# THE ANZCA BULLETIN

## MARCH 2008

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

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

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# President's message

DR WALTER THOMPSON

Welcome to the first edition of the Bulletin for 2008.

Since I prepared the report for the December 2007 edition of the 'Bulletin' the College has made a number of advances and the political landscape has changed completely.

## COLLEGE MATTERS

The College has in the last three months:

> Commenced the CPD Program
> Completed the upgrade of the website
> Introduced new accounting system software
> Upgraded the library software to facilitate access for Fellows
> Commenced a redevelopment of the examinations database and software
> Published the 2007 edition of 'Australian Anaesthesia'
> Completed several submissions to government seeking support for rural specialists

The results of the Workforce survey undertaken with the ASA have been delayed. At the time of writing, Access Economics had completed the draft of the Supply side analysis of the model but were still awaiting data from the Department of Health and Aging (DoHA) in order to complete the Demand side analysis. The College looks forward to receiving that report and we thank all the Fellows who contributed to the survey.

Council has undertaken a review of the Committees and Subcommittees of Council and has accepted the recommendations. The committee groupings will be reorganised and some committees will be disbanded. Council hopes to attract Fellows with particular interests and expertise to serve on committees, subcommittees and working groups. In the next month, the membership and Terms of Reference for the Committees and Subcommittees will be reviewed and the intention is to have the restructure in place for the New Council meeting in May.

An allocation, that has reflected some of the corporate overheads of the College which are attributable to the Joint Faculty of Intensive Care Medicine (JFICM), has been paid by JFICM since 2002. In 2007 at the request of the Joint Faculty models and proposals were developed in order to place those allocations on a realistic footing such that they reflect more accurately the total costs of JFICM within the College. The proposals which are based on ANZCA's total corporate costs and JFICM's share of them have been the subject of internal discussions with JFICM and a proposal will go to February Council.

## EXTERNAL MATTERS

The new Federal Government and various State Governments are confronted with multiple problems in the healthcare sector and they are also facing times of financial uncertainty. The Federal Government has to complete the negotiations with the States on the Australian Health Care Agreements (AHCAs) by mid year and is determined to use these negotiations to force that states to adopt health care reforms. To this end, the Rudd government is establishing a National Health and Hospitals Commission (NHHRC). This is said to be an overarching strategic body with generic appointments to advise the Commonwealth Minister of Health and Aging on the necessary short term reforms, develop performance benchmarks for the AHCA's and then to report on a long-term health reform plan to provide sustainable improvements in the health system. There is also to be a task force on preventive medicine.

It is to be hoped that the NHHRC will take the lead in discussing long term solutions with the various levels of government and the communities. However, the mantra that is increasingly coming out of Canberra is 'don't give us the problems just give us the solutions'. Hopefully, we will get a proper assessment of the problems as a precursor to the development of rational and sustainable solutions rather than the 'flavour of the month' solutions that are often put forward.

The Intergovernmental Agreement in relation to the proposals for National Registration and Accreditation has not emerged as a strong governmental agenda item so far this year.

It however remains on the COAG agenda and it is understood that there will now be regular meetings of Health Ministers between the regular COAG meetings. Other issues that are actively being pursued through the COAG process are workforce and the assessment of International Medical graduates. The Expanded Settings for Specialist Training Program (ESSTP) still has bi-partisan support and it will continue past 2009.

## COUNCIL ELECTIONS

An election for ANZCA Councillors is currently underway and it is pleasing to see the number of Fellows who have put themselves forward for election. You are encouraged to vote and also to consider how you can become involved in College activities both at a regional and national level.

## ASM 2008

I look forward to welcoming Fellows to the Annual Scientific Meeting of the College, which will be held in Sydney on May 3-7. The theme of the Meeting is 'Anaesthesia, Science, Art and Life' and a relevant and fascinating program has been developed, which will be of interest to all Fellows.

DR WALLY THOMPSON
President

POSTSCRIPT
Since preparing this report Dr Leona Wilson of Wellington was elected as President-elect. She will assume office at the ASM in May and I have conveyed the best wishes of Fellows to her on this achievement.

# The ANZCA Research Committee

**The ANZCA Research Committee is responsible for developing research policy and implementing the ANZCA Grant Program. All members of the Committee are active and experienced researchers who have a keen interest in fostering research by Fellows and Trainees, especially novice investigators. The Committee has wide representation from different regions and sub-speciality areas. We meet in March each year—to allocate reviews and spokespeople for each grant—and then again in October—to adjudicate the grants and make recommendations to Council.**

The Committee is supported by hundreds of reviewers from Australia, New Zealand and around the world as well as College Executive Officer, Jill Humphreys and her assistant, Renee McNamara.

**A/Prof Kate Leslie**
(Chair – VIC): depth of anaesthesia, sedation, pharmacology, clinical trial design

**Prof Andrew Bersten**
(Member – SA): respiratory mechanics, acute lung injury, pathophysiology of ARDS

**A/Prof David Cottee**
(Member – NSW): coronary and bronchial perfusion, chemoreflex, baroreflex, anaesthetic agents

**Prof Tony Gin**
(Member – Hong Kong): pharmacology, clinical and experimental research, obstetric anaesthesia, depth of anaesthesia

**Prof Alan Merry**
(Member – NZ): human factors and patient safety, simulation, postoperative analgesia, cardiac anaesthesia

**Prof Paul Myles**
(Member – VIC): cardiothoracic anaesthesia, quality of recovery, evidence-based practice, large multicentre trials

**Prof Michael Paech**
(Member – WA): obstetric analgesia, maternal and neonatal analgesia, acute postoperative pain

**A/Prof Tony Quaill**
(Member – NSW): coronary and bronchial perfusion, chemoreflex, baroreflex, anaesthetic agents

**A/Prof David Scott**
(Member – VIC): cognitive change and anaesthesia; regional anaesthesia; cardiac anaesthesia, pharmacology

**A/Prof Philip Siddall**
(Member – NSW): neuropathic pain, spinal cord injury, brain imaging, laboratory pain research

**A/Prof Tim Short**
(Member – NZ): anaesthetic pharmacology, international multicentre studies and anaesthetic safety

**A/Prof David Story**
(Trials Group Representative – VIC): postoperative complications, acid-base disorders, fluids and electrolytes, surveys

**Dr Steve Webb**
(JFICM Representative – WA): intensive care RCTs and long-term outcomes, bacterial pathogenesis

**Prof Stephan Schug**
(FPM Representative – WA): pharmacology, acute and chronic pain, regional anaesthesia, organisation of pain management

**Ms Jill Humphreys**
(Executive Officer [Quality, Safety and Accreditation])

**Ms Renee McNamara**
(Administrative Assistant, [Quality, Safety and Accreditation])

From top left
to bottom right:
A/Prof Kate Leslie
Prof Andrew Bersten
A/Prof David Cottee
Prof Tony Gin
Prof Alan Merry
Prof Paul Myles
Prof Michael Paech
A/Prof Tony Quaill
A/Prof David Scott
A/Prof Philip Siddall
A/Prof Tim Short
A/Prof David Story
Dr Steve Webb
Prof Stephan Schug
Ms Jill Humphreys
Ms Renee McNamara

# LAURENCE EDWARD MATHER Dip Appl Chem; BSc; MSc; PhD; FANZCA; FFPMANZCA; FRCA.

**I am delighted that the NSW Regional Committee of ANZCA has asked me to give an appreciation of the career of Professor Laurence E Mather at the time of his retirement.**

Laurie Mather and I have worked together in a very productive collaboration for more than 30 years. Our major aims have been: to develop the scientific basis of anaesthesia and pain management; to foster the careers of anaesthetists as researchers in this field; and to develop academic departments of Anaesthesia and Pain Management. It has also been our vision that the integration of teaching, clinical care and research is crucial to achieving excellence in each of these three areas individually. Laurie has been one of only a small number of 'basic scientists' in clinical departments worldwide.

During a research career spanning more than 35 years, Laurie Mather has made a major contribution by his pioneering work on the scientific basis of regional and general anaesthesia and of drug treatment for the management of acute, chronic and cancer pain. He is unusual amongst scientists in that work has been carried out at a basic science level, as well as in pre-clinical and human clinical studies. His scientific background was shaped by a BSc in Applied Chemistry which he gained by part time study while he worked as an industrial chemist. This was followed by a Masters and PhD in pharmaceutical sciences. He began to collaborate with anaesthetists and pain medicine specialists from the very beginning of his research career and this has continued. His curriculum vitae reveals a long succession of joint publications with individuals who have been prominent in developing the fields of anaesthesia and pain medicine. Examples are with Dick Climie, Michael Stanton Hicks, John J Bonica, Daniel C Moore and then our collaboration for the past 30 years. His contributions have been recognised by the award of the FANZCA, FFPMANZA and FRCA (all by election), by the inaugural Douglas Joseph Professorship of Anaesthesia, and by many invitations to act in the capacity of Visiting Professor in the United States, Europe and United Kingdom, with invitations as Rank Lecturer UK, ASRA Lecturer and the John J Bonica Distinguished Lecturer USA. In 1998-2001 he was joint Principle Investigator with me, in an NHMRC Program Grant to us as one of only 8 awards across all medical disciplines as an 'NHMRC Centre of Clinical Excellence in Hospital Based Research'. He served as a member of the Panel of Examiners for the Primary FANZCA examination from 1977 to 1988.

There is no doubt that his commitment to the linkage between basic/clinical science and patient care was kindled during his appointment from 1972 to 1975 in the pre-eminent Department of Anaesthesiology at the University of Washington in Seattle under the direction of John J Bonica. Subsequently, he was appointed as a Foundation Lecturer in the new academic Department of Anaesthesia and Intensive Care at the Flinders University of South Australia, where he remained with me from 1976 to 1990 progressing from Lecturer to Associate Professor and then to full Professorial level in 1990. In 1991, he was appointed as Foundation Professor of Anaesthesia and Analgesia (Research) in the Department of Anaesthesia and Pain Management of the University of Sydney at Royal North Shore Hospital and is now Emeritus Professor.

His research—embodied in more than 240 original publications and 50 reviews/book chapters—spans an extraordinary range of areas which are all substantial elements of clinical care. These areas include: seminal studies of the pharmacokinetics and pharmadynamics of local anaesthetics: physiological effects of epidural blockade; pharmacokinetics of epidural, intercostal and peripheral neural blockade; pharmacokinetics, effects and toxicology of opioids in the treatment of acute, chronic and cancer pain—notably with ground breaking studies highlighting the variability among individuals in opioid blood concentrations and responses, leading to the scientific basis of patient controlled analgesia; development of a scientific basis for the administration of opioids by intramuscular, intravenous, PCA, oral, rectal, spinal, transdermal and transpulmonary administration; development of new methods for the study and enhanced understanding of the pharmacokinetics and effects of intravenous sedative and anaesthetic drugs; the first major study highlighting the inadequacy of post operative pain control in children; novel development of a sheep preparation for direct study of regional drug kinetics and effects; pioneering studies in drug chirality leading to the development of clinically useful drugs such as ropivacaine and

levobupivacaine; clinically relevant studies of the effects of analgesic and local anaesthetic drugs on specific organs, and the effects of organ dysfunction on such drugs, eg. morphine disposition in renal failure, pethidine effects on myocardial function, and NSAID effects on kidneys in the presence of renal impairment; most recently studies of the peripheral, spinal cord and brain sites of action of NSAIDs and mechanisms of such actions; studies of toxic effects of local anaesthetics on heart and brain—very recent effects of GA on brain and heart LA toxic effects. Our joint review on epidural and intrathecal opioids—published in Anaesthesiology in 1984—was the most cited publication in the anaesthesiology literature over the last 60 years.

During our collaboration, he has played a key role in jointly developing two major academic Departments of Anaesthesia, which also fostered the development of two multidisciplinary pain centres, emphasising basic and clinical research relevant to anaesthesia and pain medicine. During this 30 years, he has supervised a total of 30 higher degree research students, 11 of whom were anaesthetists. Until recently, Laurie continued to be a reviewer for no less than 16 scientific journals and had a major editorial involvement in four journals. He played a substantial role in the development of the Masters Degree in Pain Management, University of Sydney, and was a major contributor to teaching in this course, which now has an international student enrolment in 20 countries and is being modified under contract to ANZCA as the first distance education module for all anaesthetic trainees. Over a substantial number of years he has also contributed to teaching in the FANZCA Primary Course in South Australia and New South Wales.

In short, Laurie Mather has made pivotal contributions to the scientific basis and practice of Anaesthesia and Pain Medicine and stands beside a handful of individuals internationally who can claim that their basic science has been translated into clinical practice. Where he stands aside from such peers is the extraordinarily rich diversity of his basic science work, complimented by an unusual blend of innovative and relevant clinical research.

Laurie on behalf of ANZCA Fellows, thank you, we salute you!

PROF MICHAEL J COUSINS
Professor & Director
Pain Management Research Institute

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Left: Dr Anthony Cheong
Right: Dr Gregory Kostandoff

## ANZCA UNDERGRADUATE PRIZES IN ANAESTHESIA FOR 2007

The recipient of the 2007 ANZCA Undergraduate Prize in Anaesthesia within the Christchurch Clinical School of Medicine and Health Sciences, University of Otago was Dr Anthony Cheong.

Dr Cheong's award was presented to him during the annual Prize Giving and Farewell Function on Thursday 15 November 2007.

The recipient of the 2007 ANZCA Undergraduate Prize in Anaesthesia within Flinders University of South Australia was Dr Gregory Kostandoff. Dr Konstandoff received his award at the Qualifying Ceremony on Monday 17 December 2007.

Our congratulations to Dr Cheong and Dr Kostandoff and may these awards be the first of many successes in their medical careers.

# Perioperative Drug-Induced Akathisia

**The following note was written to The Chair of the ANZCA Quality and Safety Committee. The author subsequently provided some very useful notes on Akathisia.**

I had hip surgery on Wednesday and post-operatively I had severe akathisia induced by fentanyl. It was 10 times worse than the pain and all I could do was grab the lifter and pull myself up and down in a kind of opisthotonos. I had warned the doctors about my genetic disposition and previous history of akathisia with anything that affects dopamine. Despite both my professional knowledge (akathisia is a well known side effect of some psychiatric drugs) and my own previous experience of akathisia (following preoperative promethazine) and my having discussed my concerns along with mutual consideration to use fentanyl as the best analgesic, three things of concern emerged. First, even I did not recognise that it was akathisia but thought it some kind of pain, so pumped even more of the offending medication in, thus compounding the problem. Second, when I did conclude that I had akathisia and told the nurse she said it was anxiety and I should try relaxing! I insisted she call the anaesthetist and tell her that I had akathisia and needed 2mg of diazepam. In the meantime, the surgeon whom I had taught as a medical student appeared [and] I demanded diazepam, which he (quite properly) refused, saying the anaesthetist had been contacted and it was her domain not his. The poor man was subjected to a torrent of abuse with an eloquence appropriate in a branch of medicine whose principal tool is verbiage. Third, the anaesthetist was in theatre and could not be reached immediately. After an agonising half hour, she changed my medication from fentanyl to tramadol, which I had been taking for two weeks pre-operatively without side effects. Within a few minutes, the akathisia was gone.

What concerns me most about this is that, had I not known what it was, it would have been dismissed by the nurses as my getting upset and agitated and needing to relax. Second, I was in intense discomfort and help took half an hour to come. I would claim that, to me, akathisia was as big an emergency as if I had gone into shock!

My question to my colleague was: Can you reassure me that the problem of akathisia is well known to anaesthetists and that they recognise that it is as serious as severe pain, requiring instant action?

There is an incidental issue here, which has only just occurred to me three months later, and that is that past history may be indicative, but it is not infallible. I had had fentanyl once previously, but only one IM dose. The IV route and no doubt higher effective dose may have been the reason for the unexpected result. Also, fentanyl is dopaminergic, not dopaminolytic, so akathisia might not have been anticipated.

### Akathisia (Restless Legs) Fact Sheet for Anaesthetists

Akathisia is a drug-induced sensation and/or empirically observable inability to be still and is conspicuously different from usual behaviour. Symptomatically, it is similar to the well known sleep-related phenomenon of 'restless legs'. The cause is any kind of medication that affects dopamine even if only peripherally, notably anti-emetics, antihistamines, antipsychotics, antidepressants and gastro intestinal drugs. There is probably genetic susceptibility.

In anaesthesia, the importance of being aware of akathisia as a side effect cannot be overstated because most persons do not recognise the symptoms, as such, themselves and health professionals may think the motor restlessness is a sign of pain or anxiety. Asking the key question: 'do you feel unable to lie still and that you must keep moving your legs?' should be a routine question for anyone who is agitated after receiving any kind of medication pre- or post-operatively. Pre-operative screening, including any family history, is recommended. For the patient, akathisia can be far worse than any pain and its detection and management should be regarded as urgent. Treatment is first to identify, then discontinue or change the causal drug. If that is not possible, anticholinergics, beta blockers or a benzodiazepine may help.

PROF J S WERRY
Emeritus Professor of Psychiatry
Department of Psychiatry, Auckland

Footnote:
Professor Werry has given permission to be identified as the patient concerned.

# AIMS Anaesthesia: A comparative analysis of the first 2,000 and the most recent 1,000 incident reports

**Many Australian and New Zealand anaesthetists have continued to submit voluntary and anonymous incident reports to the anaesthesia database of the Australian Patient Safety Foundation (APSF), commencing in 1988 with the founding of the APSF[1] and originally known simply as the 'Australian Incident Monitoring Study' (AIMS).[2]**

Analysis of the first 2,000 incident reports culminated in the publication of the 1993 Symposium issue of Anaesthesia and Intensive Care[2] and development of the Crisis Management Manual which was released in 1996. An updated version of the Crisis Management Manual, which uses data from the first 4,000 AIMS reports was released early in 2007 and is available from the APSF at cost price (http://www.apsf.net.au/dbfiles/crisismanualorderform.doc) and a web version is available for browsing at http://www.apsf.com.au/crisis_management/Crisis_Management_Start.htm.

Results of the current comparison were presented at the ANZCA ASM 2007 by Bill Runciman. It is planned to submit more specific, detailed analyses (for example on cardiac arrests, difficult intubations, regional anaesthesia, laryngeal mask airways) to peer-reviewed journals.

## METHODS

The first 2,000 AIMS Anaesthesia incident reports spanned the years 1988-1993 and analyses of these incidents form the 1993 Symposium issue of Anaesthesia and Intensive Care[2]. The most recently reported 1,000 anaesthesia incidents to AIMS, spanning the years 2002-2006, were entered and classified into the APSF's 'Advanced Incident Management System - Version 3.2', an electronic healthcare incident capturing and analysing program.[3] With this program, data are elicited using interactive computer screens which have intuitively arranged cascades of drop-down questions. These allow rapid comprehensive extraction of information and its storage in a selection of anaesthesia-relevant categories. Also, direct 'like-with-like' comparison of the two anaesthesia data sources was then achieved using on-screen windows replicated from the data in the 1993 Symposium Issue.

## MAIN FINDINGS

> The types of procedures associated with incidents were similar between the two data sets with the most common reports of incidents being from General Surgery and Orthopaedics.

> The maintenance phase of anaesthesia continues to be associated with the most reported incidents followed by the induction phase.

> In the recent 1,000 reports, there were many examples of seriously and gravely ill patients being managed, and harm was more frequently associated with corresponding ASA ratings. However, the ASA risk ratings assigned by the reporting anaesthetists did not differ significantly between the two data sets.

### Monitoring practices

> There has been a notable increase in the number of monitors commonly used in current anaesthesia practice, with peripheral nerve stimulators seeming now to be a routine monitor and BIS monitoring making an increasing appearance. However, informed interpretation of muscle twitch responses by the peripheral nerve stimulator may need further training emphasis.

> The pre-eminent value of the 'pulse-oximeter/capnograph' combination during difficulty with endotracheal intubation is again notable.

> Trans-oesophageal echo-cardiographic monitoring did not feature appreciably in the recent 1,000 series.

### Difficult and failed intubations

> There was an appreciable percentage increase in both difficult and failed intubations in the recent 1,000 compared with the 1st 2,000 reports. An inability to intubate accompanied by an inability to ventilate was a distressing feature in a number of recent reports—a situation which, in most instances, should be avoidable. In keeping with earlier data, the most successful intubation aid in

the recent 1,000 reports was the gum elastic bougie.

> The recent 1,000 data would indicate that unrecognised oesophageal intubation is now extremely rare. Arterial desaturation is now the most commonly reported complication, suggesting prolonged periods of inadequate airway control during repeated attempts at airway control.

> The lack of pre-operative airway assessment is an ongoing problem.[4] Data from an interim period (the first 4,000 AIMS reports) also showed a failure to predict a difficult airway in 52% of the reported cases.

### The laryngeal mask airway (LMA)

> The data from the recent 1,000 reports suggests that there is a significant risk of regurgitation/aspiration/laryngospasm associated with reported use of a LMA. Comparison with the 1st 2,000 data is not possible as the device had not yet made a significant clinical appearance in reports during the 1988-1993 period. There can be little doubt that the basic LMA and certain modified versions are valuable additions to anaesthesia airway management, including some situations of difficult intubation. However it seems clear from the recent data in this study that the LMA is now being used too liberally, by relatively inexperienced anaesthetists and in situations in which it is relatively or even absolutely contraindicated. There is a series of incidents in the recent 1,000 reports where, during LMA insertion attempts or use, there is pre- or intra-operative loss of airway control, removal of the LMA after unsuccessful manipulations, difficulty with subsequent endotracheal intubation attempts (sometimes in a prior unassessed airway!), pulmonary aspiration (often despite apparently adequate pre-operative fasting times), arterial desaturation and unplanned post-operative admission to a high dependency unit.

> The recent 1,000 data in this study suggest the need for an increased emphasis in training concerning the indications, contraindications and management of the LMA.

### General observations

> Data from incident reporting needs to be interpreted with caution. However, on the basis of past safety, successes with incident reporting in anaesthesia[1, 5, 6, 7] and in other fields, the technique is now established as at least one useful tool for safety improvements.

> The time-consuming task of interpreting the large number of non-standard abbreviations in many reports and sometimes the illegible writing would support the adoption of electronic and/or telephone reporting of incidents in the future.

> While the future application of electronic and secure telephone incident reporting will facilitate the capture of ongoing data, adequately trained staff will always remain necessary, along with the associated commitment and financial requirements. Such systems can no longer survive by relying on the unpaid goodwill of clinicians working in their spare time. The ownership and the location of future databases are questions with which the Tripartite Committee of ANZCA, ASA and NZSA for Quality and Safety must now address following the Committee's recently declared support for continued incident reporting and analysis in Australian and New Zealand Anaesthesia.[8]

> Ongoing trust in AIMS shown by colleagues–the continuation of voluntary and anonymous incident reporting to AIMS is to the great credit of our Specialty. However, continuation of the program depends on the maintenance of the existing trust in the security of the system (developed over many years), and the provision of regular feedback of results and conclusions. The authors also wish to express their gratitude and admiration of our many unidentified anaesthesia colleagues who continue voluntarily to contribute to the AIMS data base with such on-going trust, honesty and insight.

The APSF continues to fund an experienced part-time registered anaesthetic nurse to enter and classify incident reports, over 1,300 recent reports having been classified into AIMS 3.2, in addition to over 8,000 reports entered in the old database.

ANZCA Fellows and ASA members can request data extracts from AIMS, by contacting Peter Hibbert (peter.hibbert@apsf.net.au) who will arrange secure access.

The APSF is grateful to the Australian and New Zealand College of Anaesthetists and its Research Committee which funded a Grant in 2005 to allow comparison between the 1st 2,000 (1988-1993) and the most recent 1,000 (2002-2006) AIMS data collections across almost two decades.

JOHN WILLIAMSON
BILL RUNCIMAN
PETER HIBBERT
KLEE BENVENISTE
Australian Patient Safety Foundation
Adelaide, South Australia

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# OBITUARY

## Dr Margaret Stuart Smith OBE QJM MBChB FANZCA

From left: Professor Tess Cramond, Dr Patricia Mackay and Dr Margaret Stuart Smith

**Dr Margaret Smith (on the right), one of the two women among seven New Zealand Foundation Fellows of the Faculty of Anaesthetists, Royal Australasian College of Surgeons, died in Christchurch on 7th August 2007 aged ninety-five years.**

Margaret Stuart Smith (neé Riddell) was born in Wellington on 12th April 1912. Educated at Chilton House, Wellington, and Victoria University, Wellington, she proceeded to the University of Otago, graduating in Medicine in 1936—the same year as her brother Claude, who practised in Kaiapoe until his early death.

It was during the fourth year of the course that Dr Smith was inspired by Dr Marion Cameron (neé Whyte)—the first anaesthetist appointed to Dunedin Hospital and, in 1928, the first to hold an academic appointment in anesthetics at the University of Otago. She had done post graduate training in the United Kingdom and the USA, and was one of the first anaesthetists in New Zealand to use endotracheal intubation, intravenous fluids and spinal anaesthesia. Dr Cameron was also active in the New Zealand Medical Women's Association to which Margaret Smith was later to make such a pivotal contribution. Who could have been a better role model for a woman student like Margaret Riddell in those pioneering days?

During University vacation in fourth and fifth years, Margaret accepted the invitation of a family friend Mr R B Martin to attend his operating theatre lists. On these lists she was privileged to meet Eric Anson and Alf Slater who with her were to become Founder Fellows of the Faculty of Anaesthetists. To quote Margaret: 'I was in the operating theatre observing and giving anesthetics whenever possible'. Later as a House Officer, she was ever willing to 'swap' so that she could exchange the medical or surgical 'run' for anaesthetics.

In 1937 - 1938, there was no formal post graduate training in anaesthetics in New Zealand, so she enquired of the Royal College of Surgeons, England, regarding the opportunities for education in anaesthesia. She was advised that there would be a course at Guy's Hospital in 1937, and that a conjoint diploma (RCP & RCS) would be implemented in November 1937. The requirements involved two years as a House Officer in a major hospital and documented evidence of one thousand anaesthetics —five hundred of which were for major operations.

In 1939, as Dr Margaret Riddell, she sailed for London accompanied by her mother. She was fortunate in having not only a reference from a Senior Surgeon but also a personal reference to Dr (later Sir) Ivan Magill. On the Guy's course, her lecturers read like a 'Who's Who' of Anaesthetics—Sheldon, Rowbotham, Nosworthy and Magill.

Not surprisingly in 1939, she was successful in the Diploma in Anesthetics—New Zealand's first woman doctor to achieve this honour—and she was appointed Senior Resident Anesthetist at Leicester Royal Infirmary.

After one year, she moved to the Edinburgh Royal Infirmary where John Gillies asked her to develop an Anaesthetics Department at Bangour. This converted psychiatric hospital was to become a tri-service hospital for armed service personnel having surgery by Sir Harold Gillies for repair of burn injuries and faciomaxillary problems.

In 1945 Margaret was successful (from six applicants) in obtaining an appointment at Great Ormond Street Children's Hospital where she was to have the advantage of working with Robert Cope, pioneer paediatric anaesthetist, and Dennis Browne who was to contribute so much to the development of surgery for the repair of cleft lips and palates. Margaret returned to New Zealand in 1946.

She was appointed consultant anaesthetist to the North Canterbury Hospital Board in 1947, and continued in that role as well as in private practice until 1977, when she was appointed Honorary Consultant to the Board. As she recounted her experience with sick children, I could relate, with feeling, to her description of the daunting responsibility of providing anaesthesia for children having pneumo-encephalography. She retired from anaesthetic practice in 1982. She was the first woman President of the New Zealand Society of Anaesthetists 1976 – 1977.

At the ASM in Brisbane in 2002—marking the Golden Jubilee of the foundation of the Faculty of Anaesthetists—she proposed the toast to the College in a voice that belied her ninety years. Margaret's colleagues in Australia and New Zealand were delighted when, in 2003, she was awarded the ANZCA Medal in recognition of her contribution to our speciality.

But it is not only for her contribution to anaesthesia that Margaret Smith will be remembered. Her professional and social horizons were broad and included the Medical Association of New Zealand and the New Zealand Medical Women's Association. Her outstanding support for the Medical Women's International Association was recognised by admission to Golden Jubilee Membership in Sao Paulo in 1998. She was a Charter Member of Zonta and was honoured by the award of Life Membership of the National Council of Women.

Always forward thinking, she advocated review of the selection of medical students to prevent a shortage of general practitioners, retraining for women doctors who had taken maternity leave, planning to ensure appropriate retention of women medical graduates and utilisation of their training, because of the effect on the medical workforce of the increasing number of women in medicine, concepts now accepted but pioneering in the early 1970s. For her services to medicine and the community she was awarded the Queen's Jubilee Medal in 1977 and admitted as an Officer in the Order of the British Empire in 1990.

In 1948, she married Carl Smith, successful business man and owner of Munn's Menswear. Carl, whose degree in music was from Canterbury University College, had been introduced to the piano by his father, and it was at the University that his singing and piano skills were encouraged and developed by Victor Peters and Ernest Empson. When he was over eighty years, with Margaret, he toured the Opera Houses of Europe, bought a new grand piano and had it freighted from Europe. It was always a privilege to enjoy his music as a house guest in their lovely home. Carl was a sidesman at Christ Church Cathedral. He passed away aged one hundred and two years, just six weeks after Margaret's death.

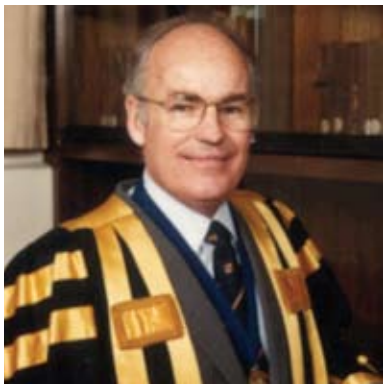
Margaret and Carl had the ability to support and sponsor each other's careers. Margaret was a pioneer working mother, who earned respect by her academic and professional standards and what would now be termed 'time management skills'. She did not ask for privileges.

They rejoiced in their three children and their extended family; sons Rodney and Tony—a gastroenterologist—and his wife Barbara, daughter Jill—a general practitioner—and her husband, John Warlow—a psychiatrist, and the nine grandchildren, in whose activities and success Margaret's pride knew no bounds. As Jill and John live in Brisbane, it was my pleasure and privilege to enjoy seeing Margaret on her frequent visits to Brisbane.

Rodney, Tony and Jill will take their comfort from Margaret's emphasis on family values and a loving stable home life, based on a Christian ethic, as well as from her pioneering contribution to our speciality, particularly in paediatric anaesthesia, medicine in general and the wider community. As the initial sadness lessens, may they have only the happy memories of an elegant, gracious mother with an old world charm and an infectious smile.

PROF TESS CRAMOND

# PAST DEANS AND PRESIDENTS



DR ROBIN WILLIAM SMALLWOOD

## Robin William Smallwood

**Robin Smallwood was the seventeenth Dean of the Faculty of Anaesthetists, Royal Australasian College of Surgeons—serving from 1986 until his retirement, which was due to serious illness only months after being elected for a second year term. He followed Professor Ross Holland and was succeeded by Professor Barry Baker.**

Robin Smallwood was born in Penang, Malaya on 27 April 1934 and lived there until being evacuated to Melbourne with his younger brother, Richard, in 1940 by his grandparents. The reason for this move was the impending Japanese invasion during the Second World War. His parents stayed in Malaya and were interned, with his father serving on the infamous Burma railway, whilst his mother—a doctor—was sent to Changi prison. There she worked as doctor to the women prisoners. Both survived their internment and the family was reunited after the war.

Robin was educated at Ivanhoe and Geelong Grammar Schools, and graduated from the medical school of the University of Melbourne in 1958. Robin chose a career in anaesthesia and commenced anaesthetic training in 1961 at the Royal Women's Hospital, Melbourne, under the tutelage of Dr Kevin McCaul—himself an ex-Dean of the Faculty who introduced epidural anaesthesia into obstetric practice in Australia, and the Royal Children's Hospital. Whilst Robin was at this Hospital, Dr Margaret (Greta) McClelland was the Director of the anaesthetic department and is widely held with Dr Mary Burnell from South Australia and Dr Andy Morgan from Sydney to have developed paediatric anaesthesia in Australia.

This was followed by registrar appointments at St Vincent's Hospital, Melbourne and The Royal Melbourne Hospital, resulting in his attaining Fellowship of the Faculty in 1964. Subsequent to this, he was appointed as a staff anaesthetist to the St Vincent's Hospital and then spent 1967 in a senior registrar post at the Welsh National University in Cardiff returning to private specialist practice in 1968. He spent a year in this capacity before being appointed as the inaugural Director of Anaesthesia at the Austin Hospital, Heidelberg, Melbourne.

It was as Director at the Austin that he fostered the specialty of Intensive Care, introducing the first unit in the recovery room before establishing ward space. He also introduced, in 1978, an anaesthetic registrar rotational training scheme that would go on to become a model for many such schemes. This was established between the Austin, Repatriation, Preston and Northcote and Bendigo Hospitals with Rotational Scheme interviews and appointments. This scheme provided, within its structure, the complete training requirements of trainees with the inclusion of rotations at third year level with obstetric and paediatric experience.

In addition to the ground breaking work at the Austin, Robin Smallwood served as a member of the Victorian Regional Committee from 1969-1976 holding the posts of Honorary Secretary and Deputy Chair at various times. From 1970 until 1983, he served on the panel of examiners in both anaesthesia and Intensive Care. He was elected to Board of Faculty in 1976 and acted in the role of Education Officer and Vice Dean before becoming Dean in 1986. He only served a part of his post as Dean until he had to resign several months before his death on 6 October 1987 at the age of 53 years. Robin resigned the post of Dean, due to illness, in July 1987 and Professor Barry Baker was appointed acting Dean until the election of a Dean and Vice Dean at the meeting of the Board of Faculty in July 1987. As well as his role within the Faculty, Robin was a member of the Australian Society of Anaesthetists and held the post of Victorian state representative to the federal executive for two years in 1974 and 1975. He was also appointed as the Australian visitor to the

annual meeting of the Australian Society of Anaesthetists in 1982.

I will leave the final words to Dr Geoff Gutteridge who knew Robin well and was integrally involved with the developments at the Austin over those formative years as Deputy Director of Anaesthesia and, later, Director of Intensive Care. 'Robin was an unpretentious, compassionate and honourable man, noted for the cheerful, dedicated and selfless manner in which he worked for the hospital, his profession and their highest ideals. His premature death is an enormous loss to the Department, the Austin Hospital and the wider anaesthetic community. He is sadly missed and will be long remembered by his friends and colleagues with respect and affection.'

The details in this essay have been obtained from three main sources that I wish to gratefully acknowledge.

DR TERRY LOUGHNAN


REFERENCE

1. G.A.Gutteridge. Obituary: Robin William Smallwood. *Anaesth Intens Care* (1988), 16, 495-496
2. A.B.Baker. Robin William Smallwood. *RACS Bulletin* Nov 1987 p38
3. G Wilson Fifty Years, *The Australian Society of Anaesthetists*. ISBN 0909814015


## CONGRATULATIONS

**Congratulations to Dr Adrian Sultana MD, FRCP(Glasg)(FANZCA:1993) who was elevated to Fellowship of the Royal College of Physicians and Surgeons in Glasgow on 25 September 2007.**

Deemed to have achieved distinction as a Physician, particular recognition was given to Dr Sultana's contribution to the peri-operative management of bariatric surgical patients.

Dr Sultana had gained the MRCP(UK) by examination in 1987 when he had trained in General Medicine in Malta and the UK prior to moving to Australia, where he is currently a Senior VMO Anaesthetist in Sydney.

# CPD Feedback

**The Continuing Professional Development (CPD) Program was introduced at the beginning of the year and is now 'live'. During 2007, substantial effort was put into ensuring Fellows were made aware of the details of the CPD Program and feedback was sought. This was the first major revision of the MOPS Program which had been running for 12 years.**

Those interested in tracking progress to date, may wish to refer to the following:

- Bulletin 7/06, page 11 '(Old) MOPS to (New) CPD'
- Bulletin 10/06, pages 17-19 'Revision of ANZCA MOPS'
- 11/06 Letter to Regional and National Committees with documents for review
- 11/06 Broadcast email to all Fellows inviting comment on the CPD Program
- Bulletin 12/06, page 9 – Notice inviting comment
- Bulletin 7/07, page 15 'CPD Program'
- 9/07 – Letter to Regional and National Committees
- Bulletin 10/07, page 9 'CPD – A thumbnail dipped in Tar'
- 10/07 – Letter to known Activity Providers
- Bulletin 12/07, page 17 'CPD Program Information'
- 1/08 – Bulk email to all Fellows and other anaesthetists.

In addition, presentations on CPD were invited for the following events:

- NSW CME Meeting 4/06 Dr Frank Moloney
- NSW CME Meeting 11/06 Prof Teik Oh
- ANZCA ASM Melbourne 5/07 CPD Committee
- ASA NSC Perth 9/07 Dr Leona Wilson
- HKCA Hong Kong 10/07 Prof Teik Oh
- NZAEC Auckland 11/07 Dr Leona Wilson
- Tasmania CME Meeting 2/08 Dr Leona Wilson
- SA CME Meeting 2/08 Prof Garry Phillips

Dr Frank Moloney will also conduct a presentation on the CPD Program at the ASA meeting in Sydney in July this year.

### Feedback

By July 2007 (six months after requesting feedback from Fellows), the CPD Committee reported that 'the general consensus is that the new CPD Program is an improvement on the current MOPS Program', and is 'something that we will need to get used to'.

There were a number of positive emails, a few critical ones and some that were considered to be a bit 'off track' because they showed misunderstandings in a number of areas.

Positive comments about the CPD Program included:

'It looks good in that it is personalised learning with objectives and getting the individual to reflect on what has been done. The toolkits are crucial. We will now have to get out of our comfort zone and adjust to this new program.'

Critical comments included:

'I take strong objection to being automatically conscripted into the College's new CPD Program. I was not aware that members of the College Council had been elected to become dictators.'

In fact, Council took this step as a 'half-way house' prior to the mandation of CPD by regulatory authorities in 2009.

'Off-track' comments included describing the CPD Program as an attempt by the College to control medical registration and de-register specialists who don't comply. In fact, the College does not register or de-register anyone, because that is the prerogative of Medical Boards/Councils. In addition, it was alleged that the program could increase stress for anaesthetists, which could be linked to divorce rates, family issues, drug addiction and have a negative impact on the world shortage of anaesthetists. Comments on the linking of CPD with stress and its associations would be pointless.

Other feedback was provided in the course of phone conversations with College staff and contained similar comments but also included statements such as that: 'reflective learning' was awful jargon, the document was poorly written, the program would be very hard for rural anaesthetists and those in private practice, that 'diary' would have been preferable to 'portfolio', the program was difficult to understand, and that effort would be required.

### Where to Now?

CPD has replaced MOPS and it has been accepted by the Australian Medical Council and the Medical Council of New Zealand. The College believes that, once CPD is mandated under national medical registration, the program will be acceptable to Australian State/Territory authorities.

It is educationally sound and will require a thoughtful and serious attempt by anaesthetists to give it a fair go. The College has produced the CPD Program with one objective—to provide a framework through which Fellows can maintain and improve their knowledge, skills and attitudes, and develop professional and personal attributes required throughout their career. It follows on directly from the FANZCA training program in many respects. The program is voluntary for 2008, although it has been decided it should be an 'opt-out' rather than 'opt-in' program (as it was for MOPS). It seems likely the ANZCA CPD Program will be acceptable to the National Registration authorities, like it is in New Zealand. Whether the authorities will introduce their own program or allow doctors to participate in approved alternative programs is not known at this stage.

It is hoped Fellows will embrace the newest and most comprehensive CPD Program of all the Colleges. As with MOPS, the committee is in the process of obtaining feedback from international Colleges—especially those in the UK, Ireland, Canada and Hong Kong.

Members of the CPD Committee are happy to speak, or be resources for regional/national meetings during 2008, as they did in 2006 and 2007. Staff of the CPD Unit at ANZCA House are also available for advice.

CPD COMMITTEE

ACEC
Anaesthesia Continuing Education Co-ordinating Committee

## SIG Executive Committees

**Special Interest Group of ANZCA, the ASA and NZSA each has an Executive Committee who coordinates the group's educational activities. Under the SIG constitution each SIG must seek nominations for members of the Executive Committee every three years. In 2008 the following SIGs will be seeking nominations for Executive Committee members.**

> Airway Management
> Cardiothoracic, Vascular and Perfusion
> Day Care Anaesthesia
> Medical Education
> Rural
> Trauma
> Welfare of Anaesthetists

All Executive Committees will be seeking new members so Fellows with an interest in becoming involved in College and Society activities and who are interested in one of these SIGSs are encouraged to consider nominating.

If you would like a nomination form or an indication of the level of involvement please contact Juliette Mullumby at the College for further information.

**Phone: (+61 3) 9510 6299**
**Email: jmullumby@anzca.edu.au**

# PAIN MEDICINE EXPERIENCE AND FANZCA TRAINING: AN AUDIT OF HOSPITAL ACCREDITATION REPORTS

DR LINDY ROBERTS

**Practising and teaching acute pain management can be a challenge for Fellows in public and private practice. My aim with this survey was to explore the quality of acute pain services in College-accredited hospitals in terms of training and service delivery.**

The College accredits hospitals for training in clinical anaesthesia. Prior to being inspected, the Head of the department completes a hospital accreditation datasheet (available at **www.anzca.edu.au/trainees/hospital-accreditation**) that includes the following pain-related fields:

**> Director of Pain Medicine: name**

**> Acute Pain:**

- Presence of a service
- Whether this is provided by the Department of Anaesthesia
- The specialist sessional allocation (ie. half days) per week.

**> Chronic Pain:**

- Presence of a multidisciplinary pain centre
- Whether this is provided by the Department of Anaesthesia
- The specialist sessional allocation per week.

**> Trainee opinions about:**

- Duration of exposure including hours or work and workload
- Quantity and quality of supervision and teaching for both acute and chronic pain.

All hospital inspection reports presented and discussed at meetings of the College Hospital Accreditation Committee (HAC) from August 2005 to April 2007, inclusive, were audited retrospectively.

## AUDIT RESULTS

### PAIN SERVICES AND STAFFING

Of the 67 hospitals inspected during the audit period, most regions were represented (NSW 25, New Zealand 14, Vic 7, Malaysia 5, Singapore 6, Queensland 3, Tasmania 2, ACT 1, NT 1, SA 1, WA 1, NSW/Victorian border 1). Figure 1 shows the ANZCA accreditation duration for these hospitals.

Sixty-one hospitals (91%) had an acute pain service (APS) and six hospitals (9%) did not, although two of the latter listed senior staff sessions in acute pain. Twenty-four hospitals (36%) had a multidisciplinary pain service.

Reported sessional numbers are shown for all 67 hospitals in Figure 2 and by duration of hospital accreditation in Table 1. It should be noted that these are nominal sessions and the College has no measure of whether or how often these sessional commitments are met. It is widely appreciated that, when departmental staffing is tight, in-theatre commitments frequently take precedence over out-of-theatre commitments (including pain rounds). Therefore, it is possible that actual specialist input to acute pain services is less than the numbers indicate.

FIGURE 1

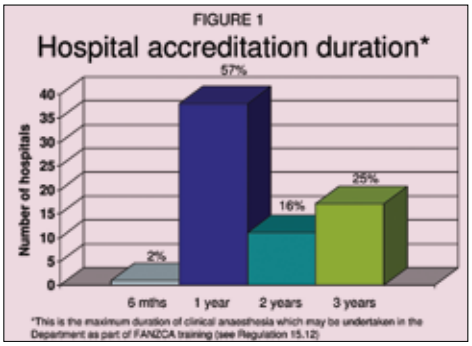



FIGURE 2

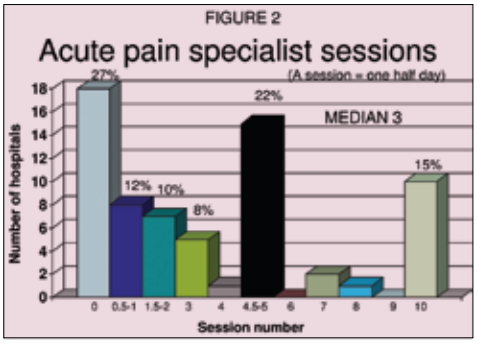
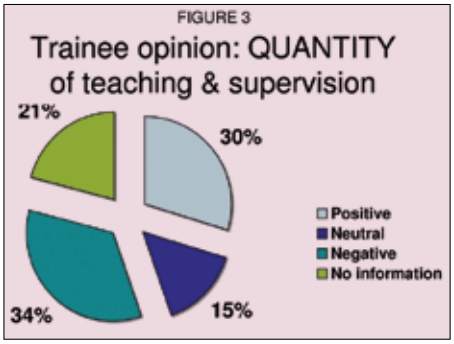


TABLE 1: Specialist sessions in acute pain for 1-, 2- and 3-year hospitals

| Number of sessions | 1 year accreditation | 2 year accreditation | 3 year accreditation |
|---|---|---|---|
| 0 | 14 | 3 | 1 |
| 0.5-1 | 5 | 3 | 0 |
| 1.5-2 | 5 | 0 | 2 |
| 3 | 3 | 0 | 2 |
| 4 | 1 | 0 | 0 |
| 4.5-5 | 8 | 3 | 4 |
| 6 | 0 | 0 | 0 |
| 7 | 1 | 0 | 1 |
| 8 | 0 | 0 | 1 |
| 9 | 0 | 0 | 0 |
| 10 | 2 | 2 | 6 |
| MEDIAN | 1.5 | 1 | 5 |

FIGURE 3




Trainee supervision levels could be used as a surrogate measure of how often there is direct consultant input to APS work; however, the College does not collect such data. Comments about supervision and teaching in acute pain provide some information.

## FEEDBACK FROM TRAINEES ABOUT ACUTE PAIN EXPERIENCE

Trainees reported the following patterns of acute pain work organisation:

- Sessional allocation (eg. 1 day or session/week) 16 (24%)
- Block allocation (from 1 week to 3 month duration) 10 (15)
- Minimal exposure to acute pain 5 (7.5)
- Daily exposure (usually smaller sites with 1-2 trainees) 4 (6.0)
- After-hours only 3 (4.5)
- Trainee also allocated to other duties (eg. labour ward, PAC) 1 (1.5)
- No information provided 28 (42)

In only two hospitals were acute pain-related workload and hours reported by trainees to be excessive. However, there was no information provided for 42% of hospitals.

Trainee opinions about quantity and quality of teaching and supervision in acute pain were classified as 'positive', 'neutral' or 'negative'.

### Examples of comments about quantity (Figure 3)

- Positive: 'excellent', 'good', '50% specialist cover', 'very good', 'adequate'
- Neutral: 'variable', 'consultant on site', 'consultant on call', 'good nurses'
- Negative: 'nil', 'poor', 'very poor', 'below average', 'often busy', 'no consultant', 'non-existent', 'minimal', 'inadequate', 'less than 2 hours/month'.

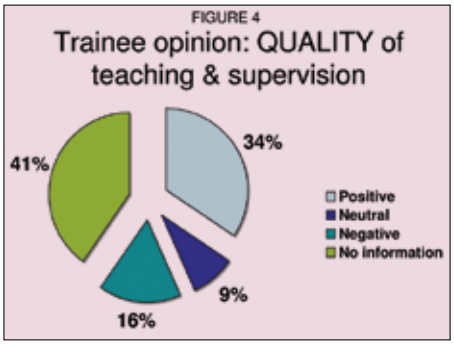
### Examples of comments about quality (Figure 4)

- Positive: 'good if it happens', 'excellent if there'
- Neutral: 'phone only', 'one hour/week', 'good nurse'
- Negative: 'opportunity lost'.

## FEEDBACK FROM TRAINEES ABOUT CHRONIC PAIN EXPERIENCE

Twenty-four hospitals reported that they had a multidisciplinary pain service (13 of the hospitals accredited by ANZCA for 3 years, 6 accredited for 2 years and 5 accredited for 1 year or less). Trainees reported that in eight of these (33%) there was regular allocation of anaesthesia trainees (for 3-month blocks in 6, a 6-week block in 1, and 1 hour/week in another). Of the remaining hospitals, exposure was minimal or nil in 13 (54%) and no information was provided for three.

FIGURE 4




## HOSPITAL ACCREDITATION COMMITTEE RECOMMENDATIONS ABOUT ACUTE PAIN

As part of the College decision about whether to accredit an institution for FANZCA training, recommendations for improvements are made. 'Must' recommendations are those that must be achieved to maintain accreditation. 'Should consider' recommendations are those that the hospital/department may wish to consider to improve the quality of the service and of teaching/training provided. Both types of recommendations are based upon College policy as outlined in College documentation. The recommendations about acute pain are shown in Table 2.

## DISCUSSION

The purpose of hospital accreditation by the College is to support departments to provide training to the next generation of specialists so that a high standard of patient care is delivered. Patients have a right to care by anaesthetists and other staff with appropriate training and experience. Such care partly depends upon appropriate staffing of Acute Pain Services, not only for direct patient care, but also for the development of protocols, educational programs for nursing and medical staff, and other administrative, research and quality improvement activities. It is unlikely that trainees will become proficient in acute pain management unless they receive appropriate teaching and supervision.

Over 90% of ANZCA-accredited Hospital Departments provide an acute pain service. However, in six out of every ten hospitals these are of insufficient quality to the extent that the College Hospital Accreditation Committee provided a recommendation for improvement. In over one fifth (22%) this was a 'Must' recommendation, that is one upon which accreditation depended. Identified issues included insufficient nurse staffing (12 hospitals, 18%) and the need to increase senior medical input (16, 24%). These deficiencies are likely to have an impact upon teaching and training in acute pain management, as well as potentially on the delivery of clinical service to patients.

**TABLE 2: Hospital Accreditation Committee recommendations about acute pain**

| | n (%) |
|---|---|
| Any recommendation | 38 (57) |
| 'Must' recommendation | 15 (22) |
| 'Should consider' recommendation | 23 (34) |

The most common recommendations (Table 3) relate to staffing, that is, nursing or senior medical input (issues with supervision and teaching usually reflecting a lack of this).

**TABLE 3. Hospital Accreditation Committee recommendations (some hospitals received more than one recommendation)**

| | |
|---|---|
| **'Must'** | |
| Nurse staffing | 8 |
| Consultant staffing | 6 |
| Trainee supervision | 3 |
| Trainee involvement in the APS | 1 |
| Resources for Chronic Pain Service (CPS) | 1 |
| Trainee involvement in CPS | 1 |
| Ensure completion of Module 10 | 1 |
| Establish an APS | 1 |
| **'Should consider'** | |
| Nurse staffing | 2 |
| Consultant staffing, leadership, management | 3 |
| Trainee supervision | 3 |
| Trainee teaching | 3 |
| Trainee involvement in APS | 3 |
| Trainee involvement in CPS | 4 |
| Resources for CPS | 5 |
| Develop a CPS | 1 |
| Limit trainee duties to APS | 1 |
| Undertake APS audit | 1 |

In approximately one third of accredited hospitals, trainees made negative comments about the quantity of supervision and teaching in acute pain. Interestingly, trainees were more likely to be positive about the quality of teaching and supervision, indicating perhaps that when it happens it is well regarded and appreciated (reflected in comments such as 'opportunity lost' and 'good if it happens').

So what of the potential impact on quality of patient care? In relation to the information gathered in this audit process, this is speculative. However, acute pain management, like other areas of anaesthesia practice, has become increasingly complex. Examples include:

> The recognition of the importance of acute pain management in preventing chronic (persistent) pain. Some acute interventions reduce the incidence of progression to persistent pain (level 2 evidence, Acute Pain Management: Scientific Evidence, 2005) with potential for a very significant impact on morbidity.

> The recognition of the phenomenon of acute neuropathic pain including the efficacy of non-opioid therapies. For example, calcitonin is effective for acute phantom limb pain (level 2, Acute Pain Management: Scientific Evidence, 2005).

> Even relatively 'straightforward' problems such as the management of complete motor block in a patient with an epidural may have profound implications for patient outcome (ie. if epidural haematoma goes unrecognised).

## WHAT IS THE COLLEGE DOING?

**1** An Acute Pain Working Party has been established by the College Education and Training Committee (ETC) to consider acute pain and FANZCA training. The Working Party membership comprises: Lindy Roberts, Chair of ETC (Chair) Mary Lawson, ANZCA Director of EducationTony Weeks, Chair of Examinations Leona Wilson, Chair of HAC and member of ETC Jane Trinca, FPM representative ETC, a representative from the ANZCA Trainee Committee.

The Working Party will consider:

> College standards regarding acute pain.

> Teaching and supervision of experience for Module 1 'Introduction to Anaesthesia and Pain Medicine' and Module 10 'Advanced Pain Medicine'. This may include greater guidance about structured assessment to practise beyond level 1 supervision in pain medicine for novice trainees.

> Support for Module 1 and 10 Supervisors and Supervisors of Training.

The Working Party will report to ETC in June 2008 and the forthcoming Review of the FANZCA Program. Input from College or Faculty Fellows or Trainees would be valued. Please send comments to Cherie Wilkinson, Executive Officer Examinations and Training **(cwilkinson@anzca.edu.au).**

**2** The College has funded the development of distance (on-line) educational materials to support teaching and learning for Module 10. This is being undertaken by Professor Philip Siddall and colleagues from the University of Sydney. It is expected to be completed in April 2008 and will be made available to trainees, Module 10 Supervisors and Supervisors of Training later this year.
**To register your interest, please email Cherie Wilkinson (cwilkinson@anzca.edu.au)**.

**3** The ANZCA Hospital Accreditation Committee is reviewing the data set about acute pain that is collected as part of hospital accreditation. It will also communicate with the Faculty of Pain Medicine about the pain centres it accredits.

**4** Acute Pain Management: Scientific Evidence, a joint College and Faculty of Pain Medicine publication, is regularly updated by the Working Party chaired by Dr Pam Macintyre. The most recent update (December 2007) is available on the College website (www.anzca.edu.au/resources/books-and-publications).

LINDY ROBERTS
Chair ANZCA Education and Training Committee
and Member ANZCA Hospital Accreditation Committee

## ACKNOWLEDGEMENT

Janet Devlin, Administrative Officer, Faculty Accreditation, for assistance with data collection.

**REFERENCES**

(all available at www.anzca.edu.au)
Acute Pain Management: Scientific Evidence.
College Professional Documents
**TE2** Policy on Vocational Training Modules and Module Supervision
**TE3** Policy on Supervision of Clinical Experience for Vocational Trainees in Anaesthesia
**TE10** Recommendations for Vocational Training Programs
**PS3** Guidelines for the Management of Major Regional Analgesia
**PS41** Guidelines on Acute Pain Management (ANZCA and FPM joint document)
**PS42** Recommendations for Staffing of Departments of Anaesthesia
**PS45** Statement on Patients' Rights to Pain Management (ANZCA and FPM joint document)

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS
ABN 82 055 042 852

# Professional Documents

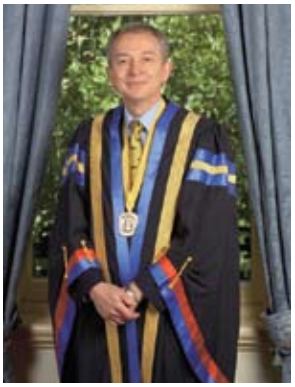
| | | |
|---|---|---|
| **TE1** | (2005) | Recommendations for Hospitals Seeking College Approval for Vocational Training in Anaesthesia |
| **TE2** | (2006) | Policy on Vocational Training Modules and Module Supervision (interim review) |
| **TE3** | (2006) | Policy on Supervision of Clinical Experience 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** | (2003) | Formal Project Guidelines |
| **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** | (2006) | Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations |
| **T3** | (2006) | 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 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 Pre-Anaesthesia Consultation |
| **PS8** | (2003) | Guidelines on the Assistant for the Anaesthetist |
| **PS9** | (2007) | Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical Procedures |
| **PS10** | (2004) | Handover of Responsibility During an Anaesthetic |

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

| | | |
|---|---|---|
| **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** | (2001) | Statement on the Standards of Practice of a Specialist Anaesthetist |
| **PS18** | (2006) | Recommendations on Monitoring During Anaesthesia |
| **PS19** | (2006) | Recommendations on Monitored Care by an Anaesthetist |
| **PS20** | (2006) | Recommendations for Responsibilities of the Anaesthetist in the Post-Operative Period |
| **PS21** | (2003) | Guidelines on Conscious Sedation for Dental Procedures |
| **PS24** | (2004) | Guidelines on Sedation for Gastrointestinal Endoscopic 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** | (2002) | Statement on Anaesthesia Care of Children in Healthcare Facilities without Dedicated Paediatric Facilities |
| **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** | (2001) | Statement on Patients' Rights to Pain Management |
| **PS46** | (2004) | Recommendations for Training and Practice of Diagnostic Perioperative Transoesophageal Echocardiography in Adults |
| **PS47** | (2002) | Guidelines for Hospitals Seeking College Approval of Posts for Vocational Training in Diving and Hyperbaric Medicine |
| **PS48** | (2003) | Statement on Clinical Principles for Procedural Sedation |
| **PS49** | (2003) | Guidelines on the Health of Specialists and Trainees |
| **PS50** | (2004) | Recommendations on Practice Re-entry for a Specialist Anaesthetist |

JOINT FACULTY OF INTENSIVE CARE MEDICINE

# Dean's message



DR RICHARD LEE

## Challenge

2008 is already proving to be an interesting and challenging year.

Sadly at the end of January, Carol Cunningham-Browne left after 18 years at FARACS, FICANZCA and then JFICM. It is recorded elsewhere in the Bulletin in more detail but Carol, as Executive Officer (EO) has been the point of contact and source of information and corporate knowledge for the Fellows, Trainees and Boards for many years. The team around her has grown over the years as the numbers of Trainees and Fellows have increased exponentially, but Carol has never lost the personal touch and concern for the well being of each individual and the group. She carried a passion for her role with her day and night, 7 days a week and this passion was infectious. Carol is going to be greatly missed, and finding a replacement to fill her shoes will be the first challenge of the year.

We are grateful that the members of the office team—Laura, Daniel, Lisa, Sumithra and now Carola—are continuing Carol's work in a most efficient and cohesive manner. Larraine Bamford is leaving soon to pursue a nursing career. While we await the appointment of a new EO the Board is again grateful to Alison Burger for her 'steady hand on the wheel'.

The next challenge will be to finalise an arrangement to pay our share of ANZCA corporate costs. In November 2007, the CEO of ANZCA submitted an initial assessment of ANZCA's total corporate costs and JFICM's share of them, which would increase the costs allocated to JFICM by ANZCA. These allocations have been levied since 2002 for rent, IT, financial services etc, extra to our usual staffing and other running costs. It has always been JFICM policy to pay our own way and as such we have been asking for an updated accounting to reflect the reality of the true costs to ANZCA of JFICM.

Talks with ANZCA executive regarding allocation of corporate costs have been ongoing since December 2007. The aims of the talks are to find an arrangement, which maintains our relationship and goodwill with ANZCA and which allows us to continue to grow the training body in a viable and productive way with a strong voice. Fortunately, negotiations appear to have been successful and a revised figure will hopefully be put to ANZCA Council for consideration in February.

The survey of Fellows on the future of JFICM was completed in November 2007. The results were:

> 343 responses were received, ie. 61% of Fellows responded
> 227 (66%) favoured establishment of a separate college of intensive care medicine
> 132 favoured formation within the next 2 years
> 92 favoured formation in 5 to 10 years
> 109 respondents did not favour formation of a separate college but all, except 20, indicated that they would join a separate college if it were formed.

The survey will be the subject of discussion at the JFICM Board Meeting at the end of this month and will likely be a focal point of the AGM in May. The Board's aim is to acquaint the Fellows with all the relevant facts and figures over the next few months.

At the end of 2007, I visited each of the national and regional committees. I was made very welcome and appreciated the opportunity to discuss the changes, which are occurring within JFICM, and the issues of concern. It was very gratifying to meet and have discussions with young and very keen Fellows and renew acquaintances with some older friends and stalwarts. The topics and issues discussed included:

> The changes to the Fellowship Exam and the aims of the changes
> The new Primary examination
> The ways of addressing the high dropout rate of Trainees to the lifestyle specialties
> The ways we have confronted the too-early transit into Advanced Training by some Trainees
> The development of Objectives and Competencies for Basic Training
> The plan to review courses and focus on 'active' training
> A new CPD program
> Survey and cost allocations.

All in all, 2008 is shaping as an exciting year, which will require the continued commitment by the specialty of time, energy and thought on the way ahead.

DR RICHARD LEE

CAROL CUNNINGHAM-BROWNE

# Carol Cunningham-Browne CCB (1989 to 2008)

**'The horror of the moment,' the King went on, 'I shall never forget.'**
**'You will though,' the Queen said, 'if you do not make a memorandum of it.'**
**—Lewis Carroll,** *Through the Looking Glass*

The moment that each Fellow and Board member thought or hoped would never happen, occurred on Friday 1st of February. Carol—who had come to represent the heart of JFICM—left after 18 years of looking after intensive care medicine training bodies at the College and, before it, the Faculty of Anaesthetists. When one reflects on Carol's contribution, it is apparent that the essence has been a dedication to the specialty and caring for each Fellow, Trainee and Board Member. She not only participated in JFICM and FICANZCA affairs, she seriously tried to improve the lot of each Fellow and the specialty.

Most Fellows will not be aware of Carol's other life as gardener, renovator, chanteuse, entertainer and athlete, but that 'other' life explains her persona—the inherent balance—and it mirrors Carol's happy nature and caring friendliness. If you know about those pastimes, you may understand how CCB came to be loved by those who worked beside her.

It is said that a garden is a form of autobiography. Gardeners are good people who nurture, tend and support. They are meticulous and must be disciplined in their routines to get their plants to not only survive, but flourish. They are patient and must plan well ahead. Attention to detail is the key. These are the nurturing qualities which were visible in Carol's daily life at JFICM. Carol's perpetual renovation is an extension of this, focused on caring for her house. Her love of singing not only gives vent to a beautiful voice, but shows her creative side and true ear. Her love of entertaining all and sundry at her home is typical of her giving and sharing with friends. Volleyball let out the competitive streak in a team environment.

Carol was a perfect match for an educational body. We teach intensive care medicine; she taught people to enjoy every moment, with her wry sense of humour and her smile. After the death of Joan Sheales, she became the longest serving employee at the College. For someone so young, full of life and active, that would be a hard title to carry. The title itself is surely explained by her commencing her career as a work-experience school student.

Carol might be remembered for the more than 50 Board meetings she organised, the agendas, the thousands of pages of minutes and the tens of thousands of letters and telephone calls to concerned trainees, the hundreds of Fellows that she knows by name and the trainees she has helped to survive to the end of the exams. But also, the legacies that Carol leaves are those of personal commitment, of developing a fine team, of demonstrating an ethos of caring, of enjoyment of work, of enjoyment of time spent with people and sense of humour. Carol's stamp on the intensive care group is so strong that one might wonder if it would have been as friendly and inclusive over those 18 years without her.

It is imperative that JFICM carries the CCB ethos and sense of camaraderie into the future.

DR RICHARD LEE

# Barnesy says Keep the Beat

**The Intensive Care Appeal is just around the corner and this year the Foundation is extremely excited to have rock legend Jimmy Barnes as the face of the Appeal.**

Jimmy Barnes is no stranger to intensive care, having undergone open heart surgery to replace a faulty aortic valve and then being re-admitted with Dressler's Syndrome—an inflammation of the sac around the heart. Fitting with Barnesy's time in intensive care, the theme for the Appeal is Keep the Beat.

Intensive Care Day is taking place on Friday the 18th of April. The theme for the day is KEEP THE BEAT – ROCK ON! The Foundation invites all Intensive Care Units across Australia and New Zealand to participate in the day's festivities by dressing up as your favourite rocker, playing music from your favourite rock band or wigging out with a crazy rock inspired hairdo—think AC/DC, The Rolling Stones, Cold Chisel and Kiss to name a few. Make sure you take photos of your celebrations for inclusion on the Foundation's website and in the June newsletter.

The aim of the Appeal is to raise the profile of intensive care in our community, as well as fundraising for this important cause. This year, Appeal merchandise will consist of children's wristbands, key tags and the new addition of a four-coloured pen with a safety pull-apart lanyard. Appeal merchandise will be available in Intensive Care Units across Australia and New Zealand, ANZ branches in Australia and Jesters Pies Stores in New Zealand.

If you would like to help out during the 2008 Appeal by selling merchandise or holding celebrations on Intensive Care Day, please contact the Foundation on 03 9340 3444 or **info@intensivecareappeal.com**.

Support from our Intensive Care Co-operative members ensures that every dollar raised during the Appeal goes towards funding intensive care research projects as well as the education of health professionals responsible for intensive care—for 2008 the Foundation funded six clinical research projects.

Application forms and guidelines for 2009 research grants can now be downloaded from the Foundation's website—www.intensivecareappeal.com. The deadline for submissions is the 30th of May 2008.

## JOINT FACULTY OF INTENSIVE CARE MEDICINE

# Policy 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** | (2003) | 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** | (2002) | 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 on Practice Re-entry for an Intensive Care Specialist |
| **PS38** | (2004) | Statement Relating to the Relief of Pain and Suffering and End of Life Decisions |
| **PS39** | (2003) | Intrahospital Transport of Critically Ill Patients |
| **PS40** | (2005) | Guidelines for the Relationship between Fellows and the Healthcare Industry |
| **PS45** | (2001) | Statement of Patient's Rights to Pain Management |
| **PS48** | (2003) | Statement on Clinical Principles for Procedural Sedation Bulletin |
| **PS49** | (2003) | Guidelines on the Health of Specialists and Trainees |

FACULTY OF PAIN MEDICINE

# Dean's message

DR ROGER GOUCKE

Last year, the President of ANZCA and I wrote to all Fellows outlining the wide range of activities that have been carried out by the Faculty over the last twelve months. With the recognition by the Federal Government of Pain Medicine as a medical specialty in its own right, the Faculty is required to engage in a large number of interactions with State and Federal authorities. While this is time consuming, it does allow the Faculty, and therefore Pain Medicine, to have a voice in these areas.

A significant portion of the Faculty's energy is devoted to our training program, including assessment of Accredited Training Units, providing support for Trainees and Supervisors of Training and running the Examination process. It is worth noting that of our 231 Fellows, 40% have now been admitted by Training and Examination.

The Board of Faculty has been aware for some time that we need to devote perhaps more of our resources and energy into providing services for Fellows. Traditionally the major visible Fellowship benefits are the Annual Scientific Meeting and our Refresher Course Day.

The inaugural Spring Meeting held on the Gold Coast in 2007 was a great success, and initial interest in the Spring Meeting—to be held at Uluru in September 2008 and focusing on Acute Pain—is also high.

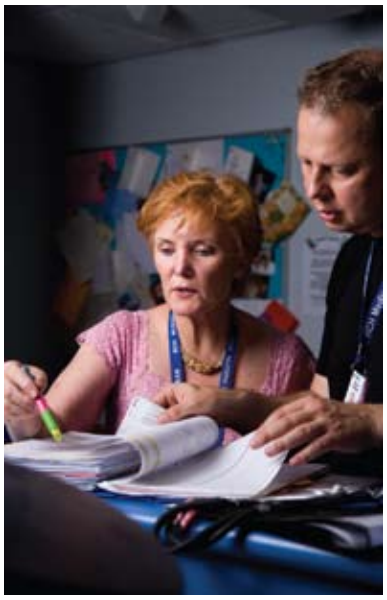
The Board has strongly endorsed the new CPD program and I would urge Fellows to take early advantage of the program to develop their thoughts and plans for self development during 2008.

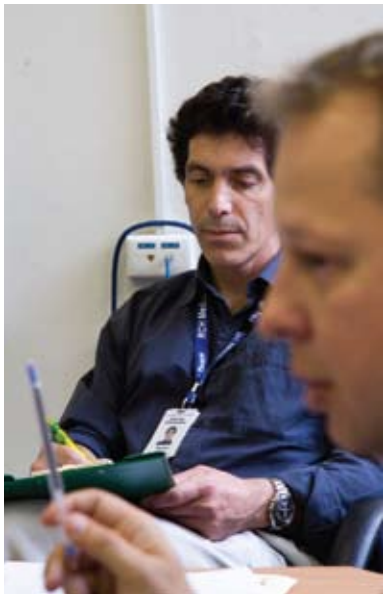
A restructure of the Board is planned to take place at the Annual General Meeting during the ASM in Sydney in May this year, with one of the thrusts of the restructure being to develop a portfolio specifically designed for Fellowship Affairs.

The initiatives I have outlined can only occur with input from Fellows; the more Fellows that are involved, the more ownership of these initiatives there will be. I would strongly encourage any Fellow who is interested in assisting the further development of the Faculty to contact Board Members or the Executive Officer for information on joining any of the Faculty's committees or sub-committees. Likewise, I would encourage Fellows who wish to have an input into the direction of the Faculty, to contact either myself or the Executive Officer. The Faculty will be what we, as Fellows, make it.

While recently reflecting on the strong growth and development of the Faculty over the last nine years, and with your continued support, we can look forward to a very exciting and challenging future for our specialty of Pain Medicine.

DR ROGER GOUCKE
Dean





# Faculty of Pain Medicine 2007 Examination

The Faculty's 2007 examination was held at Geelong Hospital. There were 17 candidates and the Faculty is pleased to report a 100% pass rate. Our thanks go to Drs Tony Weaver, Melissa Viney and Diarmuid McCoy, as well as staff at the hospital for their generous assistance in preparing and organising this examination.

Congratulations to the 2007 Barbara Walker Prize winner, Dr Duncan McKay (Sir Charles Gairdner Hospital) and to Merit Award recipient, Dr Leigh Dotchin (Flinders Medical Centre).

Dr Penny Briscoe, Chairman of Examinations with the Barbara Walker Prize Winner, Dr Duncan McKay
2007 Court of Examiners

# Report from the Board Meeting held on 4 February 2008

## DEAN ELECT

Dr Penny Briscoe, FANZCA was elected Dean-elect and will take office following the Annual General Meeting in May.

## FELLOWSHIP

Three Fellows were admitted to Fellowship by training and examination and Associate Professor Wayne Gillett, FRANZCOG (NZ) and Dr James Bartley, FRACS (NZ) were admitted to Fellowship by election.

In accordance with Administrative Instruction, 10.5 Fellowship was regretfully withdrawn from one Fellow whose subscriptions were two years in arrears.

## ASSESSMENT OF OCCUPATIONAL TRAINEE VISAS

Correspondence from the Department of Health and Ageing with regard to the role of the specialist medical colleges in the assessment of occupational trainees (442 visas) raised concerns that the processes were confusing and not well defined. It was agreed that a clear, consistent policy would be welcome so that trainees could be properly advised. Meanwhile, Unit Directors and Supervisors are advised to contact the Faculty Office for guidance.

## RECOGNITION OF PAIN MEDICINE SPECIALISTS

The Board discussed the appropriate use of the term 'pain specialist'. As considerable efforts have gone in to establishing the Faculty it was agreed that its specialty status should be defended with any institution that accords specialist status to medical practitioners. It was resolved that information be obtained from the relevant jurisdictions in Australia as to the criteria used to determine if someone is a pain medicine specialist.

## FINANCE

Reports to 31 December 2007 were not yet available. The 2008 FPM Budget has been accepted by Council without amendment.

## EDUCATION AND TRAINING

### FPM Training Program

Following input from Supervisors of Training, a Training Agreement was accepted for circulation to all current trainees and to all future trainees in their registration documentation.

A Trainee Performance Review document was also accepted which sets out the processes for independent review to determine the future of a Trainee. This process may be initiated by the Supervisor of Supervisors of Training in consultation with the Chair of the Education Committee, or by the Trainee.

### Continuing Professional Development

An audit of 5% of Fellows 2006 MOPS participation showed compliance with the Fellows' chosen program. An audit of 2007 returns will be undertaken. The Board strongly endorsed the new CPD program and encouraged participation.

## EXAMINATION

The Board acknowledged the 100% pass rate at the 2007 examination and congratulations were expressed to the candidates and Supervisors of Training on this excellent result. It is proposed that the 2008 examination will be held in NSW on 26-28 November and the Pre-examination Short Course will again be held at the Royal Adelaide Hospital. Candidates are advised not to book flights until dates and venues have been confirmed.

Dr Julia Fleming has agreed to represent the Faculty on the ANZCA Primary Examination Committee.

## TRAINING UNIT ACCREDITATION

Burwood Hospital, Pain Management Centre, Christchurch was accredited for Pain Medicine Training for a period of 3 years. The Hunter Integrated Pain Service, Newcastle, Royal Perth Hospital and Barbara Walker Centre for Pain Management, St Vincent's Hospital, Melbourne were approved for ongoing accreditation. There are currently 23 Faculty accredited training units.

The Board is considering a range of options relating to accreditation of overseas units following interest from units in South East Asia.

Dr Melissa Viney has agreed to represent the Faculty on the ANZCA Hospital Accreditaiton Committee.

## RESEARCH

### Pain Medicine Prizes

A number of abstracts have been submitted for the Dean's Prize and Faculty Free Papers session at the 2008 ASM in Sydney. The Dean's Prize will be awarded at the AGM to the paper judged to be a significant contribution to Pan Medicine and/or Pain Research. For those not eligible for the Dean's Prize, a Best Free Paper award, in the form of a certificate, will be made.

### AROC Database

Contact has been made with the Australasian Rehabilitation Outcomes Centre with regard to the possibility of using AROC to facilitate the Faculty's outcome measures data. The Faculty would be required to provide a data set and nominate a group of units who would participate. AROC would need to find a funding source to support it. A more formal presentation from the AROC Manager is awaited.

### Administrative Instructions

A significant part of the Board meeting focused on a revision of the AI's, now to be known as Regulations, with the intention of reflecting the new Board structure and addressing issues with regard to eligibility for entry into the training program and Fellowship. A final draft incorporating the suggested amendments will be submitted to the May Board meeting for acceptance.

## PROFESSIONAL

### Intercollegiate Relationships

Dr Alex Holmes, Chair, Section of Consultation Liaison Psychiatry met with the Board to discuss ways by which FPM trainees could more fully interact with psychiatry and how the Faculty might interest CL psychiatry trainees in Pain Medicine.

A Memorandum of Understanding between the FPM, ANZCA and the RACP, RANZCP, RACS and AFRM RACP, developed to strengthen the bonds between the participating organisations and to facilitate interaction at a trainee and Fellow level, was finalised for submission to the relevant College and Faculty Presidents for signature.

Progress is being made toward establishing a working party with RANZCOG to look at pelvic pain in women.

### Opioid Prescribing

The APS President and Vice President ill meet with the Minister for Health to discuss the issues of pain in the elderly and in aged care institutions. This dovetails with the development of pain management guidelines on the use of opioid analgesics. Associate Professor Milton Cohen will represent the Faculty at a meeting with the Minister's advisors. It is hoped that the Federal Government will establish a program/committee to look at the whole issue of opioid prescribing in the context of the management of pain and opoid misuse.

Another related initiative being progressed with the AMA is the issue of enhancing the management of pain in primary care. This is currently on the table and has received a positivie reception. Progress in these areas now depends on tripartite activity between the FPM, APS and government, with the issue of misuse of opioids a prominent theme.

### Drugs and Crime Prevention Committee, Parliament of Victoria

A Final Report from the Inquiry into the Misuse/Abuse of Benzodiazepines and Other Forms of Pharmaceutical Drugs is now available online from this Inquiry: www.parliament.vic.gov.au/dcpc

### Recognition of Pain Medicine as a Specialty – New Zealand

Rules for submission to the MCNZ have changed slightly, with the process now being a two part assessment. A revised submission is underway.

### TAC Policies on Spinal Injection and Radiofrequency Procedures, Pain Infusions and Implantable Pain Therapy

There was a consensus at the Board Meeting that the Faculty was not in a position to endorse these documents at this time and the TAC has been advised accordingly.

## CONTINUING EDUCATION

### Annual Scientific Meetings

Drs Susie Lord (NSW) and Charlotte Johnstone (NSW) will represent the Faculty at the 2008 New Fellows' Conference.

Dr Andrew Rice, UK, has accepted the invitation as the FPM Foundation Visitor and Dr Steven Passik has accepted the invitation as the Queensland Visitor (Pain Medicine) for the 2009 ASM in Cairns.

Dr Jeffrey Mogil (Canada) has accepted invitation as the FPM Foundation Visitor for the 2010 ASM in Christchurch.

### Spring Meeting 2008

Plans for this combined meeting with the ANZCA/ASA/NZSA Acute Pain Special Interest Group and the IASP Acute Pain Special Interest Group are well advanced.

## COMMUNICATIONS

The new Faculty website has been launched and Fellows and Trainees are invited to provide feedback and contributions.

## CORPORATE AFFAIRS

### Strategic Planning

The Board agreed on a new structure to take effect from May 2008. A Fellowship Affairs portfolio has been developed with the aim of devoting more resources and energy into providing services to Fellows. A Continuing Education and Quality Assurance Committee will be formed under this portfolio to focus on Quality Assurance Issues.

### Board Election

Five nominations have been received for four places and a ballot will proceed. Dr Frank New representing the Royal Australian and New Zealand College of Psychiatrists is elected unopposed.

### Access Economics Report: The high price of pain: the economic impact of persistent pain in Australia

This report is available for viewing on the website:

http://www.accesseconomics.com.au/publicationsreports/showreport.php?id=142

FACULTY OF PAIN MEDICINE

# 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 |
| **PS40** | (2005) | Guidelines for the Relationship Between Fellows and the Healthcare Industry |
| **PS41** | (2007) | Guidelines on Acute Pain Management |
| **PS45** | (2001) | Statement on Patients' Rights to Pain Management |
| **PS48** | (2003) | Statement on Clinical Principles for Procedural Sedation |
| **PS49** | (2003) | Guidelines on the Health of Specialists and Trainees |

## ANZCA Professional Documents adopted by the Faculty:

| | | |
|---|---|---|
| **PS4** | (2006) | Recommendations for the Post-Anaesthesia Recovery Room (Adopted February 2001) |
| **PS7** | (2003) | Recommendations on the Pre-Anaesthesia Consultation (Adopted November 2003) |
| **PS8** | (2003) | Guidelines on the Assistant for the Anaesthetist (Adopted November 2003) |
| **PS9** | (2007) | Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical or Surgical Procedures (Reviewed 2007) |
| **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** | (2006) | 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** | (2006) | Recommendations on Minimum Facilities for Safe Anaesthesia Practice in Operating Suites (Adopted May 2006) |