the fresh water, the fresh clean air and the productive soils a healthy environment supplies. We need the wood that grows in healthy forests and the food that the ocean provides year after year. Life as we know it depends on these ecosystems.

Anaesthesia and the environment

How are we, in our professional lives as anaesthetists, contributing to this GEC?

It is apparent that we do have an impact because the practice of anaesthesia is by necessity an activity that consumes large amounts of resources and produces considerable quantities of waste. The operating theatre setting multiplies these impacts. The need for sterility, safety and infection control has seen the development of copious amounts of packaging and a myriad of single-use items that are made from both plastics and metal. The cleaning of equipment and linen requires electricity, water and sometimes toxic chemicals. Biological and chemical waste must be disposed of in ways that do not endanger current or future generations. Theatre air-conditioning and ventilation consume massive amounts of energy. Further, a hospital itself is like any other business. Its commercial activities consume resources and create greenhouse gases.

Quantifiable impacts

For the specific practice of anaesthesia there is currently not enough published data available to make a meaningful estimate of our impact on the environment. The overall impact of the health care sector is similarly difficult to estimate accurately.

Most of the information about the health care sector's impact is not peer reviewed or referenced. Some comes from companies complete with commercial bias, the units used vary between metric and imperial, and the units themselves vary between volumes and weights, the way of determining "per patient" figures varies and the case load of individual hospitals is rarely discussed. Further, the data is often based on information from the last century that, given the rapid changes in health care delivery systems in the last 10 to 20 years, is unlikely to be accurate today.

The best current estimate of the overall impact the health care sector has on the environment comes from the *2004 Material Health* report[1]. It examined in depth the ecological footprint of the National Health Service (NHS) in England and Wales.

Ecological Footprint

To determine exactly what impacts humans are imposing on the environment, the concept of the ecological footprint has been developed. It measures the area of biologically productive land and sea required to provide the resources we use and to absorb the waste we create. Using this concept, the World Wide Fund for Nature (WWF) *Living Planet Report 2008* shows that we are currently turning resources into waste faster than nature can turn the waste back into resources[2]. Using a financial analogy, rather than living off the interest from our bank account with nature, we are making withdrawals that are eating into our financial capital. Our account balance at the "Ecobank" is going backwards.

The WWF estimates that we currently need about 1.3 earths to supply the resources for our current lifestyles and at the existing rate of consumption we will need two earths to sustain us by about 2030[3]. In other words we will soon be looking for another planet to provide the resources we require.

So how does the provision of health care fit into this picture? *The Material Health Report* found that the NHS in England and Wales has a footprint of 4.9 million global hectares (gha) where one global hectare is one hectare of biologically productive space on earth. To put this into perspective, the UK has a total footprint of 317 million gha, Australia 157 million gha and the US 2,803 million gha[2].

If you divide the total biologically productive area of the earth by the world population you get 2.1 gha available for each person alive in 20054. In comparison, the NHS uses 0.09 gha per-capita, England and Wales 5.39 gha, Australia 7.8 gha and the US 9.4 gha. For a stark contrast, China only uses 2.1 gha per-capita[4].

Thus, the NHS per-capita footprint uses 4.3% of the global available footprint per person and its total impact contributes 1.7% to the UK's global footprint. Given that the proportion of GDP spent on health care in Australia is similar to the UK (just under 10%) and that our standard of patient care is also similar, it is likely that our health care system makes a similar contribution of around 2% to Australia's global footprint.

Our footprint and the future

The Earth is beginning to struggle under the weight of the impacts of our current way of life. The human ecological footprint has already exceeded what is available on our planet and unless either our lifestyles change or population growth ceases the Earth's prognosis looks grim.

The health care sector makes a small but significant contribution to the GEC. Obviously we as anaesthetists make an even smaller impact and if we act alone we will be unable to save the planet.

However, there are many reasons we should act to reduce our footprint. First, we have to start somewhere. If all industries and individuals took the attitude that they couldn't make a difference then nothing would ever change. Second, as Paul Kelly has famously sung "from little things, big things grow"[5]. If anaesthetists can reduce their ecological footprint, other groups may take note and either be shamed or challenged into action. Much like a single bacteria ballooning into a large colony on a plate of agar, action by anaesthetists has the potential to rapidly spread throughout the health care sector.

I am advocating that instead of despairing and continuing with the status quo, we should act now and begin to reduce the boot size of our anaesthetic footprint.

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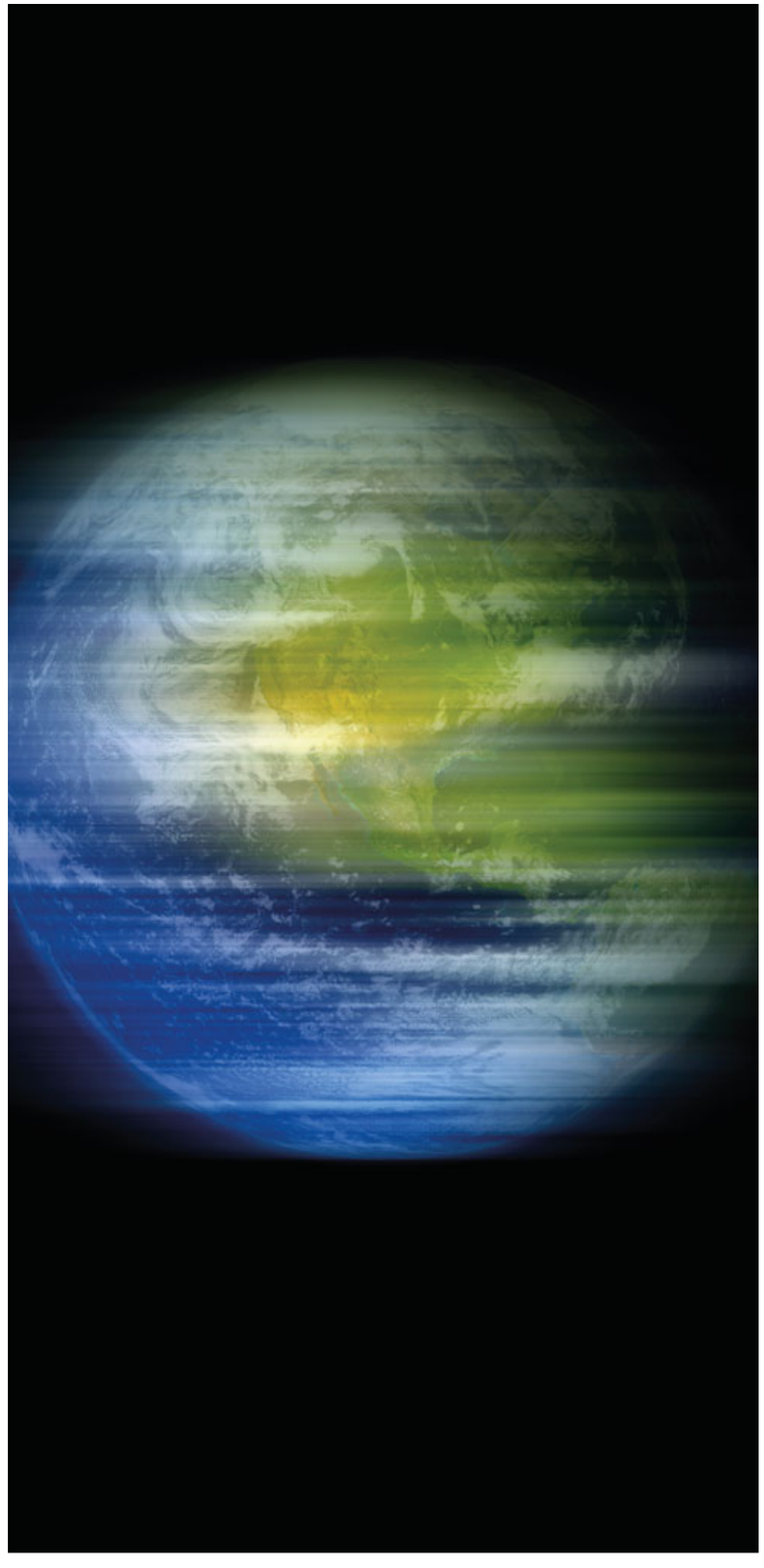
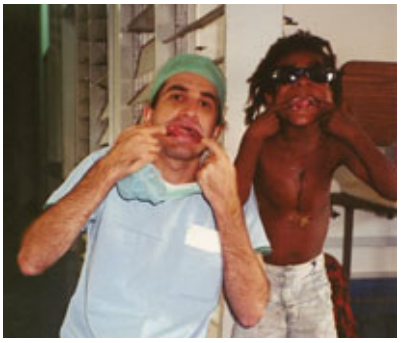




Right: Darren Wolfers with a satisfied customer, taken day two post-VSD repair in Port Moresby General Hospital.

Honours for Operation Open Heart in Papua New Guinea

Left: Matthew Crawford with Papua New Guinea Prime Minister Sir Michael Somare and one of the ICU nurses, Margaret Bresnahan from Sydney Children's Hospital.

Operation Open Heart was established in 1986 by the Seventh Day Adventist Hospital in Wahroonga NSW, to deliver open heart surgical procedures for populations in the South Pacific. The teams comprise cardiology, cardiothoracic surgical, perfusion, anaesthetic and nursing personnel as well as a post-operative recovery team. Some larger teams have biomedical, physiotherapy, radiology and pathology support. Most of these areas receive service provision, with minimal educational training for the local medical personnel.

Funding for the projects is derived from multiple sources, including AusAid, host country governments, Australian and local donors, including Rotary, airlines and other transport organisations, medical suppliers and the Seventh Day Adventist Hospital. All team members take leave from work and pay their own airfare, but they are provided with meals and accommodation.

In 1993, a decision was made to include Papua New Guinea as a destination, as it was felt that of all the sites visited, PNG would be the most likely to be able to develop its own program, with the support of the strong local medical school. The emphasis of this program has always been education. After some initial indifference from the PNG government and the refusal of the health department to provide us with the same health care workers we had already trained in surgery, anaesthesia and post-operative care, a dramatic change occurred when the government was unable to provide even minimal support for the project. At that stage the Director of the Port Moresby General Hospital went on national TV and radio and appealed to the local community, as well as the corporate sector, for funding. The response was amazing, with more money being donated to the project within 48 hours than the government had in the previous five years. Since then the project has taken on a life of its own, and has become important politically.

This year marked the 15th year of the project in PNG. Over 550 cases have been performed, with a mortality rate of less than 1.9%. The last three years have been mortality free, with an average of 60 cases being done each week. Local surgeons and anaesthetists perform most of the closed procedures such as PDAs. We help them for shunts and coarctations and pacemaker insertions. The Australian team mainly performs open heart surgical cases, for the most part ASDs, VSDs, Fallot's tetralogy, Anomalous Pulmonary veins and valve reconstructions or valvotomies. Most patients are children or young adults with children. We do not do any "lifestyle diseases" such as coronary artery grafting.

Selection for the program involves working closely with the local medical teams, both adult and paediatric. A cardiologist visits PNG one week before the main team and ECHOs about 200–250 patients and selects 50–60 patients for us to evaluate. Cases are chosen on the basis that they will spend one day in the ICU, thus not blocking another patient from their operation, have a "low mortality" risk, be able to live a normal or markedly improved lifestyle afterwards, and be a valuable resource for their family and the PNG population as a whole. Repeat operations are generally not offered unless there has previously been an unsatisfactory result.

PNG is the only project site that has managed to train a group of medical and nursing staff to be able to perform cardiac surgery by themselves. With their ability to perform closed work, they can deal with half of the surgical load required. This year we have managed to have the surgical and anaesthetic staff spend one year in Chennai, India, undertaking continued training in "open heart" surgical procedures. Our focus will now be on further training them in bypass surgical techniques with the hope that one day they will be able to master this process by themselves.

One can argue that developing highly complex surgical services in a Third World country that is struggling to meet basic health care needs, is a waste of precious resources, and that was certainly much of the criticism that was levelled at the project in the early days. The spin offs, however, have been one of the main benefits to PNG. These have included a development of an ICU service, with nurses trained in mechanical ventilation, dramatic changes to blood bank screening and supply of factors, improvements on pathology, radiology, computing, air conditioning, gas supplies and electricity supplies, as well as the retention of key staff members within the public sector, that will continue to develop health care in PNG long after we are gone.

This year a number of long-term members of the PNG Operation Open Heart team, including two anaesthetists, were awarded Independence Day Honours awards by the PNG Governor General. They were Matthew Crawford, Insignia of the Member of the Order of Logohu ("ML") for 15 years of service and Darren Wolfers, Insignia of the National Logohu Medal ("LM") for nine years of service.

This has certainly been one of the most challenging and rewarding experience of our time in medical practice, and we would urge others to become involved in these outreach projects. Being able to work in a situation where everyone has the same goal, no clipboards, minimal if any hospital politics, and being able to sit down at night with your work mates for dinner, a beer or glass of wine, has much to recommend it.

Matthew Crawford
Director of Anaesthesia & Surgery,
Sydney Children's Hospital
FANZCA, FJFICM, FFPMANZCA

The CPD Program
Your questions answered

Participation in a CPD program has now been mandated by ANZCA from January 2009 for all practising Fellows. The new CPD program introduced in January 2008 has replaced the MOPS program.

Over the past few months the College has received a number of enquiries relating to the CPD program. Summarised below is a list of commonly asked questions:

Q: Do I need to send in an annual summary form for the CPD program and what is the deadline?
Online users are able to enter their activities and print off their statement of participation whenever it is needed. A CPD plan needs to be entered and several activities before the "Print your statement of participation" link appears on the annual CPD review page.

Offline users participating in the three-year program do not need to submit their hard copy portfolios to ANZCA, as previously required for the MOPS program. Participants can summarise their year's activities on the annual summary form online to print out a statement of participation or mail the hard copy format to the College in order to receive a statement of participation.

Q: Do I need to submit my evaluation of my CPD Plan each year?
The CPD Plan evaluation is not required until the end of the triennium. ANZCA has developed a Toolkit on how to Conduct an Evaluation of your CPD which is available online and is designed to help you evaluate your CPD participation.

Q: I live and work in regional Australia as a private practitioner, how can I meet the minimum requirements for my CPD Portfolio?
In the case of the remote practitioner who finds it difficult to travel to meetings and conferences, there are other elements of the Program for claiming credits:

- The Reflection toolkit explains mechanisms for gaining credits under Category 3/Level 2.
- Your CPD Portfolio can be used for written records and your activity can be recorded on the online CPD Portfolio.
- Recording reflection notes of your own experiences is claimable under Category 3/Level 2, for three credits per hour and could assist the private practitioner in gaining important quality assurance activities and credits.

ANZCA are continually attempting to assist Fellows through the transition to the mandated CPD Program. We will be updating the website to help simplify navigation and recording of activities in the CPD Portfolio. The College will also be providing an updated list of approved events for the CPD Program with advice on how to obtain CPD credits.

While this is a flexible three-year process, some jurisdictions already require evidence of annual participation and we fully expect this to be the universal requirement in Australia with the introduction of national registration. The table below explains the current situation with regional registrations.

ANZCA staff are available to provide assistance and answer any questions. This includes help in navigating the online program. Staff can talk you though what you need to record and how to record it. They can also assist with determining where the activities you undertake fit within the program. Please do not hesitate to call the CPD Coordinator, Teresa Brandau-Stranks, on +61 3 9510 6299 or email cpd@anzca.edu.au.

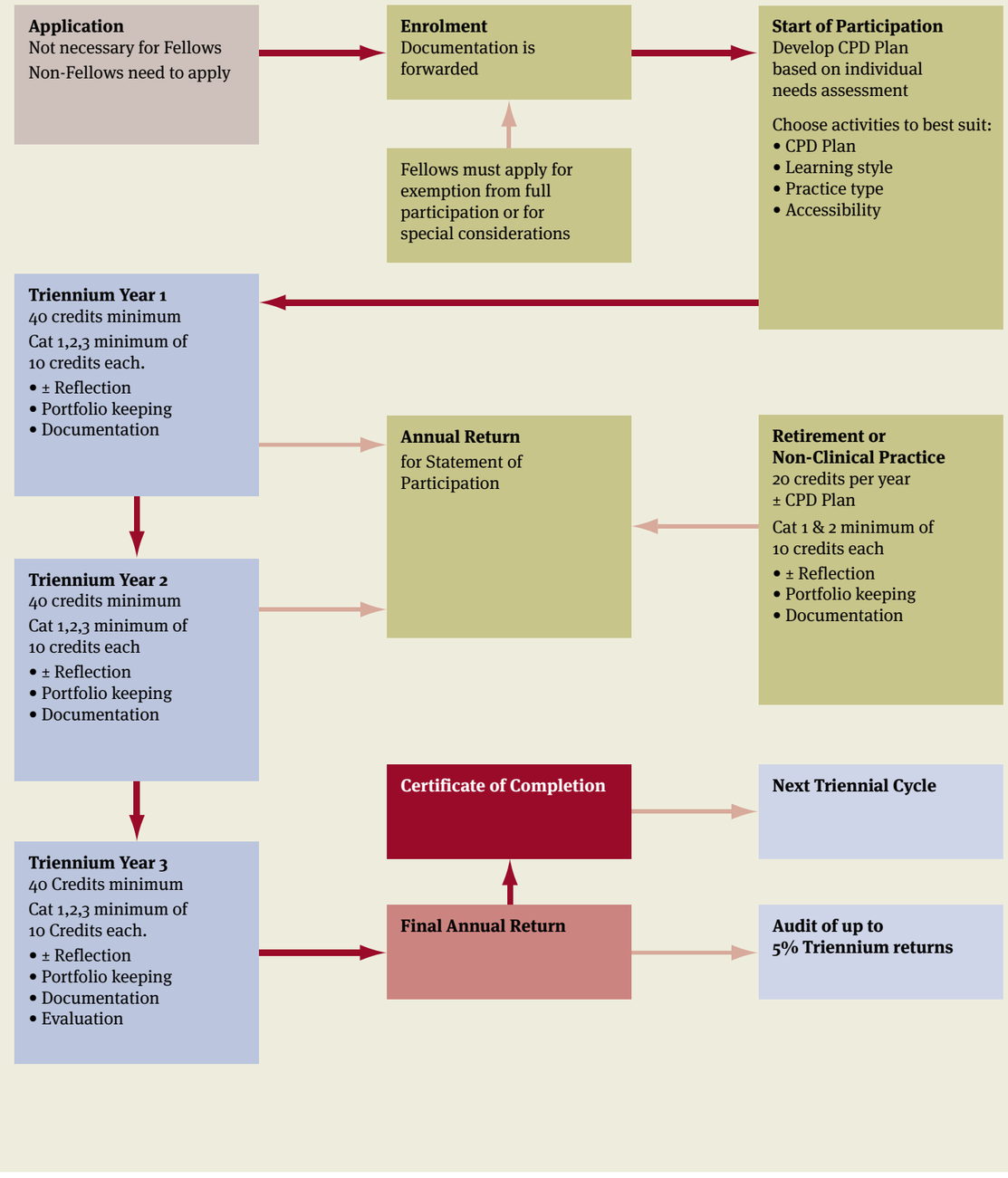
The ANZCA CPD Program Flowchart (at right) explains the CPD process in more detail and can help you answer the questions on your individual situations.

Summary of CPD Participation for Registration

Region	*Compulsory*	*Comments*
New South Wales	Yes	CPD Statement of Participation by birthdates
Victoria	No	Certificate of Good Standing
Queensland	No	Certificate of Good Standing
South Australia	No	CPD Question on Registration Form
Tasmania	No	CPD participation questions on Registration Form
Northern Territory	No	CPD Question on Registration Form
ACT	No	Certificate of Good Standing
Western Australia	No	Certificate of Good Standing
New Zealand	Yes	CPD Statement of Participation submitted quarterly depending on birthdates

Dr Frank Moloney
Chair, CPD Committee

CPD Program Flowchart



The sceptics guide to mentoring


Dr Greg Downey

There is a strong push in our medical fraternity, and others, to foster professionalism among our trainees. Concepts such as honesty and integrity, practicing ethically and dutifully, communicating effectively and empathically are being advocated in order to produce responsible, accountable, caring individuals who are able to contribute as well as benefit from their roles in medicine. Producing anaesthetists with the above attributes sounds like a tall order, but the implementation of techniques such as mentoring may go some way towards promoting these issues in addition to providing support for our trainees.

For some of us, the concept of mentoring may seem like a good idea. But for many, it can appear foreign and an unnecessary indulgence. Most senior anaesthetists will have had little, if any, experience of it, and could perhaps be excused for having opinions such as:

- "We didn't need it in my day".
- "Surely trainees can manage their own affairs".
- "Why can't we stick to the hard facts of education instead of this touchy-feely nonsense?".

So, if we and our predecessors didn't need it, then why is it becoming popular now?

There are a number of possible explanations:

- Mentoring has become commonplace in the business world as a means of nurturing and supporting potential protégés.
- There is strong intuitive appeal in terms of support for our colleagues and the organisation and promoting self-respect and personal fulfillment.
- Management of stress. Trainee anaesthetists have been identified as a group that are regularly exposed to stressful situations[1] and should have a system of support[2].

Supporters in the medical fraternity suggest a multitude of advantages such as: improved emotional literacy; better handling of conflict and the consequences of error and mishap; better integration into the medical community; better handling of the frustration, disorientation and disillusionment that can confound medical work; skill rehearsal; improved ability to communicate and career development.

But can mentoring actually achieve all this? The evidence is not strong, and most positive studies are poorly designed. A systematic review in JAMA of 39 papers[3], many of which had methodological limitations, revealed the following advantages attributed to mentoring:

- Greater career satisfaction than those without a mentor.
- Greater satisfaction with training.
- Important in career advancement.
- Likelihood of promotion.

Mentoring has also been shown to influence:

- Selection of a speciality[4].
- Interest in academic medicine[5,6].

A survey of registrars in our institution (all of whom are mentored) was unable to demonstrate improvements in specific skills such as problem solving, judgment, management of error, conflict resolution, stress management and interest in research, among others. However, there was overwhelming support for the program in terms of its ability to support and encourage, manage transition, job satisfaction and career development. In addition, there have been a number of instances where the mentor has been able to step in and help to manage conflict, stress or breakdown.

The lack of adequate evidence for its effectiveness might make one wonder why bother. But perhaps mentoring does not lend itself well to academic study. Our trainees say that the mentoring program provides acknowledgment, back-up and, more importantly, the assurance that there is someone at a senior level that has their interests at heart. Just as in any relationship, these are difficult concepts to study.

Can we be sure that mentoring, as compared to other forms of personal development, is the best method of supporting our trainees? Mentoring, in fact, is only part of the overall development of the individual, which is based on multiple inputs, good and bad. What it does provide perhaps, is "at the coal face" management of evolving issues, which any number of preemptive courses and disciplines may prove inadequate for.

So what is it?

Classically, it refers to personal and professional development by a wise and trusted guide. There are multiple roles ascribed to mentors such as advisor, coach, teacher, listener, counselor, resource facilitator, etc. But essentially mentoring has two major functions: provision of role models and perspective.

A role model is simply a person we look up to, someone whose thoughts and actions we admire and wish to emulate. Identification of, and with role models is a natural process, something that occurs throughout life and that influences, not only our approach to life, but in fact how we develop as a society or organization[7].

Perspective: there are multiple situations in life and work where we are stressed, angry, confused or frustrated. In such situations it's difficult to see the wood for the trees. The mentor can provide the environment in which to step back and take a considered look at the situation with a view to its resolution.

How can it be put into practice?

In our institution, a department meeting determined that there was a need to teach professionalism and that mentoring could be an efficient way to achieve this. A coordinator was given responsibility for the program and a committee was set up incorporating people who had demonstrated an interest in personal and professional development. All members of the department were asked about their willingness to participate as mentors and, surprisingly, none declined. Information was provided by the coordinator to mentors and trainees at the outset and continuously regarding the functions and logistics of an effective mentoring relationship. The committee decided that all trainees were to take part in the program and they were asked to choose three consultants who they looked to as role models. Most were given their first choice. Each consultant was limited to no more than two trainees. The participants are asked to meet at least monthly in order to establish a relationship such that when needed, the mentor is the one to turn to. This happens in most cases.

It is interesting to note that in general, the mentors chosen are the "likely candidates" – consultants with an outgoing personality, interest in others and with a proven track record of success in their careers and personal lives. Instruction is given on how a mentoring relationship is set up, how to conduct meetings and regular handouts on topics of interest. No formal training is given and mentors are expected to rely on their own abilities to foster the relationship, something made somewhat easier by the fact that trainees choose them as role models. Nonetheless, the relationship between mentor and trainee does not happen overnight. It requires at least a moderate amount of time and effort. To be effective, a bond of trust between mentor and trainee needs to develop, just as in any relationship. Once that bond is established, a long term association of benefit to both parties results.

Conclusion

A mentor is not a prerequisite for advancement or success, and mentors do not have any magic powers to fashion great individuals. But they are concerned with making the most of human potential and with aiding trainees to be successful in their own right

In truth, nobody actually needs to be mentored, just as nobody really needs that extra slice of pie or that expensive car or house. However, it may be desirable in order to produce individuals who act professionally, who have a rewarding career and who are making a contribution to the community. These are blatantly old-fashioned notions. But, if we look around us at those who have the most fulfilling lives in our fraternity, it may be that these and other 'noble' attributes underpin that fulfillment. In addition, personal experience and simple observation tell us that these are the very characteristics that our patients value in us. If a mentoring relationship can contribute to this, it may be of significant value.

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FANZCA Module Sign-Off

ANZCA's Education and Training Committee reiterates how Modules should be signed off, particularly if a Module is done at more than one hospital. This information is aimed at Module Supervisors and Supervisors of Training as well as trainees.

The ANZCA training program currently comprises five years of approved supervised clinical training, (Basic followed by Advanced), Primary and Final Examinations, an EMST or EMAC course and a program of twelve modules. The modules form the syllabus.

Module 1 Introduction to Anaesthesia and Pain Management

Module 2 Professional Attributes

Module 3 Anaesthesia for Major and Emergency Surgery

Module 4 Obstetric Anaesthesia and Analgesia

Module 5 Anaesthesia for Cardiac, Thoracic and Vascular Surgery

Module 6 Neuroanaesthesia

Module 7 Anaesthesia for ENT, Eye, Dental and Maxillofacial Surgery

Module 8 Paediatric Anaesthesia

Module 9 Intensive Care

Module 10 Pain Medicine – Advanced Module

Module 11 Education and Scientific Enquiry

Module 12 Professional Practice

The College Professional Document pertaining to the modules is *TE2 – Policy on Vocational Training Modules and Module Supervision*. Some modules are specialty specific, others comprise a number of subspecialties. Each module groups learning objectives with learning experiences such as clinical exposure and requisite knowledge, skills and attitudes. Modules 2 and 12 are assessed online. Module 11 requires completion of a Formal Project, signed off by a Formal Project Officer, under the terms of TE11, Policy on the Formal Project. Trainees may be eligible for an exemption from the Formal Project as per TE11. This requires an application in writing to the Director of Professional Affairs Assessor. All other modules are signed off by a module supervisor.

Apart from the fact that modules 1-3 must be completed during basic training, the modules do not have to be completed sequentially, neither were they designed to be done as dedicated rotations (except for ICU Module 9, which requires minimum one month blocks). It is possible to complete a module over several terms in more than one training site. This allows flexibility for the trainee as well as departments. ANZCA accredited departments should have a module supervisor appointed for any module for which it is possible for a trainee to gain experience. At the start of a rotation, the trainee should seek out the relevant module supervisors, meet with them and discuss what the trainee's clinical and educational needs are in order to meet some or all of the core objectives for the modules for which they are seeking experience. The module supervisor should assist the trainee in setting some realistic goals within a specified time-frame and oversee their progress. A learning plan should then be documented in the learning portfolio.

Progressing through a module

The trainee has to record their clinical experience in their learning portfolio. This is not just the number of lists or sessions (some modules specify a minimum number of clinical sessions). Ideally, the trainee will have entered case mix, degree of supervision, skills learned, and any significant learning points, and then relate this range of experience to the core trainee aims of the module. In addition, their learning plans, reflection on their experiences and some evidence of self-assessment is desirable.

Partial module completion

At the end of the rotation, the trainee should once again meet with the module supervisor. The experience gained during the term may or may not be sufficient to complete the module. There may be insufficient sessions (if a minimum number has been specified), the core aims may not have been met, the planned goals may not have been achieved, or the amount of experience may just not be enough to satisfy all the objectives (knowledge, skills and attitudes) necessary for completion. If this is the case, having reviewed the contents of the learning portfolio, and having discussed this with the trainee, the module supervisor can do a partial sign-off, that is, he or she can sign and date a page of the portfolio, together with the hospital and dates of the term, documenting that some of the module requirements have been met.

Module sign-off on completion

Once a trainee feels they have fulfilled the requirements for completion of a module, they should seek out the relevant module supervisor, with their learning portfolio, and spend some time together reviewing it.

The trainee needs to be able to validate that they have completed the specific clinical experience, have self-assessed that they have achieved the core aims (and their own goals as set out in their learning plan) and that they have completed any module-specific assessments. Once satisfied that the trainee has confirmed all these with the module supervisor, they both sign the Module Completion Form K. This must also be countersigned by the Supervisor of Training.

A module supervisor can recognise prior module experience from another term or rotation, provided there is sufficient evidence of such in the portfolio and the other module supervisor has signed it.

Overall, however, module sign-off is not just about completing a number of sessions or cases, it is a demonstration by the trainee that they have been exposed to a sufficient depth and breadth of clinical experience in a particular area, that significant learning has occurred, that knowledge has been acquired and skills have been gained.

Evidence of reflective practice is a sign of development of a professional attitude that needs to occur throughout one's career as a specialist.

Dr Genevieve Goulding
ANZCA Councillor

International Medical Graduate Specialists

The introduction of ANZCA's new International Medical Graduate Specialists (IMGS) process from January 2009 follows an extensive review over the past two years. The new process is aimed at being more definitive, with introduction of a workplace-based assessment in lieu of an examination for some candidates, taking into account trends internationally, nationally in both Australia and New Zealand, including moves towards national registration in Australia.

A number of new documents have been posted on the ANZCA IMGS website. Minor but important changes have been made to the IMGS documents already on the website.

The new process clarifies IMGS entering temporary Area of Need positions or entering the IMGS process directly.

Key points

- To be considered "Substantially Comparable" to FANZCA, an IMGS must have had substantially comparable training and assessment to FANZCA. The curriculum must be comparable to that of ANZCA, carried out in institutions which meet standards set by the accrediting body, following two years of post MBBS Prevocational Medical Education and Training (PMET). The duration of anaesthesia training must be at least five years of structured training leading to a qualification recognised by national government agencies as qualifying the individual for specialist anaesthesia practice. Assessments must include regular in-training formative assessments, and summative examinations in both basic sciences and clinical/professional practice. All candidates require 12 months of Clinical Practice Assessment under oversight and a workplace-based assessment to be eligible for recommendation for specialist recognition and ability to apply for FANZCA.
- "Not Comparable" is the classification for those IMGS not meeting the criteria in the first point who are judged on paper assessment, or by the IMGS Interview Panel as being unable to achieve the standard required of a College Fellow within two years. These IMGS still have the ability to seek to satisfy AMC requirements, to enter the ANZCA training program, and to request recognition of prior learning.
- "Partially Comparable" are people who are recognised as IMGS, but judged to need up to 24 months of additional supervised training, plus examination, and workplace-based assessment in order to achieve recommendation for specialist recognition and eligibility to apply for FANZCA.
- Definition of IMGS is a medically qualified person who has undergone specialist anaesthesia training in their own country, graduated, and become eligible to work as a specialist in that country.
- Continuing Professional Development (CPD), (with satisfactory evidence), is a requirement for consideration of classification of both substantially comparable and partially comparable.
- Those IMGS who have received two years of post MBBS Prevocational Medical Education and Training and completed a three- or four-year specialist qualifying program in their country of origin may have considered by the Interview Panel one year of additional post-specialist qualification training under supervision in a tertiary/academic institution.
- Assessors for workplace-based assessment, Areas of Need on-site assessment and Clinical Practice Assessment visits may claim credits under the ANZCA CPD program.

Enquiries regarding the IMGS process should be directed to Jill Humphreys or Renee McNamara at jhumphreys@anzca.edu.au or rmcnamara@anzca.edu.au after visiting the College website *www.anzca.edu.au/imgs-aon/*

Professor Garry Phillips
Chair, IMGS Committee

Pigs, burns and curly tails

In the early 1970s, the Burns Unit at the Royal Children's Hospital in Melbourne was suddenly faced with the management of a number of children presenting with extensive full-thickness burn injuries. This prompted a renewal of interest in the use of fresh pigskin as a temporary cover for burn wounds.

While early debridement and split skin autografts offer the best form of wound coverage, this approach is limited in massive burns by the lack of donor sites available to obtain split skin for grafting.

The aim of temporary cover of burns sites with pigskin is to reduce excessive fluid loss, act as a barrier against burns wound sepsis, protect the wound from mechanical trauma, and help control pain.

Plans to obtain pigskin were made with some degree of urgency. The State Research Farm at Werribee agreed to supply a pig to the hospital, on a weekly basis, for harvesting of a large split skin graft taken from one side of its body. This would be performed under anaesthesia by a member of the surgical staff. We were also informed that these were valuable "pathogen free" pigs and were to be returned alive and intact (minus, of course, the split skin from their side) to the research farm after the procedure.

All that was needed to complete the plan was an anaesthetist. I was selected for the task not on the basis of any experience, skill or knowledge, but primarily because of my junior status within the Department of Anaesthesia. In addition, it seemed that all the other members of the Department had suddenly developed an intense interest in vegetarianism, animal rights, Judaism or any other cause they could find that would preclude them being selected.

Having no knowledge of pig anaesthesia, I consulted what literature I could find on the subject and gleaned the following:

- Pigs can never be considered fully fasted for anaesthesia. They always have a potentially "full stomach", with its attendant risk of vomiting and aspiration under anaesthesia. If fasted in an enclosure, they will eat their faeces if hungry. After all, they are pigs.
- Pigs have excellent veins in their ears, suitable for cannulation and intravenous induction of anaesthesia.
- A clear airway may be difficult to maintain in a pig. Manoeuvres such as chin-lift and jaw-thrust are problematic, and endotracheal intubation is made difficult by the airway taking an acute, almost 90° turn just beyond the vocal cords.

There was limited information on how pigs react to anaesthetic agents commonly used in humans. Two points were of concern:

- Pigs are susceptible to malignant hyperthermia, not only in association with anaesthetic agents but even with significant exercise and stress. Landrace pigs are particularly susceptible to stress, and risk becoming "roast pork" if sufficiently stressed.
- Pigs are much more sensitive than humans to non-depolarising muscle-relaxant drugs. These drugs need to be titrated carefully to avoid the need for prolonged positive-pressure ventilation.

Armed with this knowledge, I prepared an anaesthetic machine, some intravenous equipment, drugs, masks and intubating equipment in the animal laboratory operating room. This room was on the first floor at the rear of the hospital and it was here, on the first morning, that I nervously awaited the arrival of the attendants with my first "patient".

When they failed to arrive in the operating room and I was called to go to the goods delivery laneway at the back of the hospital, it suddenly became apparent to me that my role was to be larger than I had anticipated.

In the laneway was a panel van and beside it were the driver and his assistant, both anxious to get my signature for the delivery of a pig. I peered into the back of the panel van and was confronted by my first view of my patient — a snorting, smelly, very grubby pig with an excess of oral and nasal secretions and weighing about 100 kg. His aggressive stance and demeanour indicated clearly that there would be no cooperation with any medical procedure.

My approach to pig anaesthesia required a hurried revision. There was no way this pig was going to proffer me one of his ears, with its excellent veins, and allow me to establish intravenous access and then administer drugs to render him more compliant.

The only possibility was to somehow get the pig to turn round and present his buttocks to me at the open window at the back of the panel van. Sweet talking and cajoling failed, but shoving and prodding finally got the buttocks within range and I prepared for action. Using a stabbing motion, reserved for intramuscular injections into violent and uncooperative adults, I plunged a hypodermic needle deep into the nearest buttock and emptied my preloaded syringe of 1 g ketamine — hopefully into a gluteal muscle — before quickly moving to a safe distance away.

The pig was angered by this assault, but the ketamine soon took effect and he fell on his side, adopting an air of sweet repose, although snoring loudly, indicating some degree of airway obstruction.

Much haste was now required. Four able bodies, myself included, quickly lifted the unconscious pig out of the panel van and placed him on a sheet on the ground. He was then rapidly hosed down before being transferred to a clean sheet. By lifting the sheet at each corner, we carried our snoring pig hurriedly into the hospital. The noisy, obstructed, breathing pattern intensified as we ascended the stairs to the animal laboratory. Appalled at the thought of having to assist breathing en route with mouth-to-snout ventilation, we quickened our pace. I was greatly relieved to finally get the pig onto the operating table, where I was able to deliver 100% oxygen via a conical face mask, suction the nose and pharynx, and thus restore a clear airway.

I deepened the anaesthesia by adding halothane to the oxygen delivered from the anaesthetic machine and then placed a large intravenous cannula into one of the pig's superb ear veins. I then attempted to intubate the trachea. This proved very difficult, and after multiple attempts I finally succeeded by using a malleable wire and then passing a cuffed endotracheal tube over the wire.

My greatest fear throughout the procedure was that the pig would develop malignant hyperthermia. The thought of my patient becoming roast pork kept me nervously vigilant.

The skin harvesting went well, and after emergence from anaesthesia the pig was transferred, in a somewhat dazed state, uneventfully back into the panel van and home to Werribee.

Flushed with success and now armed with a proven approach, we prepared for the next pig to arrive the following week. On its arrival in the back of the panel van, I was confronted with a new pig and a new problem relayed to me by the lone driver.

En route to the hospital from Werribee and passing through Footscray, the driver's assistant noted that the pig was trying to climb out of the open window at the back of the panel van. The van was stopped and the driver and his assistant attempted to push the now almost fully extruded pig back into the panel van.

Unfortunately, the pig fell out onto the ground, injuring the leg of the assistant driver, and then escaped into suburban Footscray. The assistant was taken to a local hospital while the driver, with help from some local council workers, eventually got the pig back into the van and finally to my care.

In response to this incident, the State Research Farm sternly warned us they would send no more pigs unless we sedated them before departure to ensure the health and safety of the driver, his assistant, the panel van and the pig.

How best to sedate a pig for a journey across Melbourne in a panel van? Clinical pharmacology was in its infancy in the 1970s, and conclusions drawn from human studies and applied to animals were risky. What was needed was a drug that would calm the pig and take away its desire to escape but not sedate excessively. At that time there was much interest in the anaesthetic literature in the drug droperidol.

Droperidol had been used to treat severe agitation in psychotic patients. It was said to produce marked tranquillisation and sedation, allay apprehension and provide a state of mental detachment and indifference while maintaining a state of reflex alertness. Just what we wanted in our pigs! However, there had been some disturbing reports of the drug causing a state likened to a "locked-in syndrome", with marked inner turmoil experienced by the patient despite the external appearance of calm. There was no time for trials, and we reasoned that, if the pig did indeed feel locked in, this would

make unruly behaviour even less likely.

Droperidol was in fact given on only one occasion: 10mg intramuscularly 30 minutes before departure to the hospital. The pig arrived calm and awake, even tranquil. We, however, remained apprehensive, being unsure what this pig was really thinking.

We anaesthetised three pigs in total and the harvested skin was used as temporary skin cover to good effect. It was said that the children's appetites improved, even to the extent that one child reportedly "would now eat almost anything". This is, of course, purely anecdotal and I find it difficult to attribute this observation to the nature of the temporary skin cover used.

Soon after these three successful anaesthetics, a Surgical Research Fellow arrived at the hospital keen to start a research project on oesophageal atresia, using piglets as an animal model Unfortunately, being now regarded as the pig anaesthesia expert in the hospital, I once again found myself seconded to the animal laboratory to anaesthetise pigs. These, however, were piglets, weighing only about 8 kg each, and were much less of a challenge. In fact, it soon became almost a pleasure to anaesthetise these happy little piglets. They were small enough for me to carry to the operating theatre in my arms. If they squealed or struggled, which usually occurred only when I started to anaesthetise them, they would immediately become quiet if, with one hand, I held them upside down by their hind legs. Then with my other hand I would place the anaesthetic mask over their snout and anaesthesia induction would take place calmly. The induction was so calm and smooth I have at times been tempted to try this technique on uncooperative small children. As with adult pigs, intravenous cannula placement in the ears was easy and endotracheal intubation difficult.

I anaesthetised 10 piglets in total, with only one untoward event: one piglet had a short episode of profound hypoxaemia and appeared to have a somewhat "cerebral" grunt for the first 24 hours after surgery, but then reverted to behaving in a normal piggy way.

The research study on the piglets did not produce any breakthroughs in surgical practice, but did demonstrate that pericardium is probably not a suitable material to bridge the gap in the oesophagus when repairing oesophageal atresia.

There was very little science in my pig anaesthesia experience either, except for one important observation that sadly remains little known even today. I discovered that when piglets were adequately anaesthetised (ie, did not respond to surgical stimulation), their curled tails became straight. I took it on myself to call this the "Mullins sign", with the hope of making a name for myself in the paediatric porcine anaesthesia literature. But despite quite brazen self-promotion of this sign over the past 30 years, the Mullins sign has failed to receive due recognition.

With the acceptance of this article for publication by the MJA, I can now say with a mixture of pride and humility that the Mullins sign is finally "in the literature".

Geoffrey C Mullins, MBBS, FANZCA,
Perth, WA.

Mullins Geoffrey C. **Pigs, burns and curly tails.** MJA 2008; 189 (11/12): 666-667.

PICC lines re-visited – Episode 3

In response to concerns related to PICC lines (expressed by Queensland Health as well as being highlighted by Dr Philip Ragg in The ANZCA Bulletin, March 2007 and December 2008), a letter from the Therapeutic Goods Administration (TGA) was received by Professor Barry Baker on 19 December 2008, outlining results of investigation into reports of adverse events. The outcome is a planned improvement of manufacturers' instructions about the use of PICC lines as well as advice on the risks of trimming PICC lines. To view the letter in full *(Alert: Result of the Therapeutic Goods Administration (TGA) investigation into adverse event reports about PICC guidewires)* please go to the ANZCA link: *www.anzca.edu.au/news/announcements*

National Blood Supply Contingency Plan – 2008

In December 2008, the National Blood Authority released its National Blood Supply Contingency Plan, approved by Australian Health Ministers. It states that the 'National Blood Authority (NBA), is responsible for ensuring that Australians have an adequate, safe, secure and affordable blood supply.'

The plan outlines the risk management approach taken to assessing the possible problems, governance arrangements and the broad overarching strategies in place to mitigate a supply or demand crisis. It enunciates three levels of accountability:

- National
- Operational
- Clinical – 'the role of clinicians and pathology providers in managing demand through strong triage and vetting processes based on clinical needs.'

Each institution is required to have in place an emergency blood management plan to assist all players when supply is short.

This is an excellent document which deals with the normal blood sector arrangements; blood and blood product management; crisis planning; preparation for and mitigation of a crisis; and response at all levels.

An appendix (page 29) lists patient categories to assist in prioritisation of red blood cell transfusions.

Two annexes deal with:

A. Red Blood Cell Response, and

B. Plasma Products Response: plasma-derived and recombinant product response plan

The plan is well worth reading, especially noting the levels of alert for clinicians and the actions they should take or be involved in (white alert / yellow activate / red activate / green deactivate) and the guidance for prioritisation of (red blood cell) transfusions (priority 1 includes resuscitation, emergency and urgent surgical support, and non-surgical anaemia which must be treated).

See *www.nba.gov.au/nbscp*

A review process of the Contingency Plan is already underway.

Garry Phillips
South Australia

Changes to Medical Oxygen Connections

Background

Until now, large medical oxygen cylinders, i.e. size D, E, F and G have been supplied with a screw-thread connection (AS240 Type 10). This connection is also used on nitrogen, industrial air and argon cylinders and occasionally has resulted in misconnections. Until about 10 years ago, large medical air cylinders were also supplied with an AS240 Type 10 screw connection. Mix-ups between air and oxygen occurred. This problem was solved by providing all sizes of medical air cylinders with a pin-indexed connection. However, the problem of possible misconnection of large oxygen cylinders to nitrogen, industrial air or argon lines and cylinders with those gases connected to oxygen lines remains.

The Solution

All medical oxygen cylinders will be pin indexed in accordance with the recent AS2473.3 amendment. The conversion will be done by all suppliers on a State by State basis over the next two years. The regulators used on the current large cylinders will not fit the new pin indexed cylinders and must be changed.

It is recommended that every Anaesthetic Department and Intensive Care Unit request that the gas supplier for their hospital contact them a week before their conversion date so that they can be prepared and cooperate with the change-over.

Hospitals with bioengineering departments should also ensure that bioengineering are notified of the changeover plans.

Problems

Failure to convert free-standing D, E, F or G cylinders used around the wards and on mobile ventilators may jeopardize patients who require oxygen.

Small pipelines supplied from cylinder banks may lose supply if the changeover is not coordinated.

Backup cylinder banks with AS240 Type 10 connections used with liquid oxygen supplies may not be replaceable if there is a failure.

John Russell
South Australia

The Incidence of Transoesophageal Echocardiography – Related Complications in Victorian Cardiac Surgery Centres

Over the past decade, the Victorian Consultative Council on Anaesthetic Mortality and Morbidity has received a small number of case reports of complications related to the use of transoesophageal echocardiography (TOE) in cardiac surgery (perforations or tears of the oesophagus or upper stomach). Several international studies had estimated the incidence of TOE-related complications as very low, of the order of 3-4 per 10,000 cases. Using the Australian Society of Cardiac and Thoracic Surgeons database between 2001 and 2007, we sought to define the local incidence and outcome from TOE-related complications, and assess any possible risk factors, such as age or sex.

Figure 1

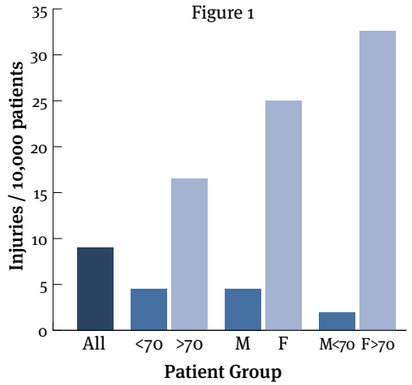


Figure 1 summarises the key findings. Overall, the incidence of TOE-related complications was higher, at 9 per 10,000, with a mortality rate of 2 per 10,000. Patients aged over 70 years had a relative risk of 3.7 compared to those under 70 (95% CI 1.2-11.7). Women had a relative risk of 6.5 compared to men (95% CI 2.0-21.1). Females over 70 had a relative risk of 22 compared to men under 70 (95%CI 2-182).

We concluded that older women have a substantially greater risk for TOE-related injury.

Reference:

Piercy M, McNicol L, Dinh DT, Story DA, Smith JA. Major complications related to the use of transesophageal echocardiography in cardiac surgery *J Cardiothorac Vasc Anesth, 23:62–65 2009.*

Mathew Piercy
Victoria

Legislation in relation to incident reporting

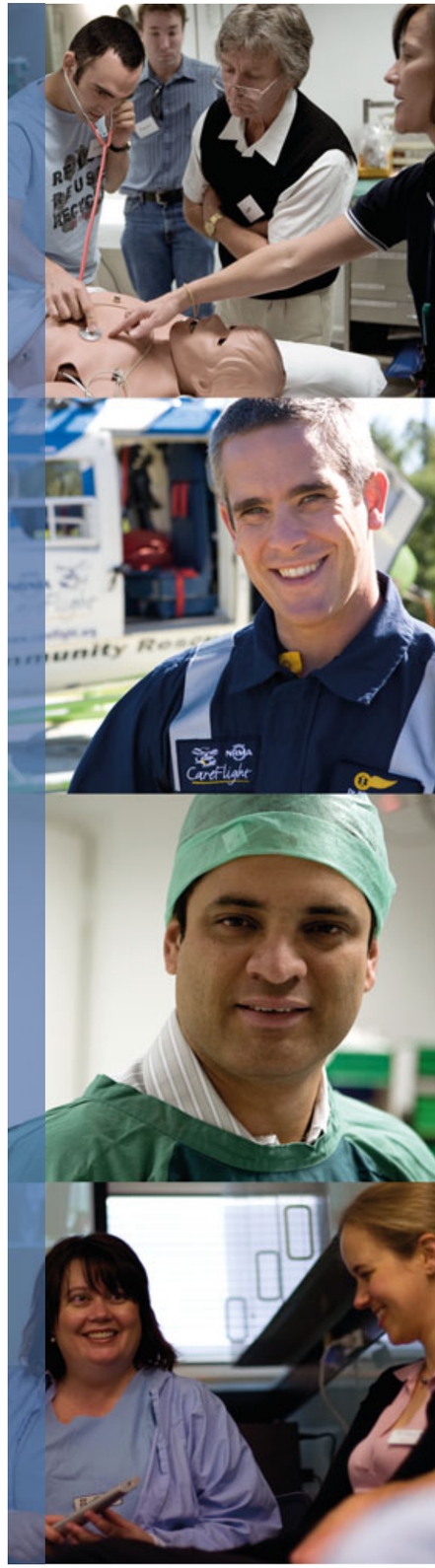
The Australia and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC) is making great progress in setting up a specialty specific incident reporting system for use by anaesthetists throughout Australia and New Zealand. Many anaesthetists have asked about the legal implications of this activity. Michael Gorton and Bruce Corkill QC regularly advise the College on legal matters in Australia and New Zealand, and in conjunction with the members of the ANZCA Quality and Safety Committee they have very kindly prepared two documents advising on the relevant legislative issues. These can be seen on the Quality and Safety section of the ANZCA website, under Legal Matters.

The ANZTADC program has been registered as a protected Quality Assurance Activity in Australia and New Zealand, and appropriate ethics committee approvals are being sought. In New Zealand there will be one application nationally (and this is in progress). In Australia, ethics approval is not required for an approved quality assurance activity but may be required for national publication of the results. ANZTADC is in the process of applying for ethics approval at the pilot test sites. The situation will become clearer when the responses of the ethics committees and hospital administrations at the pilot sites are known. This quality assurance protection for ANZTADC incident reporting in both countries prevents the disclosure of any information that would identify an individual practitioner or patient. This also applies to court proceedings. In exceptional cases, the health minister may overrule the legislation but this would not normally apply to legal action against an individual practitioner. The ANZTADC process will have considerable protection and also be anonymous, so even for more serious events the legal risk will be low. Nevertheless, the decision to report an incident lies with each individual.

It should be noted that the ANZTADC incident recording and reporting activity is completely separate from local hospital incident recording systems and also separate to open disclosure requirements of the state or country in which you practice.

The ANZTADC program will place considerable emphasis on analysis of the reports and on feedback. We hope that the majority of anaesthetists will report regularly, so that we can all learn from one each other's experience and improve patient safety.

Alan Merry, New Zealand
Martin Culwick, Queensland



Major complications of central neuraxial block: report on the Third National Audit Project of the Royal College of Anaesthetists

One of the great frustrations when trying to interpret the reported incidence of a complication in our speciality is the quality of the basic data. The numerator is often derived from voluntary reporting, retrospective surveys or analysis of closed claims data. The denominator is often a 'best guess' derived from the funding statistics of hospitals and insurers. These limitations are accentuated when the incidents being studied occur less frequently as is the case with serious complications following central neuraxial blockade (CNB). To this statistical uncertainty is added a 'clinical uncertainty' in the interpretation of case reports for a procedure as complex as epidural anaesthesia, which integrates individual judgement and skills, intricate delivery systems and an interaction with broader hospital systems. A failure of any component or combination of components may result in patient injury and ascribing causation can be extremely difficult if not impossible.

Against this background, the Third National UK Audit Project of the Royal College of Anaesthetists on Major Complications of CNB is an extraordinary achievement.[1] This is the largest ever reported prospective audit of complications following CNB with a unique and 'robust' data base. The denominator data were obtained from a census, which achieved a remarkable 100% return rate from all NHS hospitals in the UK!

The numerator was derived from a comprehensive audit of major reported complications over a 12-month period led by a network of local reporters in *every* hospital, supplemented by reports from other specialties such as radiology and neuro- and spinal surgery. This was further cross referenced against litigation and indemnity fund databases supplemented by literature and internet searches.

Reflecting the uncertainty and ambiguity inherent in assessing some of the case reports, the results are reported both 'pessimistically' and 'optimistically', but in either case are generally very reassuring. With a denominator of over 700,000 cases the incidence of permanent injury following CNB was 4.2 per 100,000 cases in the worst-case scenario or 2.0 per 100,000 in the best case. The incidence of death or paraplegia was 1.8 or 0.7 per 100,000 respectively. Further, two-thirds of the injuries resolved fully.

'Mining the data' reveals further information. CNB includes epidurals and spinals as well as combined spinal-epidurals (CSE) and caudals in the perioperative, obstetric and chronic pain situations. Perioperative epidurals were associated with a higher incidence of complications (8 and 17 per 100,000, best and worst case, respectively) and CSE techniques accounted for 13% of permanent injuries and deaths yet were only 6% of CNB performed. Although obviously the use of these techniques in this situation may simply reflect an older, higher-risk population than, for example, the obstetric patients. Sub group comparisons must be made with caution and may not be valid.

The article and an accompanying editorial[2] make very informative reading. However, the Clinical Reviews of the project published online by the Royal College of Anaesthetists are even better.[3] The clinical aspects of the project are reviewed by complication type and indication, with individual case studies and quantitative analysis as well as expert comment. The learning points are then highlighted.

The individual risk-benefit analysis, which underpins clinical decision making and subsequent informed consent, is always going to be complicated and difficult where CNB is involved. We are well assisted, however, by reliable resources such as this quite awesome project from the UK and its report.

Patrick Hughes
Victoria

References:

1. Major complications of central neuraxial block: report on the Third National Audit Project of the Royal College of Anaesthetists
T. M. Cook, D. Counsell, J. A. W. Wildsmith, and on behalf of The Royal College of Anaesthetists Third National Audit Project
BJA 2009 102: 179-190.
2. Central neuraxial block: defining risk more clearly D. J. Buggy BJA 2009 102: 151-153.
3. Available from *http://www.rcoa.co.uk/*

MHANZ (Malignant Hyperthermia Group of Australia and New Zealand) and the MH resource kit

MHANZ[1] was officially formed in November 2004 as a fundraising group for malignant hyperthermia (MH) research and testing throughout Australia and New Zealand. The group collaborates in many areas of research and meets once a year to review the latest clinical and diagnostic advances in this specialised field.

All members are directly involved in research and in-vitro contracture testing for MH. Anaesthetic members of MHANZ include Robyn Gillies (Vic), Elaine Langton (NZ), Philip Nelson (WA), Neil Pollock (NZ), Margaret Perry (NSW), Neil Street (NSW), Mark Waddington (NZ) and Rob Whitta (NZ).

MHANZ has developed the MH resource kit with the help of expert opinion, literature review and international guidelines. The crisis task cards for the kit were the original idea of the Southern Health Simulation and Skills centre[2]. These have been modified after simulation testing by the MHANZ. The Australian and New Zealand College of Anaesthetists endorsed the resource kit in 2008.

The resource kit is designed as a guide and a practical memory aid and it has been prepared for a typical MH case. It is still the responsibility of the practitioner to look at the circumstances of each case and whether the application of all or some of the advice in the kit is appropriate. The resource kit can be downloaded from the website *www.malignanthyperthermia.com.au* or from the college website *www.anzca.edu.au* (search term – malignant hyperthermia).

1. Address for correspondence:
MHANZ Group,
c/o Dr Robyn Gillies,
Department of Anaesthesia and Pain Management, Royal Melbourne Hospital,
Grattan Street, Parkville 3050.

Phone: +61 3 9342 7540
robyn.gillies@mh.org.au
www.malignanthyperthermia.com.au

2. Southern Health Simulation and Skills Centre,
Moorabbin campus,
Monash Medical Centre,
Centre Road,
East Bentleigh, Victoria 3165.

Phone: +61 3 99288314
brendan.flanagan@southernhealth.org.au
www.southernhealth.org.au/simcentre/

Library update

Book donations

Thanks to Dr David Brown and the Royal Hobart Hospital Department of Anaesthetics, and Dr George Waters for recent significant book donations to the ANZCA Library.

Evidence-based practice corner

Clinical Practice Guideline Handbooks
The Library has collated a list of handbooks on developing clinical guidelines. ANZCA Library staff are always happy to assist with evidence-based practice and development of clinical guidelines.

Available online at: *http://www.anzca.edu.au/resources/library/research-tools.html*

Cochrane Library Training Dates for 2009
The Cochrane Collaboration/Australasian Cochrane Centre offers workshops on topics such as developing a protocol, diagnostic accuracy and analysis in capital cities around Australia.

Timetable available online at: *http://www.cochrane.org.au/training/timetable.php*

New databases

CareSearch is an online resource that can help clinicians find relevant evidence about palliative care and trustworthy resources

Available online at: *http://www.caresearch.com.au*

PROQOLID – Patient-Reported Outcome and Quality of Life Instruments Database

Available online at: *http://www.proqolid.org/*

ECRI Institute notices

The ANZCA Library subscribes to ECRI publications on Operating Room Risk Management and Health Device alerts and information. Check this space regularly for updates on the latest information produced by ECRI.

Recent notices include:

- Device alerts on various anaesthesia kits, anaesthesia units, and breathing circuits in anaesthesia.
- Executive Summary on warming cabinets.

Contact the ANZCA Library for further information.

New technologies and online tools

Anesthesia case log tracking made easy
iPhone or iPod Touch users can now use an application for anaesthesia case log tracking. iAnesthesia: Case Logs was designed by anaesthetists and allows the user to track case information such as patients and equipment.

Available online at: *http://www.caselogs.org/index.php/iphone-app/*

WinkingSkull.com
WinkingSkull.com is an interactive study aid on human anatomy. Sign up today for free access to material on all areas including the upper and lower limbs, neuroanatomy, head, neck and back. Available online at: *http://www.winkingskull.com/*

New titles

Anaesthesia and intensive care A-Z: an encyclopaedia of principles and practice / Yentis, Steven M; Hirsch, Nicholas P; Smith, Gary B. – 4th ed – Edinburgh: Churchill-Livingstone, 2009.

Board stiff three: Preparing for the anesthesia orals / Gallagher, Christopher J. – 3rd ed – Philadelphia, PA: Butterworth Heinemann Elsevier, 2009. (Book; DVD)

Clinical pain management: Acute pain / Macintyre, Pamela E [ed]; Walker, Suellen M [ed]; Rowbotham, David J [ed]. – 2nd ed – London: Hodder Arnold, 2008.

Clinical pain management: Cancer pain / Sykes, Nigel [ed]; Bennett, Michael I [ed]; Yuan, Chun-Su [ed]. – 2nd ed – London: Hodder Arnold, 2008.

Clinical pain management: Chronic pain / Wilson, Peter R [ed]; Watson, Paul J [ed]; Haythornthwaite, Jennifer A [ed]; Jensen, Troels S [ed]. – 2nd ed – London: Hodder Arnold, 2008.

Clinical pain management: practice and procedures / Breivik, Harald [ed]; Campbell, William [ed]; Nicholas, Michael K [ed]. – 2nd ed – London: Hodder Arnold, 2008.

Cousin & Bridenbaugh's neural blockade: in clinical anesthesia and pain medicine / Cousins, Michael J [ed]; Carr, Daniel B [ed]; Horlocker, Terese T [ed]; Bridenbaugh, Phillip O [ed]. – 4th ed – Philadelphia: Wolters Kluwer / Lippincott Williams & Wilkins, 2009.

Essentials of neuroanesthesia and neurointensive care / Gupta, Arun K; Gelb, Adrian W. – Philadelphia, PA: Elsevier Saunders, 2008.

Obstetric anesthesia and uncommon disorders / Gambling, David R [ed]; Douglas, M Joanne [ed]; McKay, Robert S F [ed]. – 2nd ed – Cambridge: Cambridge University Press, 2008.

Oh's intensive care manual / Bersten, Andrew D [ed]; Soni, Neil [ed]. – 6th ed – Edinburgh: Butterworth-Heinemann Elsevier, 2009.

Ultrasound guidance for nerve blocks: principles and practical implementation / Marhofer, Peter. – Oxford: Oxford University Press, 2008.

Westmead anaesthetic manual / Padley, Anthony. – 3rd ed – North Ryde, NSW: McGraw-Hill, 2009.

Contact the library

Web *www.anzca.edu.au/resources/library*
Phone +61 3 8517 5305
Fax +61 3 8517 5381
Email library@anzca.edu.au

International news and resources

A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population / NEJM
Implementation of the checklist was associated with concomitant reductions in the rates of death and complications among patients at least 16 years of age who were undergoing noncardiac surgery in a diverse group of hospitals.

Available online at: *http://content.nejm.org/cgi/content/full/NEJMsa0810119*

International Anesthesia Research Society (IARS) 2009 Annual Meeting Registrations are now open: *http://www.iars.org/congress/annualmeeting.asp*

FDA Alerts Public about Danger of Skin Numbing Products
The U.S. Food and Drug Administration has issued a Public Health Advisory alert about potentially serious and life-threatening side effects from the improper use of skin numbing products.

Available online at: *http://www.fda.gov/bbs/topics/NEWS/2009/NEW01947.html*

Major complications of central neuraxial block: report on the Third National Audit Project of the Royal College of Anaesthetists
T. M. Cook, D. Counsell, and J. A. W. Wildsmith on behalf of The Royal College of Anaesthetists Third National Audit Project. British Journal of Anaesthesia 2009 102(2):179-190.

Available online via the ANZCA Journal list

Interventional procedure overview of ultrasound-guided regional nerve block / NICE
Available online at: *http://www.nice.org.uk/nicemedia/pdf/661_Ultrasound-guided_regional_nerve_block_for_web_230708.pdf*

WHO Guidelines for Safe Surgery
Available online at: *http://www.who.int/patientsafety/safesurgery/knowledge_base/WHO_Guidelines_Safe_Surgery_finalJuno8.pdf*

General anaesthesia versus local anaesthesia for carotid surgery (GALA): a multicentre, randomised controlled trial / Lancet 2009; 372: 2132-42
Conclusion: There was no definite difference between general anaesthesia and local anaesthesia for carotid surgery, with decisions to be made on an individual basis.

Available online via the ANZCA Library Journal List

Cyberchondria: Studies of the Escalation of Medical Concerns in Web Search / Ryen White; Eric Horvitz
Cyberchondria encompasses symptoms of non-medically trained people using the World Wide Web to find health information and self-diagnose, thereby increasing anxiety.

Available online at: *http://research.microsoft.com/research/pubs/view.aspx?type=Technical%20Report&id=1595*

Transformation of the Intensive Care Unit (TICU) Measures [Collection] / VHA Inc
Care and Communication Quality Measures [Set]

Sepsis Quality Indicators [Set]

http://www.qualitymeasures.ahrq.gov/Browse/DisplayOrganization.aspx?org_id=1896&doc=9953

Analgesia and anesthesia for the breastfeeding mother / Breastfeed Med 2006 Winter;1(4):271-7 (Guideline)
Major recommendations cover:

- Analgesia and anaesthesia for labour
- Postpartum anaesthesia
- Anaesthesia for surgery in breastfeeding mothers
- Specific agents used for anaesthesia and analgesia

Available online at: *http://www.guideline.gov/summary/summary.aspx?view_id=1&doc_id=11232*

Physicians and the Joint Commission – The Patient Safety Partnership

1. The role of the physician in The Joint Commission
2. Focus on patient safety – accreditation process, standards and performance measurement
3. Patient safety initiatives
4. Enhancing physician involvement in quality and safety improvement initiatives

Available online at: *http://www.jointcommission.org/NR/rdonlyres/433B9886-F95E-40B8-B25A-FE521D34E936/0/PhysiciansandTheJointCommission.pdf*

Value-Based Anesthesia / Anesthesiology Clinics, Vol. 26, No. 4, Dec 2008
Articles include:

- Is it possible to measure and improve patient satisfaction with anesthesia?
- How much work is enough work? Results from a survey of US and Australian Anesthesiologists' perceptions of part-time practice and part-time training

Available in hardcopy at the ANZCA Library.

Notice to New Zealand Fellows and trainees

A core collection of anaesthetic textbooks is available for loan from the New Zealand office of the College. Please check the library catalogue via the ANZCA Library website.

Contact details for the New Zealand office are as follows:
New Zealand National Committee (ANZCA)
PO Box 7451
Wellington South
New Zealand

Phone (04) 385 8556
Fax (04) 385 3950
Email anzca@anzca.org.nz

Regions

Australian Capital Territory

New ANZCA office
ANZCA will have new headquarters in the Australian Capital Territory (ACT) with the opening of an office at 6/14 Napier Close in Deakin. A new Regional Coordinator has also been appointed. Vena Murray commenced working with ANZCA on March 10. Vena was formerly the CEO of Swimming Australia.

Conferences
Two conferences are being held in Canberra this year: the very popular Floriade Conference in September and the SPANZA ASM to be held at the end of October. The theme is 'New Frontiers in Paediatric Anaesthesia'. More details about both of these conferences will be distributed in the coming months.

South Australia / Northern Territory

The 25th short course on intensive care medicine was held on February 25–27 at Ayers House in Adelaide. Fifty-two intensive care trainees attended. The course is aimed at trainees who are preparing for the JFICM Fellowship Examination and includes tutorials and sessions on the written examination, vivas and hot cases. Despite increasing the number of places available, this course continues to remain heavily oversubscribed.

A Continuing Medical Education (CME) meeting was held on February 18 at the Women's and Children's Hospital (WCH) in Adelaide. The title of the meeting was 'An Anaesthetic Sojourn'. The guest speaker was Dr Haydn Perndt and Dr Steve Kinnear was presented with the Gilbert Brown Award from the Australian Society of Anaesthetists (ASA).

Tasmania

Clinical teaching workshop
An all-day workshop was conducted as part of the Tasmanian Regional Committee (TRC) combined ANZCA / ASA Annual Scientific Meeting. Mary Lawson (Director of Education at ANZCA) gave a series of practical teaching workshops. The theme of the meeting was effective feedback and assessment. It complimented a dedicated registrar workshop on effective feedback held two days previously as part of the same ASM. The timely combination of these workshops will be very useful for translating some of what was learnt into everyday clinical and teaching practice. Departmental directors, supervisors of training and interested clinical teachers attended the workshop.

The next clinical teaching workshop is scheduled for mid-year in Launceston.

Registrars workshop
As part of the February ANZCA/ASA Combined ASM, Tasmanian trainees were invited to participate in a half-day seminar with the ANZCA's Director of Education, Mary Lawson. A good-humoured afternoon session concentrated on trainees receiving feedback and actively seeking feedback from supervisors. Trainees were also updated on the current projects of the Education Development Unit and had an opportunity to ask questions about the College.

Joint ANZCA/ASA Committee and Presidents:

Back row from left: Dr Mark Reeves (Chair, ANZCA Tas.), Dr David Brown (Treasurer ANZCA/ASA Tas.), Dr Richard Waldron (Treasurer ANZCA), Dr Stuart Day (Chair, ASA Tas.) Dr Stephen Reid (Director of Anaesthesia, Royal Hobart Hospital), Dr Chris Wilde (Chair, Trainee Committee Tas.).

Front row from left: Dr Susannah Sherlock (ANZCA Committee), Dr Leona Wilson (President of ANZCA), Dr Liz Feeney (President of the ASA), Dr Lia Freestone (Secretary of ANZCA/ASA Tas.), Dr Andrew Mulcahy (ASA Vice-President).

Supervisors of training and trainees at an Orientation to Anaesthesia, held on Friday, February 27 2009 at the College.

1. Dr Abhay Umranikar, Dr Michael Shaw and Dr Tony Leaver.

2. Dr Rachel Shanks, Dr Liam Broad, Dr Auday Hasan and Dr Ravi Ramadas.

3. Dr Rick Horton and Dr Maggie Wong.

Victoria

The new year commenced with the final full-time course for advanced trainees. The course was well attended and included trainees from around Australia.

Key event dates:

Courses
April 6, 8, 15, 20: Primary Trial Orals
May 11, 13, 18, 20: Final Trial Orals
May 11–22: Primary Full-time Course

Continuing Medical Education (CME) and events
April 29: Matthew Chan (ANZCA House) – Topic: 'Hot Air – Full Steam Ahead'

May 16: Airway Workshop for Fellows and trainees (ANZCA House)

July 25: ASA/ANZCA Combined Meeting (Sofitel, Melbourne) – Topic: 'Anaesthesia Right Now – A Clinical Update'

September 25: Anaesthetic Registrars Scientific Meeting (ANZCA House)

Details and registration forms can be found at *www.vic.anzca.edu.au/training*

An orientation to anaesthesia was held on 27 February at the College. The event was well attended by trainees and supervisors of training.

Trainees
Obstetrics and Paediatric Anaesthesia Training Scheme (OPATS) 2010
Applications are invited for a position in the above training scheme which is coordinated through The Royal Women's Hospital, Monash Medical Centre and The Royal Children's Hospital. Applicants should have completed 24 months of accredited anaesthesia training and hold their Part 1 FANZCA.

This training scheme is aimed at providing sub-specialty training experience in obstetric and paediatric anaesthesia for trainees in their third or fourth year of accredited anaesthesia training. All posts are accredited with ANZCA.

OPATS positions for 2010 will not be advertised in the newspaper in 2009. For information about selection for the 2010 program and/or an application form (once applications open), please contact:

Dr. Maggie Wong
Supervisor of Training
Department of Anaesthesia
The Royal Women's Hospital
Phone: 8345 2000
Email: maggie.wong@thewomens.org.au

Dr Damian Castanelli
Supervisor of Training
Department of Anaesthesia
Monash Medical Centre
Phone: 9594 6666.
Email: Damian.Castanelli@southernhealth.org.au

Important Dates for Obstetrics and Paediatric Anaesthesia Training Scheme (OPATS) 2010

Applications open: May 30 2009

Applications close: July 3 2009

Interview (to be held at ANCZA House): July 30 2009

Email applicants interim selection results: August 6 2009

Email applicants final rotations: September 18 2009

Victorian Trainee Committee
A new committee was created in February and it is organising a mentor or buddy system to promote the welfare of trainees.

Queensland

Part Zero Course – 'Zero to Hero', an introduction to anaesthesia
The Part Zero Course is held annually for trainees. This year's course convenor, Dr Chris Breen, brought together a varied program covering ten topics, presented by a devoted and willing group of anaesthetists. Topis covered included: the role of ANZCA, the Australian Society of Anaesthetists (ASA), QARTS, the training program and modules, passing the primary exam, welfare of anaesthetists, managing consultants, formal projects, surviving ICU and exam preparation courses.

Thanks to all the presenters for their contribution: Dr Jeremy Brammer, Dr Anton Loewenthal, Dr Tim Wong, Dr Mark Gibbs, Dr Genevieve Goulding, Dr David Belavy, Dr Joe Power, Dr George Pang, Dr Gamini Wijerathne and Dr Chris Breen.

Dr Chris Breen has produced an information booklet of the day. If you would like a copy, please contact Linda Cuffe at the ANZCA Queensland Office: qldevents@anzca.edu.au

Overseas Trained Specialist Anaesthetists Network (OTSAN)
OTSAN is an organisation formed by Overseas Trained Specialist Anaesthetists in 2006 as a non-profit, self-help group, aiming to facilitate professional and social integration in Australia. The aim is to assist in the areas of the FANZCA exam, immigration and visas, jobs and industrial relations, liaison with local and national bodies, integration and social networking.

OTSAN met on February 21 and 22 at ANZCA House in Melbourne. Delegates from South Australia, Northern Territory, Tasmania, Victoria, New South Wales and Queensland attended, making this OTSAN's tenth education meeting and its most successful yet.

Dr Sanjay Sharma, based at Ballarat Hospital, convened the meeting and organised a contingent of capable speakers to present a broad base of educational topics over the two days. Dr Rajesh Brijball, president of OTSAN, and Dr Sanjiv Sawhney were also involved with the organisation of the meeting remotely from Queensland. Dr Michael Steyn, originally from Scotland and Director of Anaesthesia at the Royal Brisbane and Women's Hospital, and Jill Humphreys, Executive Officer of IMGS Accreditation at ANZCA, were on hand to liaise with delegates. The meeting also gave delegates the opportunity to meet and discuss issues with others facing similar circumstances.

OTSAN endeavour to hold three 'education meetings' annually. The next meeting will be held in Brisbane on the weekend of July 18–19. The September venue is yet to be confirmed.

If you would like further information regarding OTSAN, please contact Dr Rajesh Brijball at rajesh_brijball@health.qld.gov.au

ANZCA/ASA Combined CME Committee of Queensland – 12th Annual Queensland Registrars Meeting
Twelve registrars presented their Formal Projects at the 12th Annual Queensland Registrars Meeting held on Saturday, February 28 at the ANZCA Queensland office. A diverse range of subjects were covered.

Dr Matthew Bryant and Dr David McCormack were announced as the winners of the Tess Cramond Prize. Dr Cramond made a speech (her last official engagement as she retired on March 1, 2009) and presented the doctors with their certificates.

Dr Mark Gibbs, the Regional Education Officer and Director of Anaesthesia at Ipswich Hospital, organised a new perpetual plaque with the title of 'Supporting Hospital of the Tess Cramond Prize Winner'. The plaque was presented to the Cairns Hospital this year.

Dr Diana Khursandi presented the Axxon Health Prize to Dr Marc Maguire. The 'ASA Chairman's Choice Prize' was awarded to Dr Marc Maguire and Dr Nick Hutton.

Dr Sarah Greenwood received a special mention for her interesting presentation on communicating with the deaf. Dr Andrew Jorgensen presented his projects as Principal House Officer and also received a special mention. Presentations were also made to Drs Petra Millar and Mark Dilda, Merit Winners of 2008.

New South Wales

Professor Garry Phillips visited the ANZCA Sydney office in early February to conduct a Workplace Based Assessment workshop. Dr Leonie Watterson assisted Prof Phillips explain the new program to the NSW Regional Committee.

A Clinical Teaching Course workshop "Teaching in Small Groups" will be run in the Crows Nest office in late March. This full-day workshop will explore ways in which small groups can be used as a method of teaching anaesthesia. The activities and discussion will focus on developing understanding of small group dynamics and strategies to promote maximum participation of all group members.

The Part II Refresher Course In Anaesthesia was conducted at Royal Prince Alfred Hospital from February 9–20. The two-week full time course was run for those trainees presenting for their Final Fellowship Examinations this year. The course was fully subscribed to, culminating on the final day of the course with an anatomy day at Sydney University. Courses planned for the remainder of this year include:

May 4–15: Primary Refresher Course In Anaesthesia (Royal Prince Alfred Hospital)

October 12–23: Primary Refresher Course In Anaesthesia (Royal Prince Alfred Hospital)

Date to be advised for the Part Zero 'Introduction to Anaesthesia' Course

This year the NSW ACE Committee is planning two major education meetings. On August 8 at the Sydney Hilton Hotel we will be hosting a day meeting on "Oxygen". This will encompass everything about oxygen from its storage and delivery in the hospital to the mitochondria in cells where it gets used and all the potential problems with delivery inside and outside the body on the way. Later in the year, on November 14–15, we will be hosting our first weekend meeting in Wollongong. In conjunction with a committed group of local anaesthetists, we will be running the weekend meeting on preoperative assessment, a subject that has relevance to all anaesthetists whatever their field of practice. We are also investigating the feasibility of one or two evening meetings throughout the year, with the dates, venues and topics yet to be decided.

Western Australia

Dr Jodi Graham with Anaesthetic Trainees during Part Zero Course.

WA Part Zero Course
The 2009 Part Zero Course, convened by the Group of ASA Anaesthesia Clinical Trainees (GASACT) Senior Representative Dr Ana Licina, was held at the Western Australian office on Thursday, January 29.

Coinciding with their orientation week, 15 first-year trainees attended the course. The aim of the course was to provide trainees with an introduction to the anaesthetic program – where to start, what to expect and a few hints on finding their feet.

Sponsored by Schering-Plough, the afternoon began with lunch and was followed by an introduction by Dr Licina and the ANZCA WA Trainee Committee Deputy Chair, Dr Emelyn Lee.

Thanks to Dr Suzanne Bertrand, Dr Rob Edeson, Dr Lindy Roberts, Dr Jodi Graham, Dr Daniel Ellyard and Dr Kevin Hartley for their participation.

GASACT Chair Dr Ana Licina with Part Zero Sponsor Barry Weinmann from Schering-Plough.

New Zealand

College representatives in Wellington for a meeting with the new Minister of Health, Hon Tony Ryall. Professor Alan Merry (ANZCA Councillor) Dr Leona Wilson (ANZCA President) and Dr Vanessa Beavis (Chair of the ANZCA New Zealand National Committee).

Matters raised with the New Zealand Minister for Health, Hon. Tony Ryall
The President of ANZCA, Dr Leona Wilson, Professor Alan Merry, New Zealand Councillor, Dr Vanessa Beavis, Chair of NZNC, and Heather Ann Moodie, New Zealand Executive Officer, met with the Minister for Health on February 17.

Perioperative Mortality Review Committee
ANZCA has been working with the Ministry of Health, RACS, RANZCOG and JFICM for a number of years to have a perioperative mortality review committee established. ANZCA strongly urged the Minister to support this important initiative.

Protected Quality Assurance Activities (PQAA)
Last year NZNC applied to the Ministry of Health for PQAA status for activities undertaken as part of the ANZCA CPD Program. Approval was delayed because of the Ministry's review of the HPCA Act and a change of government. Approval has been given for protection of the Australian and New Zealand Tripartite Anaesthesia Data Committee (ANZTADC) which has now been gazetted.

Workforce issues
ANZCA briefed the Minister on its current demand and supply of anaesthetists workforce study in Australia and foreshadowed a similar study in New Zealand in 2009.

Medical Council of New Zealand (MCNZ) – meeting with the MCNZ CEO and staff involved in IMGS assessment and supervision
On February 13, the ANZCA President, Dr Leona Wilson, the Director of Professional Affairs, Professor Garry Phillips and members of NZNC and staff held a meeting with the Medical Council CEO and staff in the New Zealand office to discuss the new ANZCA process for International Medical Graduate Specialists (IMGS) assessment, including the workplace-based assessment. ANZCA is keen to ensure that this new process can fit in with MCNZ IMGS assessment processes.

The meeting was very constructive and a number of issues were clarified. Supervision arrangements for IMGS were also discussed.

Supervision of IMGS
The Medical Council is seeking ANZCA's opinions on the supervision process for IMGS who are going through the vocational registration process in New Zealand, especially where the doctor is practising in the more isolated and small centres in New Zealand.

The proposed use of practice visits (Periodic Assessment of Performance) for all vocationally registered specialists
The MCNZ is currently consulting on its proposal to introduce periodic assessment of performance (PAP) as part of the CPD and recertification requirements. The ANZCA CPD Committee and NZNC have raised many important issues regarding this proposal and these have been submitted to MCNZ.

Submissions and consultations
NZNC has been involved in the following consultations and submissions this year.

- Medical Training Board discussion papers
- PHARMAC (Crown pharmaceutical management agency): Proposal to amend restrictions on musculoskeletal pharmaceuticals and to reduce the subsidy for EC aspirin
- Ministry of Health (MoH): nominations and or applications for the Perinatal and Maternal Mortality Review Committee for the one vacancy for a member with knowledge of Pacific Island health.
- Ministry of Health (MoH) Maternity Action Plan 2008–2012
- Medical Council of New Zealand (MCNZ) consultation: Draft statement for doctors on the subject of advertising
- Clinical Training Agency: Purchase Intentions 2009/10
- PHARMAC consultation document: "Relevant Practitioner" Pharmaceutical Schedule definition
- PHARMAC: Request for nominations for clinical advisors on volatile Anaesthetics
- MoH Report on the HPCA Act Review
- MCNZ consultation document: The proposed use of practice visits (periodic assessment of performance) as part of CPD
- MCNZ: Proposed new framework for the supervision of international medical graduates (IMGs)
- Health & Disability Commissioner (HDC) Review of the Act and Code
- New Zealand National Safe Medication Management programme: electronic prescribing – speciality requirements
- District Health Board NZ (DHBNZ) Workforce forecasting for anaesthetists
- NQIP Draft Guidance Document: Central Venous Catheter-related Bloodstream Infections

If any Fellows would like to read any of the discussion documents or the NZNC submissions, please contact Heather Ann Moodie at the ANZCA New Zealand office via email hamoodie@anzca.org.nz.

Dean's Message

It is with great pleasure that I report on the progress made towards the establishment of the College of Intensive Care Medicine of Australia and New Zealand (CICM). What follows will, I believe, show that the Board and staff of JFICM have taken very seriously the mandate of the Fellowship to establish CICM within a reasonable timeframe and in a responsible way. Before reporting on progress, it needs to be clearly stated that the progress made so far has only been possible with the great goodwill and support of both ANZCA and the RACP.

Progress
As previously reported, the CICM has been incorporated as a body limited by guarantee, with a robust constitution, which will serve it well in the future. On February 27 the current JFICM Board was appointed as the Interim Board of CICM. This will allow both Boards to operate in parallel, with gradual transfer of functions from the JFICM Board to the CICM Board over the coming months, so that a smooth transition is effected. The office bearers of the CICM Board are P.V. van Heerden, President, J.M. Myburgh, Vice-President and B. Venkatesh, Treasurer. The new Board members have had initial instruction in their duties, responsibilities and liabilities as directors of CICM and are ready to take on the challenges that face any new enterprise.

Timelines
With the above in place, there is now much hard work to be done to make sure the systems that support CICM functions are put into place over the coming months – e.g. IT systems, website, human resources. A suitable site must be found to accommodate the new College and be fitted out to a suitable standard. Whether to rent or buy premises is still under discussion and will clearly depend on the resources available to CICM when operations commence. All the documents to allow functioning of CICM are being put in place e.g. regulations, policy documents. There are many other details which the JFICM staff are working hard at getting ready for when CICM commences operations. It is envisaged that CICM will commence full functioning on 1 January, 2010. This date has been chosen to allow all procedures to be put in place and also practically, as the JFICM books are run on a calendar (and not a "financial") year, it will allow for clear delineation between JFICM/ANZCA finances and those of CICM. Subscription notices sent to Fellows at the end of 2009 will therefore be for CICM's account, as will any other potential financial call on Fellows to fund CICM. The actual financial requirements to commence operations are being determined and will inform the quantum of the 2010 subscriptions and the need for a financial call on Fellows. Hopefully this will be clearer by the time of the AGM held in Brisbane in June this year.

CICM symbols
The JFICM staff are putting a lot of energy into developing a suitable coat of arms and a crest for CICM. Once ideas have been developed, then a few designs will be presented to the Fellows and Trainees to vote on. It is also planned to have a competition for the best motto for the new College.

Hong Kong Committee
The election of Prof. G. Joynt, from Hong Kong to the Board of JFICM, and now CICM, has already paid dividends in that a new Hong Kong Committee has been established to foster the interests of Fellows and Trainees in Hong Kong. We look forward to the further development of this committee for the benefit of JFICM/CICM in Hong Kong.

Trainee Committee
On a slightly less positive note, the Board is very concerned about the degree of apathy among trainees with regard to being involved with the Trainee Committee (TC). The TC is very important to the Board, as this is the mechanism by which the Board is kept informed of matters of interest and concern to trainees. Clearly the Board can set up the structure for trainee representation, but is somewhat powerless to coerce trainees to take advantage of the opportunity to express their views. Trainees are invited to discuss any matters that may improve the lure of serving on the TC with any member of the Board or with the JFICM staff on +61 3 9530 2861.

ASM June 2009
Plans have been finalised for the JFICM 2009 ASM and AGM to be held in Brisbane from 12–14 June 2009. The title of the ASM is "Energy Crises Large and Small. Metabolism, Microbiology and Sepsis." The meeting promises to offer an excellent programme of speakers and all the benefits of networking with other Fellows and Trainees.

I warmly invite you all to join us in Brisbane in June and I look forward to seeing you there.

Prof. P.V. van Heerden
Dean, JFICM
President, CICM

The February meeting of the Board of the Joint Faculty of Intensive Care Medicine was held in the Ulimaroa Boardroom on Thursday, February 26. Dr Leona Wilson, President of ANZCA and Dr Peter Hicks, President of ANZICS, attended the meeting.

Admissions to Fellowship
The Board approved admission of 19 New Fellows to the Joint Faculty, including two who were admitted as Fellows by examination in Paediatric Intensive Care Medicine.

Financial Results for 2008
Jess McKay, the ANZCA Director of Finance, informed the Board that the final figures for the Joint Faculty's finances for 2008 should end up being close to budget, which is an operating surplus of around $85,000. Income for the year was down on budget due to a lower than anticipated income from examination fees, however this was offset by savings in a number of areas, including staffing costs, travel and accommodation. Ms McKay stressed that at this stage the results were provisional and subject to audit.

2009 Annual Scientific Meeting
Planning for the JFICM 2009 ASM, to be held in Brisbane from June 12–14 is well underway, with registration brochures about to be posted. The theme of the meeting is to be 'Energy Crises Large and Small' with a focus on showcasing local and international research into metabolism and endocrine function as they relate to the critically ill. The local organising committee, led by Scientific Convener Professor Rob Boots, has done an excellent job of assembling an impressive array of speakers, including international keynote speakers Professor Djillali Annane, Dr Frank Martin Brunkhorst and Professor Marin Kollef.

A highlight of the JFICM ASM is the conference dinner, which includes the graduation ceremony for new JFICM Fellows and the presentation of awards. This year the G A (Don) Harrison medal for the best performing candidate at the Fellowship Examination will be presented to Dr Edward Litton (May exam) and Dr Sara Allen (October exam). The Oration at the Graduation Ceremony this year will be delivered by Dr Carole Foot.

The ASM will be preceded by the second JFICM New Fellows Conference, which will be held at Coolum from June 10–11. Immediately following the conclusion of the ASM, on Sunday afternoon (June 14) a Supervisors of Training workshop will be held at the conference venue.

JFICM Medal
The Joint Faculty of Intensive Care Medal is awarded to recognise an outstanding contribution to the specialty of intensive care medicine. The Board enthusiastically supported the proposal to award the JFICM Medal for 2009 to Dr Felicity Hawker, who was the inaugural Dean of the Joint Faculty. Dr Hawker will be presented with the award at the ASM dinner.

2010 Annual Scientific Meeting
Planning is underway for next year's ASM, which is to be held in Sydney from 4–6 June. Dr Deepak Bhonagiri is the scientific convener.

Upcoming Examinations
Forty-six candidates have entered for the first Fellowship Examination for 2009, which will be held in Brisbane, 28–29 May (Oral section). The written section will be held at various locations on 3 April.

Ten candidates have entered for the first Primary Examination for 2009, which will be held in Melbourne on 1 May (Oral section). The written section was held on 2 March.

Honorary Fellowship
The Board received a proposal to make the award of Honorary Fellowship to Professor Napier ('Nip') Thomson in recognition of his contribution both to the development of the Joint Faculty and also to the field of renal and transplant medicine. The Board voted unanimously in support of this proposal. Professor Thomson will receive his Fellowship at the conference dinner at the ASM.

Intensive Care Foundation update

Intensive Care Appeal 2009
The Intensive Care Appeal will be held from April 14–27 with Intensive Care Day taking place on Friday, April 24. The theme for this year's Appeal is 'I thank you' and gives Australians and New Zealanders the opportunity to say thank you to those ICU teams who have saved their lives or that of a loved one. This year merchandise boxes will contain pens only, with key tags and wristbands available upon request. Pens will be priced at $3 per item.

All ICUs are encouraged to celebrate the Appeal to help raise funds to ensure the Foundation can continue to fund research well into the future.

If you like further information please contact Hayley on +61 3 9340 3444 or via hayley@intensivecareappeal.com

Annual ICU Donation
All ICU Directors across Australia and New Zealand will have received a letter encouraging their ICU to make an annual donation of $1,000 to the Intensive Care Foundation. This donation will go directly to research in intensive care.

This initiative has been brought about due to the overwhelming number of requests for funding received every year. With your help the Foundation will be able to fund more projects in Australian and New Zealand, projects that your hospital or colleagues will be involved in.

Thank you to those ICUs who have already begun supporting this initiative – your donations and commitment are much appreciated. For those wishing to find out more, please contact Tracy on +61 3 9340 3444 or tracy@intensivecareappeal.com

2010 research grants
Applications for 2010 Foundation grants opened at the end of January with submissions due Friday 29 May 2009. Application forms and guidelines are available on the Foundation's website at *www.intensivecareappeal.com*

Critical Splash
Dr Stuart Lane, Intensive Care Specialist at the Nepean Hospital and Senior Lecturer in Critical Care at the University of Sydney, will be undertaking the "Everest of open-water swims", The English Channel, in August this year to raise funds for the Foundation.

To support Stuart visit *www.intensivecareappeal.com* to find out how you can help raise much needed funds for intensive care research.

Dean's Message

After difficult economic times in 2008, people were looking forward to the new year of 2009, but that has been marred in Australia, once again, with Mother Nature controlling the forces of this massive country. The fires in Victoria have been devastating and the floods in the north have also created widespread heartache. Attending the College in Victoria during February, one could tell from the smell of smoke in the air, the haze and the red moon that things were still not under control. To all those people who have lost loved ones or other precious things, our thoughts are with you all. As medical practitioners we need to give in whatever way we can to support those affected, be that time, effort or economically.

With the week of intense heat in South Australia, and temperatures hitting 47 degrees, I was lucky enough to be away in Hawaii attending the American Academy of Pain Medicine (AAPM) Meeting. Seven Fellows from Australia attended their meeting and were all made to feel incredibly welcome. The AAPM awarded Roger Goucke a Presidential Commendation recognising leadership in establishing cross cultural connections between FPM and the AAPM. Nik Bogduk received a Founder's Award for outstanding contributions to the science or practice of Pain Medicine.

Roger and I were invited to attend the AAPM and ABPM Board Meetings and also their Examination Committee Meeting, and Colin Goodchild and Roger attended the Editorial Board Meeting. The Faculty started liaison with the American Academy and the American Board of Pain Medicine (ABPM) in 2000 through our journal Pain Medicine. The impact factor of this journal has risen from .68 in 2003 to 2.741 in 2007.

Michel Dubois, the President of the ABPM attended our examination at St Vincent's Hospital in Sydney in November of last year and was very impressed with the whole process and the time and dedication put in by all examiners. At this point the ABPM believe the cost of transporting that process to North America to be prohibitive. Interestingly, they have approximately 200 Fellows attending their examination each year and their examination comprises two, three-hour multiple choice question papers.

It became obvious in discussion that

Dr Penelope Briscoe

their training program is also not as structured as ours and does vary across North America, and so I think we, as a small Faculty, can be incredibly proud of the training and assessment process that we have developed for our young doctors.

As part of the meeting there was a Pacific Rim dinner attended by Roger and myself, several other FPM Fellows and members of the AAPM and a number of doctors from mainland China, including Professor Han from Beijing. The aim of this dinner was to encourage two-way communication so that we can all work together to promote the speciality of Pain Medicine in our countries. In mainland China, Pain Medicine is now recognised as a speciality (as in Australia) and any teaching hospital over a certain size must have a pain clinic within it. They have also recently run their first exam and had 600 candidates. However, the pass rate for that exam was approximately 30%.

North America is yet to have Pain Medicine recognised as a specialty and so they are organising a national summit under the guidance of the American Medical Association, to push the cause of Pain Medicine in the United States. Once again Australia can be justifiably proud of the fact that, with the hard work of a number of our Board Members and Garry Phillips (ANZCA Director of Professional Affairs), we have been able to attain Australian Medical Council recognition of Pain Medicine as a specialty in Australia. We are now working on the same process for New Zealand.

Ten years since the Faculty was formed, we have come a long way and this has been due to the hard work of our Board, and I would like to acknowledge in particular, Roger Goucke and Milton Cohen who have decided after 10 years on the Board that they need to retire to allow new young blood to come on and also to allow succession planning to occur. I thank them for their contribution which has been immense and although they are both retiring from the Board I know they are going to be continuing to contribute to the Faculty in a number of ways.

It is also my pleasure to announce that we had six nominations for the six vacancies on the Board this year and therefore do not have to go to election. The two new Board Members are Raymond Garrick from Sydney, who has been on the Examination Panel for a number of years and for the last 12 months has been the Chair of Examinations, and Guy Bashford from Wollongong, who has been a contributor to Pain Medicine in Australasia for many years. Ray and Guy are both Fellows of the Royal Australasian College of Physicians; Ray is a neurologist and Guy through the Rehabilitation Faculty, and I think this is extremely timely as we as a specialty need to involve our parent colleges more. I'm hoping that Ray and Guy, with input from Carolyn Arnold (who was re-elected to the Board), can work with the RACP to raise our profile and to encourage its younger Fellows to get involved with the Faculty.

Leigh Atkinson has been working diligently with the Royal Australasian College of Surgeons and, in fact, has negotiated a memorandum of understanding to the sum of $23,500 over the 2009-2011 triennium for a Pain Medicine Program as part of their Annual Scientific Congress

This year, the FPM ASM Visitor for Cairns, Dr Andrew Rice, will be flying to Brisbane to present at the RACS meeting, as will several other Fellows of our Faculty. RACS has also linked their website to ours so that their Fellows can access a number of our professional and educational documents and I would therefore like to thank Leigh for his tireless efforts in raising our profile with the College of Surgeons.

The Board continues to receive applications from many people for Fellowship either by election or through the training program. Two years ago, we added both the Royal Australian College of General Practitioners and the Royal New Zealand College of General Practitioners to specialty groups who could apply to do training, and once they have passed the process go on and be awarded Fellowship. We currently have three general practitioners training. We have also had a number of enquiries from other specialty groups and our regulations state that people who have an Australasian specialist qualification acceptable to the Board can enter training.

In addition, for people who have been in practice for a while and do hold an Australasian specialist qualification, we have now introduced a new pathway by which they can be granted Fellowship. This involves the candidate applying for election via the normal process (see Regulation 3.2). The Board can decide, after having viewed the information provided by the candidate, to elect them directly to Fellowship or to offer them the process by which they can register with the Faculty for six months, be provided with the usual training documentation and then, upon completion of the examination process and case report process, be granted Fellowship without further training.

This pathway is to encourage people, who perhaps have been in clinical Pain Medicine practise equivalent to at least three years FTE and are unable to go back and enter a training program, that they can apply for and be awarded Fellowship by completing the above requirements. As a Board, we feel we should encourage people who would like to gain Fellowship, to assess whether or not they meet our requirements and then to apply for election with a detailed CV and confirmation of their Pain Medicine experience and then the Board can make the decision.

The examination is a rigorous process and does encompass the practise of acute, cancer and persistent pain, but the feedback we have from the candidates who have sat the exam is that they do believe that it is fair (but rigorous), and so this new pathway may encourage practitioners who have not met the criteria for election previously to reapply.

I would like to take this opportunity to acknowledge the retirement of Professor Tess Cramond who has contributed to Pain Medicine practice for over 40 years. Those of us involved in Pain Medicine in Australasia have all been aware of Tess's enthusiasm and her great success in encouraging young doctors in Queensland to undertake Pain Medicine training through her unit. We wish her all the very best in her well-deserved retirement.

I would also like to acknowledge the hard work of all Fellows who contribute to the Faculty in so many ways. We are a small Faculty and we do need the support of all our Fellows and so, if currently you are not contributing to the Fellowship, please feel free to contact myself or Helen Morris and we will be able to utilise you in some role for our Faculty.

Penelope Briscoe
Dean

likewise admitted as an honourary Fellow of the Australian Chapter of Palliative Medicine (RACP) for her contribution to the development of palliative medicine. Throughout her illustrious career, she has been honoured by many bodies in recognition of her contributions to both the anaesthetic community and the general community. The College/Faculty honoured Prof Cramond with the Gilbert Brown Prize in 1967 and the Robert Orton Medal in 1987. The Orton Medal is the highest award the Faculty can bestow on a practicing Fellow. At a government level, she has been honoured with an Order of the British Empire (OBE) in 1977, Officer of the Order of Australia (AO) in 1991 and a Centenary Federation Medal in 2003.

Refresher Course Day – May 1 2009

The Faculty will hold its seventh annual Refresher Course Day in Cairns preceding the ANZCA ASM. The meeting theme is 'Unravelling the Chaos of Pain'. The program is headlined by international guests, Professors Andrew Rice, Steven Passik and Rollin Gallagher, and complemented by national leaders in neuroradiology, pain and addiction medicine. The registration brochure is available online or by contacting the Faculty office.

Spring Meeting in Melbourne

Plans are underway for the Faculty's 2009 Spring Meeting in Melbourne. The theme will be 'Duelling with Pain', aiming to strengthen the ties and improve communication between the groups as we learn to better manage challenging patients. Contact Marta Dziedzicki, Meeting Coordinator via email: mdziedzicki@anzca.edu.au or on +61 3 8517 5308 for more information.

NSW Regional Committee Faculty of Pain Medicine

The NSW Regional Committee Faculty of Pain Medicine, having been constituted last year, held its first meeting in February 2009. Issues of importance to trainees and fellows are being identified. We aim to hold a dinner social function for our Fellows possibly in July which would allow Fellows and trainees to meet in an informal setting and discuss FPM issues and understand the role of the committee. An educational session is being planned later in the year. A communication bulletin "The Algometer" will be published three times a year to keep Fellows abreast of recent developments. The committee will also participate in the coming AMA Careers Day in conjunction with Anaesthesia and we hope to raise the profile of Pain Medicine and attract recruits to the speciality in time to come. Pain medicine tutorials geared towards the fellowship exams under the guidance of Dr Paul Wigley will commence shortly in Royal North Shore Hospitals and all trainees are encouraged to attend.

Report from the Board Meeting held on 16 February 2009

Faculty Board

Dr Penelope Briscoe was re-elected as Dean for a second year.

Following a recent call for nominations for the Faculty Board, there were six nominations for the six vacancies, therefore a ballot will not be required. The New Board will take office following the Annual General Meeting in May and will comprise:

* Carolyn Ann ARNOLD, FAFRM RACP, *Victoria*

* Rupert Leigh ATKINSON, FRACS, *Queensland*

* Penelope Anne BRISCOE, FANZCA, *South Australia*

Christopher HAYES, FANZCA, *New South Wales*

* David JONES, FANZCA, *New Zealand*

Brendan Joseph MOORE, FANZCA, *Queensland*

Frank James NEW, FRANZCP, *Queensland*

Edward Archibald SHIPTON, FANZCA, *New Zealand*

** Guy Michael BASHFORD, FAFRM RACP, *New South Wales*

** Raymond GARRICK, RACP, *New South Wales*

* Re-elected unopposed
** Elected unopposed

Dr Roger Goucke and A/Prof Milton Cohen did not seek re-election and will retire from the Board in May.

Regions are to be encouraged to form a Regional Committee and if they are not represented on the Board, the Chair of that Committee can be invited to attend.

Relationships Portfolio

Physician representation on the Board
To reflect the recent reorganisation of the Royal Australian College of Physicians and the fact that the predominant physician group in the FPM is rehabilitation medicine, it was resolved to revise Regulation 1.1.3 pertaining to representation on the Board to read: "At least two shall be Fellows of a Division or a Faculty or a Chapter of the Royal Australasian College of Physicians (RACP)."

Divisions: Adult Medicine; Paediatrics and Child Health

Faculties: Rehabilitation Medicine; Public Health Medicine; Occupational and Environmental Medicine; Sexual Health Medicine

Chapters: Addiction Medicine; Palliative Medicine

Liaisons with Colleges
Professor Michael Murphy, President of the Neurosurgical Society of Australasia, met with the Board to discuss opportunities for dialogue and collaboration between the two organisations. Four neurosurgeons have now completed training in Pain Medicine and there was discussion about how the Faculty might become more relevant to all neurosurgeons.

RACS have included a link to the Faculty and FPM Resources in their recently re-launched website. Communications are ongoing to coordinate the FPM ASM Visitor's participation in the RACS ASC in Brisbane.

The Faculty is developing a document in conjunction with RANZCOG promoting the value of interdisciplinary and multidisciplinary pain clinics as being best practice for the management of pelvic pain.

The working paper on *Prescription Opioid Policy: Improving management of chronic non-malignant pain and prevention of problems associated with prescription opioid use*, developed by the Australasian Chapter of Addiction Medicine with FPM input, has been published and is about to be launched.

The Faculty has provided support to Canadian-based Fellows in their efforts to establish Pain Medicine as a recognised specialty in Canada.

Trainee Affairs Portfolio

International Medical Graduates
Following advice from the Chair, ANZCA IMGS Committee, the Faculty has been informed that trainees with a UK or Irish anaesthesia Fellowship who would be assessed at interview as having "Advanced Standing towards Substantially Comparability" to FANZCA may, having completed at least 12 months training in a Faculty-accredited training unit within Australasia, satisfactory In-Training Assessments, examination and Case Report

Report from the Board Meeting held on 16 February 2009

Continued

requirements, be awarded FFPMANZCA. However, these candidates will be advised that they cannot practice anaesthesia within Australasia without meeting the requirements of the ANZCA IMGS process.

ANZCA Curriculum Review
The Dean had made a submission to the ANZCA Curriculum Review on behalf of the Faculty after consultation with a number of FANZCA FFPMANZCAs. Submissions from the Acute Pain SIG and other Faculty Fellows were also among the 121 submissions received from a wide range of groups and highlighted the key challenges which need to be addressed.

Training Unit Accreditation
Royal Melbourne Hospital (Vic) and Concord Repatriation Hospital (NSW) were re-accredited for a further three-year period. The Royal Children's Hospital, Melbourne was re-accredited for a period of 12 months followed by a paper review.

During a review of chronic pain management services in Victoria it has become evident that funding for chronic pain is a real concern in creating positions for pain specialists. Funding arrangements within the state vary significantly and the government has expressed reluctance to increase available funds. The Department of Human Services has engaged Aspex Consulting to undertake this review and the Dean and several Victorian Fellows have provided input. A report is pending.

Examination
The 2009 Examination venue was confirmed as Royal North Shore Hospital on 25–27 November. The Pre-Examination Short Course program at the Royal Adelaide Hospital will now run over two-and-a-half days. Dates for 2009 have been confirmed as 9–11 September.

Fellowship Affairs Portfolio

Fellowship

New Admissions
Six new Fellows were admitted to Fellowship taking the number of Fellows admitted to 260.

Alternative Pathway
Further to earlier advice that the Board was exploring reestablishment of the Alternative Pathway for applicants for Election to Fellowship who have been working in Pain Medicine, have a qualification acceptable to the Board, but whose knowledge base is not clearly known to the Board, Regulation 3 has now been amended. Applicants are invited to apply for election by the normal process under Regulation 3.2. The Board may then either award Fellowship directly (Regulation 3.2.1) or following satisfactory completion of examination and case report requirements without further training (Regulation 3.2.2). Applicants will be considered through the Election to Fellowship application process.

Honours and Appointments
The Board acknowledged and congratulated the following recipients:

- Professor Alan Forbes Merry – appointed as an Officer of the New Zealand Order of Merit (ONZM) in recognition of services to medicine, in particular anaesthesia.
- Professor Michael J Cousins – awarded the Orton Medal by ANZCA Council for distinguished services to anaesthesia which will be conferred during the Cairns ASM.
- Dr Roger Goucke was awarded a Presidential Commendation by the AAPM, recognising leadership in establishing cross cultural connections between FPM and the AAPM.
- Professor Nikolai Bogduk – AAPM Founders Award for outstanding contributions to the science or practice of pain medicine.

Pain Medicine Specialist
The Board discussed the issue of non-Fellows using the term "Pain Medicine Specialist" and this was highlighted as an issue requiring vigilance with concerns about confusing the public. It was agreed that the Faculty should be proactive and notify registration bodies in Australia and New Zealand that FFPMANZCA is a rigorous qualification and that those without it should not be permitted to advertise themselves as pain specialists. There was discussion of using an alternative title such as "Consultant Physician in Pain Medicine" or "Pain Medicine Physician" and this will be explored further as part of a brief on promoting the Faculty.

Research

Standardised Outcome Measures in Persistent Pain
Alfred Health (Victoria) and Hunter Integrated Pain Service (NSW) and a number of centres around the county will proceed with a pilot core outcomes database project. A number of database issues are currently being addressed. Further details will be published in Synapse in due course.

Professional

Recognition of Pain Medicine as a Specialty – New Zealand
The application is now in the final stages of drafting with the support of Dr Steuart Henderson, ANZCA Director of Professional Affairs, and is being progressed as a matter of urgency.

National Pain Summit
A number of Board Members will participate in a Pain Summit Committee which will also include APS, MDF and nursing representation. The National Summit, being organised by the Pain Management Research Institute in partnership with the MBF Foundation, will now proceed in 2010, however a date and venue have yet to be confirmed. Involvement of physicians and surgeons and the Faculty Regional Committees will be sought.

AMC Good Medical Practice: Code of Conduct
The AMC are currently analysing submissions and the results of the consultations but have not nominated a specific date for the release of a further draft at this stage. The latest information is available at *http://goodmedicalpractice.org.au/consultation/*

Continuing Education & Quality Assurance

Scientific Meetings
2009 ASM
Registration brochures for the Refresher Course "Unravelling the Chaos of Pain" have been circulated and registrations have commenced. Dr James Seymour has been invited to speak on Irukandji at the 2009 Faculty Dinner.

2009 Spring Meeting
Planning for the Faculty's Spring Meeting at the Sofitel Melbourne, 16–18 October 2009 are well underway. The International Visitor will be Dr Roman Jovey MD, Medical Program Director CPM Centres for Pain Management, Immediate Past-President of the Canadian Pain Society, Ontario, Canada. The meeting theme will be *"Duelling with Pain"* with sessions focused on capturing the interest of pain physicians, anaesthetists and addiction medicine specialists.

2010 Spring Meeting
It was resolved that the 2010 meeting will be held in the Hunter Valley with Dr Chris Hayes as Convenor.

Resources Portfolio

Finance
The Board met by teleconference on 3 December to ratify the 2009 Budget and subscription and fee structure. It was resolved that the FPM Subscriptions for 2009 be increased by 7.5% but with an increase of 5% for Fellows who pay within four weeks of the due date of 1 January 2009. It was also resolved that the FPM Examination fee be increased by 7.5% and that other FPM Fees be increased by half of the percentage increase agreed upon for ANZCA fees. ANZCA Council had agreed to the Faculty raising its subscription and fees by half of the percentage increase agreed upon for ANZCA taking into account the Faculty's concerns that its Fellows are paying subscriptions to both the Faculty and their primary specialty.

At the February Board Meeting, the Financial Reports to 31 December 2008 were accepted. The Board noted that the higher than budgeted surplus was a result of the high level of attendance at Faculty CME events and a successful cost reduction program.

OBITUARY

Dr Russell Geoffrey Cole

1920–2008

Photo: The Royal Melbourne Hospital Archives

Russell Geoffrey Cole, who died on November 2, 2008, was born in Melbourne on October 28, 1920. He was educated at Scotch College and subsequently at the University of Melbourne. He is well-remembered by fellow medical students as an engaging, extroverted and convivial companion.

He graduated as MBBS in 1944 and forthwith elected to serve the country in the Royal Australian Navy as medical officer in MAS Bataan until 1948 and became a Surgeon Lieutenant. Throughout his career, Russell Cole maintained his association with the Royal Australian Navy (RAN) after being appointed Senior Anaesthetic Specialist to the RAN in Victoria, and was a member of the Volunteer Reserve with the rank of Surgeon Lieutenant Commander. In 1964 he was awarded the Volunteer Reserve Officers Decoration, RAN and in 2000 the Australian Service Medal 1945–75.

During the Vietnam War, he further served for a period on secondment from the navy to the army in Vietnam where he worked as an anaesthetist at the Vung Tau Hospital in Vietnam and participated in many hair-raising episodes of helicopter retrieval of injured soldiers.

In 1949 he returned to Melbourne and was appointed a demonstrator in anatomy at the University of Melbourne and clinical supervisor at The Alfred Hospital. Soon after, in 1950, he commenced his long association with the Royal Melbourne Hospital up to his retirement in 1987. At that time Russell Cole, along with the late Dr Alfred Nathan, were appointed as the first anaesthetic registrars in the newly established Department of Anaesthesia, the first in Victoria under a full-time director. This department was initiated with the recognition that the existing staffing by visiting anaesthetists could no longer cope with the increasing demands and complexities of contemporary surgery, particularly the expansion of thoracic surgery and neurosurgery.

In 1951, Russell Cole traveled to London and worked as an anaesthetic registrar at St Thomas' Hospital where he obtained the Diploma of Anaesthetics (DA) and subsequently in 1954 attained the Fellowship of the Faculty of Anaesthetists of the Royal College of Surgeons. This was the start of his long and happy association with St Thomas' Hospital where he later worked for two six-month sabbatical periods and renewed treasured friendships.

Upon his return to Melbourne in 1952, he readily obtained the DA of the University of Melbourne and became a Fellow of the Faculty of Anaesthetists, Royal Australasian College of Surgeons in 1956 and subsequently a Fellow of the Australian and New Zealand College of Anaesthetists in 1992.

In 1952, he entered part-time practice with the Melbourne Anaesthetic Group, a group of private anaesthetists. After becoming an assistant honorary anaesthetist at the Royal Melbourne Hospital, he was promoted to full honorary status in 1954 and also held appointments at the Footscray and District Hospital (now Western General Hospital) and the Repatriation General Hospital and in 1953 became Acting Director of Anaesthetics at the Royal Women's Hospital. Just as the management of cancer pain was pioneered in Sydney by Brian Dwyer, Russell Cole became his counterpart in Melbourne, having had a long interest in the anatomical basis of nerve blocks and having published informative articles on the relief of intractable pain by nerve block.

In 1962, he decided to change direction. He ceased private anaesthetic practice, and was appointed a full-time executive medical assistant at the Peter MacCallum Cancer Hospital with duties that included supervision of the Consultant Pain Relief Clinic, in which he maintained a deep interest until his retirement.

In 1965, Russell Cole was appointed Director of Anaesthetics at the Royal Melbourne Hospital, succeeding the legendary Norman James, a post which he held until 1980. Thereafter he remained as a senior staff specialist until his formal retirement in 1985, after which he was appointed a Consultant Anaesthetist to the Hospital. He continued medical activities for a further several years, including medical officer to Pentrige Prison, endoscopy lists and surgical assistance.

Russell Cole was an inveterate traveller. In addition to his time at St Thomas' Hospital, he held appointments as a Fellow at the Mayo Clinic, Rochester NY, as a Visiting Professor at the South Western Medical School in Dallas, TX, and he delivered popular lectures on chronic pain management in many centres in South Africa and South East Asia. He also provided anaesthetic support for eye surgery on indigenous patients in the Northern Territory, Australia.

Russell Cole's committee activities included membership in 1956 of the Victorian Regional Committee of the Faculty of Anaesthetists, anaesthetic advisor to the Standards Association of Australia, and a representative for Australia on the Australian-Asian Committee of the World Society of Anaesthesiologists. He was an extremely social person who attracted the friendship of anaesthetists and surgeons alike in his sphere. Indeed, as well as his procedural skills, this was the foundation of his successful tenure as Departmental Director.

Physically, Russell Cole was an extremely robust individual who strongly believed in the benefits of physical exercise. He was never to be seen catching a lift, despite the location of the operating theatres on the ninth floor of the hospital. His numerous sporting activities included tennis, skiing and golf, all undertaken at a high level of skill. Although always courteous and accommodating and easy to communicate with, he did not compromise on his Wednesday afternoon appointment at Kooyong Tennis Club, whatever the rostering policies might dictate.

It was therefore a sad blow that on the golf course in 2000 he suffered a cerebrovascular event that left him with a physical infirmity which he endured for his final eight years. To his great credit he adjusted to his incapacity and continued to interact with his many friends and colleagues and continued traveling abroad. His wife, Tup, was devotedly supportive in his latter years and she and her daughters, Rowena and Victoria, have our deepest sympathy.

Dr Patricia Mackay
December 2008

OBITUARY

Dr Nalin Rohitha Wijeyesekera

1943–2008

Dr Nalin (Wijey) Wijeyesekera was born in Colombo, Sri Lanka (then Ceylon) in 1943. He was the fourth son of Nicodemus Wijeyesekera, a prominent public health specialist. Sadly, his much loved father died when he was 11 years old. Nicodemus Wijeyesekera was keen that his sons become doctors also and this paternal wish influenced the young Wijey. He studied medicine in the Faculty of Medicine, University of Ceylon (Colombo) from 1963 to 1968, graduating MB.BS. in 1969. He began his anaesthesia training in Colombo and passed the London primary FFARCS. In 1971, he passed the ECFMG and in that same year he became aware that the UK was to change its immigration laws meaning that subjects of former British colonies would no longer have entry rights. Wijey wished to continue his anaesthesia training in the UK so at some personal cost immediately left Ceylon for London and obtained full registration with the GMC in 1972. The desire to further his training in the UK and the pending immigration law changes meant that his newly-formed family was separated for a while. His wife, Deepti, was not to join him in London until 1973 and their three-year-old daughter, Shamila, joined them in 1974. His first anaesthetic job in the UK was as a registrar in Whittington Hospital, London. Wijey obtained his Final FFARCSI in 1978. In 1980, following a brief stint in the USA, Wijey was appointed as a consultant anaesthetist in Wellington Hospital, New Zealand. He was awarded FFARACS in 1984 (FANZCA in 1992). He continued in anaesthesia practice in Wellington until 2008.

Wijey's special interest was neuroanaesthesia and he formed a close partnership with prominent Wellington neurosurgeon Balakrishnan that lasted a practicing lifetime. He enthusiastically volunteered his skills for the newly formed neurovascular and craniofacial unit with David Glasson and Balakrishnan. His calmness and close contact with the neurosurgeons while performing complex neurosurgery, especially surgery in sitting position, made all the surgeons feel very comfortable working with him. His reputation and techniques for neuroanaesthesia in the sitting position were widely recognised in other neurosurgical units in New Zealand.

Wijey's high level of skill, experience and his calm and patient nature endeared him to all of his anaesthetic, surgical, nursing and technical colleagues and also to generations of Wellington anaesthetic trainees. Wijey was of the school of anaesthesia where unless you looked carefully you would never be aware of his actions; he was the antithesis of anaesthetic flamboyance. This did not mean that his skills were not of the highest order, quite the contrary. In his last 10 years of practice, Wijey divided his time between Wellington Hospital and private anaesthesia practice. He continued in private practice after his retirement and was still working clinically until a few months before his final illness.

Going to work as an anaesthetist was a pleasure to Wijey, and he took genuine pleasure from the daily badinage that is part of hospital life. Sadly, he was predeceased by his adored wife Deepti who died three years before his illness. Her loss deeply affected Wijey, although of course that would not have been obvious except to those who knew him well. Wijey was a great traveller and intensely interested in what was happening in other countries. He tended to couple his travelling with work as an anaesthetist and would use his annual leave to do locums in other countries, doing this work in Canada, the Netherlands, Sweden, Australia and Saudi Arabia. In his younger days he was a keen track athlete and maintained a lifelong interest in cricket.

Wijey was the embodiment of his Buddhist faith in his gentle and dignified manner. Never was this more evident than in his final illness which he accepted with a calmness, serenity and an utter lack of self-pity that was truly remarkable.

He is survived by his much-loved daughter Shamila and two grandsons Solomon Nalin Gurr and Jai Lamont Gurr.

Phil Thomas
FANZCA
February 2009

Dr Brian Donald McKie

1939–2009

Brian McKie passed away on January 18, a fortnight before his 70th birthday. Brian was born in Poona, India, where his parents were missionaries. He was educated at Trinity and Carey Grammar Schools in Melbourne and graduated from Melbourne University in Medicine in 1962.

After his resident jobs undertaken in Geelong, he went to New Guinea where he worked for two years. On his return, he undertook his anaesthetic training in Melbourne gaining his FFARACS in 1968. He was appointed to an Uncle Bobs fellowship in the Anaesthetic Department at the Royal Children's Hospital in 1969. He participated in intensive care and in anaesthesia and became one of the cardiac team. After four years, he decided to move to private practice in Geelong. He continued on the sessional staff at the Royal Children's Hospital for 29 years, even after he changed course in midlife and went into the church.

He graduated B. Theology in 1993 and was then ordained into the Baptist Church. He was involved with Belmont Church in Geelong, then Traralgon before returning to Aberdeen Street Baptist Church in Geelong until his retirement. In retirement he continued to work part time and made a big impact on the Euroa Church while filling in there.

Brian was a quiet, unassuming man who had a deep commitment to both his careers. He played an important role as conciliator on several committees at Geelong Hospital and elsewhere. Brian's concern for the wellbeing of people and his wise counsel helped many of his parishioners and reassured many of his patients. He was a mentor to young people and provided foster care to several children. Brian had a concern for many social issues and was a member of the interchurch gambling task force.

He contributed, with Anne Thorp, the only paper published for about 30 years on awareness during anaesthesia in children. It was probably the first such study.

Brian was very musical and was able to play the organ by ear. He also sang, including several performances of the Messiah in the Town Hall, and wrote a pantomime. He also enjoyed a game of squash.

I had the pleasure of travelling to several conferences with Brian. In 1970 on the way to Canberra for the third Asian Australasian Congress in a VW beetle we had two windscreens broken on one day. It poured rain after the second one which added to our discomfort. In 1973 we went to a meeting in Malaysia followed by a Faculty of Anaesthetists conference in Singapore. It was another trip with many interesting episodes, including Devonshire tea at Cameron Highlands! In 1976 we drove to Surfers Paradise for the ASA meeting and were apprehensive about running out of petrol between Jerilderee and Narrandera – places named on the map where we hoped to obtain petrol didn't seem to exist. Travelling with someone for days generates a deeper understanding between people and these travels enhanced our friendship.

With the passing of Brian McKie, many of us have lost a good friend. Our sincere sympathy is extended to his wife, Dorothy, and their children, Cathy, Jenny, Barbara and Andrew. The blessing at the conclusion of his funeral, written by himself, had some valuable messages. "Go in peace. Don't be sad but share God's joy with others. Be kind to each other – life is too short to do otherwise. Life is a precious gift – live it to the full while you can. God be with you. Amen."

Dr Kester Brown
FANZCA
February 2009

Professional documents

Following the normal review process by Council, the following Professional Document has recently been withdrawn:

PS48 – *Statement on Clinical Principles for Procedural Sedation*

Australian and New Zealand College of Anaesthetists

ABN 82 055 042 852

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

TE1	(2008)	*Recommendations for Hospitals Seeking College Approval for Vocational Training in Anaesthesia*
TE2	(2006)	*Policy on Vocational Training Modules and Module Supervision* (interim review)
TE3	(2006)	*Policy on Supervision of Clinical Experience for Vocational Trainees in Anaesthesia*
TE4	(2003)	*Policy on Duties of Regional Education Officers in Anaesthesia*
TE5	(2003)	*Policy for Supervisors of Training in Anaesthesia*
TE6	(2006)	*Guidelines on the Duties of an Anaesthetist*
TE7	(2005)	*Guidelines for Secretarial and Support Services to Departments of Anaesthesia*
TE8	(2003)	*Guidelines for the Learning Portfolio for Trainees in Anaesthesia*
TE9	(2005)	*Guidelines on Quality Assurance in Anaesthesia*
TE10	(2003)	*Recommendations for Vocational Training Programs*
TE11	(2008)	*Formal Project Guidelines* (interim review)
TE13	(2003)	*Guidelines for the Provisional Fellowship Program*
TE14	(2007)	*Policy for the In-Training Assessment of Trainees in Anaesthesia*
TE17	(2003)	*Policy on Advisors of Candidates for Anaesthesia Training*
TE18	(2005)	*Guidelines for Assisting Trainees with Difficulties*
EX1	(2006)	*Policy on Examination Candidates Suffering from Illness, Accident or Disability*
T1	(2008)	*Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations* (interim review)
T3	(2008)	*Minimum Safety Requirements for Anaesthetic Machines for Clinical Practice*
PS1	(2002)	*Recommendations on Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia*
PS2	(2006)	*Statement on Credentialling and Defining the Scope of Clinical Practice in Anaesthesia*
PS3	(2003)	*Guidelines for the Management of Major Regional Analgesia*
PS4	(2006)	*Recommendations for the Post-Anaesthesia Recovery Room*
PS6	(2006)	*The Anaesthesia Record. Recommendations on the Recording of an Episode of Anaesthesia Care*
PS7	(2008)	*Recommendations on the Pre-Anaesthesia Consultation*
PS8	(2008)	*Guidelines on the Assistant for the Anaesthetist*
PS9	(2008)	*Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical or Surgical Procedures*

Professional documents

Continued

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PS10 (2004) *Handover of Responsibility During an Anaesthetic*
PS12 (2007) *Statement on Smoking as Related to the Perioperative Period*
PS15 (2006) *Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery*
PS16 (2008) *Statement on the Standards of Practice of a Specialist Anaesthetist*
PS18 (2008) *Recommendations on Monitoring During Anaesthesia*
PS19 (2006) *Recommendations on Monitored Care by an Anaesthetist*
PS20 (2006) *Recommendations on Responsibilities of the Anaesthetist in the Post-Anaesthesia Period*
PS21 (2003) *Guidelines on Conscious Sedation for Dental Procedures*
PS26 (2005) *Guidelines on Consent for Anaesthesia or Sedation*
PS27 (2004) *Guidelines for Fellows who Practice Major Extracorporeal Perfusion*
PS28 (2005) *Guidelines on Infection Control in Anaesthesia*
PS29 (2008) *Statement on Anaesthesia Care of Children in Healthcare Facilities without Dedicated Paediatric Facilities* (reissue)
PS31 (2003) *Recommendations on Checking Anaesthesia Delivery Systems*
PS37 (2004) *Regional Anaesthesia and Allied Health Practitioners*
PS38 (2004) *Statement Relating to the Relief of Pain and Suffering and End of Life Decisions*
PS39 (2003) *Minimum Standards for Intrahospital Transport of Critically Ill Patients*
PS40 (2005) *Guidelines for the Relationship Between Fellows and the Healthcare Industry*
PS41 (2007) *Guidelines on Acute Pain Management*
PS42 (2006) *Recommendations for Staffing of Departments of Anaesthesia*
PS43 (2007) *Statement on Fatigue and the Anaesthetist*
PS44 (2006) *Guidelines to Fellows Acting on Appointments Committees for Senior Staff in Anaesthesia*
PS45 (2008) *Statement on Patients' Rights to Pain Management and associated responsibilities*
PS46 (2004) *Recommendations for Training and Practice of Diagnostic Perioperative Transoesophageal Echocardiography in Adults*
PS47 (2008) *Guidelines for Hospitals Seeking College Approval of Posts for Vocational Training in Diving and Hyperbaric Medicine*
PS49 (2008) *Guidelines on the Health of Specialists and Trainees*
PS50 (2004) *Recommendations on Practice Re-entry for a Specialist Anaesthetist*

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Australian and New Zealand College of Anaesthetists

and

Joint Faculty of Intensive Care Medicine

ABN 82 055 042 852

Professional documents

IC-1 (2003) *Minimum Standards for Intensive Care Units*
IC-2 (2005) *Intensive Care Specialist Practice in Hospitals Accredited for Training in Intensive Care Medicine*
IC-3 (2008) *Guidelines for Intensive Care Units seeking Accreditation for Training in Intensive Care Medicine*
IC-4 (2006) *The Supervision of Vocational Trainees in Intensive Care*
IC-6 (2002) *The Role of Supervisors of Training in Intensive Care Medicine*
IC-7 (2006) *Secretarial Services to Intensive Care Units*
IC-8 (2000) *Quality Assurance*
IC-9 (2002) *Statement on the Ethical Practice of Intensive Care Medicine*
IC-10 (2003) *Minimum Standards for Transport of the Critically Ill*
IC-11 (2003) *Guidelines for the In-Training Assessment of Trainees in Intensive Care Medicine*
IC-12 (2001) *Examination Candidates Suffering from Illness, Accident or Disability*
IC-13 (2008) *Recommendations on Standards for High Dependency Units Seeking Accreditation for Training in Intensive Care Medicine*
IC-14 (2004) *Statement on Withholding and Withdrawing Treatment*
IC-15 (2004) *Recommendations of Practice Re-entry for an Intensive Care Specialist*

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Australian and New Zealand College of Anaesthetists

and

Faculty of Pain Medicine

ABN 82 055 042 852

Professional documents

PM2 (2005) *Guidelines for Units Offering Training in Multidisciplinary Pain Medicine*
PM3 (2002) *Lumbar Epidural Administration of Corticosteroids*
PM4 (2005) *Guidelines for Patient Assessment and Implantation of Intrathecal Catheters, Ports and Pumps for Intrathecal Therapy*
PM5 (2006) *Policy for Supervisors of Training in Pain Medicine*
PM6 (2007) *Guidelines for Longterm Intrathecal Infusions (Analgesics/Adjuvants/Antispasmodics)*
PS3 (2003) *Guidelines for the Management of Major Regional Analgesia*
PS38 (2004) *Statement Relating to the Relief of Pain and Suffering and End of Life Decisions*
PS39 (2003) *Minimum Standards for Intrahospital Transport of Critically Ill Patients*
PS40 (2005) *Guidelines for the Relationship Between Fellows and the Healthcare Industry*
PS41 (2007) *Guidelines on Acute Pain Management*
PS45 (2008) *Statement on Patients' Rights to Pain Management and Associated Responsibilities*
PS49 (2008) *Guidelines on the Health of Specialists and Trainees*

College Professional Documents adopted by the Faculty:

PS4 (2006) *Recommendations for the Post-Anaesthesia Recovery Room (Adopted February 2001)*
PS7 (2008) *Recommendations for the Pre-Anaesthesia Consultation (Adopted November 2003)*
PS8 (2008) *Guidelines on the Assistant for the Anaesthetist (Adopted November 2003)*
PS9 (2008) *Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical or Surgical Procedures (Adopted 2008)*
PS10 (2004) *The Handover of Responsibility During an Anaesthetic (Adopted February 2001)*
PS15 (2006) *Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery (Adopted February 2001)*
PS18 (2008) *Recommendations on Monitoring During Anaesthesia (Adopted February 2001)*
PS20 (2006) *Recommendations on Responsibilities of the Anaesthetist in the Post-Anaesthesia Period (Adopted February 2001)*
PS31 (2003) *Recommendations on Checking Anaesthesia Delivery Systems (Adopted July 2003)*
T1 (2008) *Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and other Anaesthetising Locations (Adopted May 2006)*

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