

Australian and New Zealand College of Anaesthetists

ABN 82 055 042 852

Faculty of Intensive Care
Faculty of Pain Medicine



Bulletin

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

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Editorial

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

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

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

Regional Committee offices can be contacted via email as follows:

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

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President's Message

Teik E Oh, MD, PANZCA

LOOKING OUTWARDS

The historic CSM last month with the Hong Kong College of Anaesthesiologists (HKCA) was a resounding success. Few venues can match the magnificent Hong Kong Convention Centre on the Wanchai waterfront. The Grand Foyer where the Opening Ceremony was held, with its majestic Victoria Harbour backdrop, said it all. This spectacle heralded a superb scientific and social program, executed through faultless organization. Australasian delegates departed intellectually and gastronomically satiated, albeit considerably depleted of their battered Aussie and Kiwi dollars.

A smaller group left for a satellite meeting in Beijing. This was yet another historic meeting of ANZCA, HKCA, and the Chinese Society of Anaesthesiology, the equivalent body of the People's Republic of China. The one-day meeting on a range of topics was topped with visits to historic sights. ANZCA thanks colleagues who put together the CSM and the satellite meeting, and this is recorded elsewhere in this *Bulletin*.

If you think about it, our College, which is a body of professionals from two countries operating under one system, went to "one country, two systems". The visit no doubt left impressions on Australians and New Zealanders. First-time visitors would have been amazed by the splendour and buzz of Hong Kong. This Big Apple today is a far cry from that of *The World of Suzie Wong*. Those who went to Beijing saw a metropolis of new spaghetti highways, sprouting high rises, five -star hotels, and endless traffic. We were impressed and awed by relics of the 3,000-year cultural history of China, and not a little intimidated by the speed of progress of modern China. Our impressions of China and its Hong Kong Special

Administrative Region (SAR), should lead to reflections on our own countries.

Australia and New Zealand are large landmass countries with small populations. We are lucky countries in that we still have enviable lifestyles, but we are not big players in the scheme of things. For example, the trade in our All Ords and NZSE indices make up about 1% of the world stock market. Our per capita GDPs fall behind the US, Canada, many European countries, Japan, Singapore, and the Hong Kong SAR. With relatively few people and not being movers and shakers in the world, we need friends. Our links have been with the UK traditionally, and more recently with the US, but we are not in Europe or North America. Indeed, we are not even in the same hemisphere. Australia and New Zealand are not Asian countries or Pacific Island countries, but we do lie in the Asia-Pacific basin. Here is where we especially need to build friendships and ties.

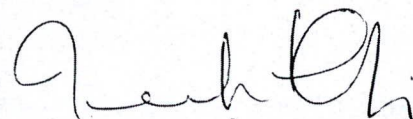
When ANZCA withdrew examining in Hong Kong, Malaysia, and Singapore a decade ago (where we had been examining since 1967), we turned away a generation of anaesthetists. These anaesthetists are now senior practitioners and professional leaders in their countries and SAR, but to them ANZCA, Australia, and New Zealand are not relevant. And yet, in Beijing, I met a number of bright, young, English-speaking, Chinese anaesthetists who had recently spent Fellowships in the US and Canada. They now have ties to North America, and their respect and goodwill to their *wai guo ren* teachers are immeasurable. Remember that they will become anaesthesia leaders in their economic and military giant of a country of 1.3 billion people. Who can boast that the leader of China's anaesthetists was once a trainee or Fellow in *their* department? Other Asian and Asia-Pacific countries,

i.e. our neighbours, will similarly grow in wealth and influence, albeit not as spectacularly.

Australia and New Zealand cannot afford to harbour a fortress mentality. History tells us that the *Ming* dynasty (1368-1644) repelled foreign contacts, believing that their advanced society could be self-contained and self-serving. This xenophobic and blinkered vision (or lack of one) brought about the isolation and eventual decline of imperial China. There is a lesson to be learned here.

One of ANZCA's strategic plans is to increase ties with Asian-Pacific countries, and Council will develop more initiatives to this. Well, what can we all do? We can provide aid in medical care and education to underdeveloped neighbours. Many individual Fellows have already given their time unselfishly to do this in Fiji, Papua New Guinea and other Pacific island nations, as well as in some South East Asian countries. ANZCA has formed an Overseas Liaison Committee with the ASA and

NZSA to co-ordinate this. With wealthier nations, we can seek partnerships in training, continuing education (such as the recent CSM), raising the bar in professional standards, and research. We can also offer basic or advanced training in our departments. Fellows can help promote links with Asia-Pacific colleagues in their hospitals and practices. Heads of Departments should try to establish Fellowships for talented anaesthetists from Asia and the Pacific Islands. Ties, friendships, and partnerships bring professional and intellectual exchanges, trade, growth, wealth, and security for our future generations. No man is an island. For island states, Australia and New Zealand cannot afford to be islands. We must look outwards, afar and most especially, close by.



TEIK OH

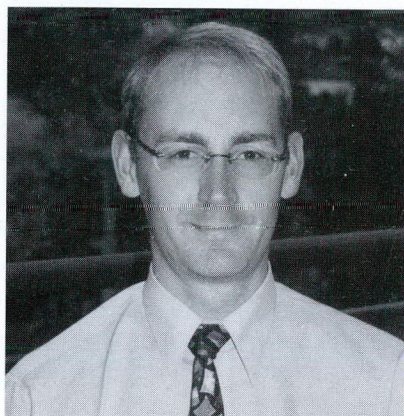
ANZCA Prizes for 2001



The recipient of the Prize for The University of Adelaide was Dr Andrew Lok. Dr Lok was presented with his award by the Vice President, Dr Richard Willis, during the recent South Australian Combined ASA/ANZCA Continuing Medical Education Meeting.



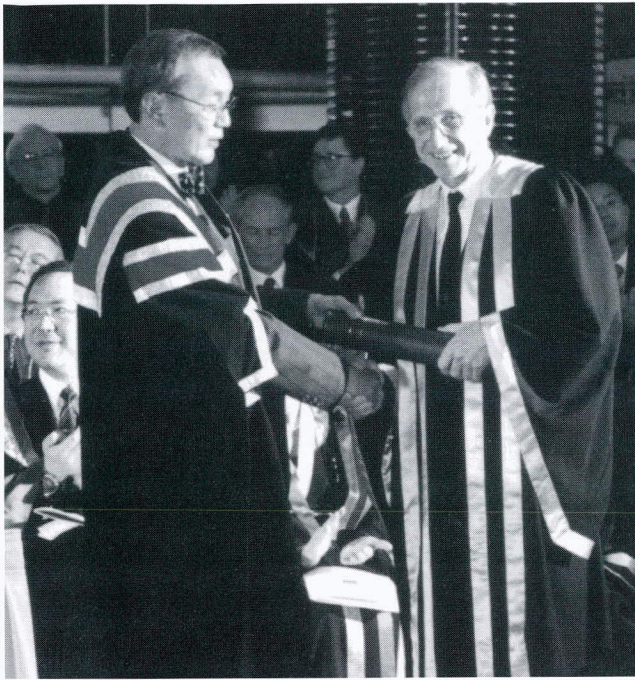
The Prize for Flinders University was awarded to Dr Rob Wilcox and Dr Shanthi Sarma. Dr Wilcox also received the "Section of Anaesthesia Medical Students Prize 2000/2001" from the Royal Society of Medicine, UK.



Dr Michael Lumsden-Steel (above) and Dr Elisabeth Spurr were awarded the Prize for the University of Tasmania.



Dr Vandhana Chetty from the Fiji School of Medicine was awarded the ANZCA Book Prize at the School's graduation ceremony.



Honorary Fellowship

Citation — Archibald Ian Jeremy Brain

'The Council of the Australian and New Zealand College of Anaesthetists admits from time to time distinguished persons who have made a notable contribution to the advancement of the science and practice of anaesthesia and/or intensive care, and who are not practising anaesthesia or intensive care in Australia or New Zealand.'

Mr President, I have the honour to present to you Archibald (Archie) Ian Jeremy Brain for conferment of Honorary Fellowship of the College.

Archie Brain was educated in Singapore, Japan and Yorkshire, before studying at Oxford University, where he obtained his Bachelor of Arts with Honours in Modern Languages in 1963. He studied Medicine at the Radcliffe Infirmary in Oxford, and St Bartholomew's Hospital London, graduating in 1970. His interest in anaesthesia led to completion of the Diploma of Anaesthesia in London in 1972, and Fellowship of the Faculty of Anaesthetists of the Royal College of Surgeons in Ireland in 1977. His arts interests were maintained, and his Masters Degree was awarded in 1988.

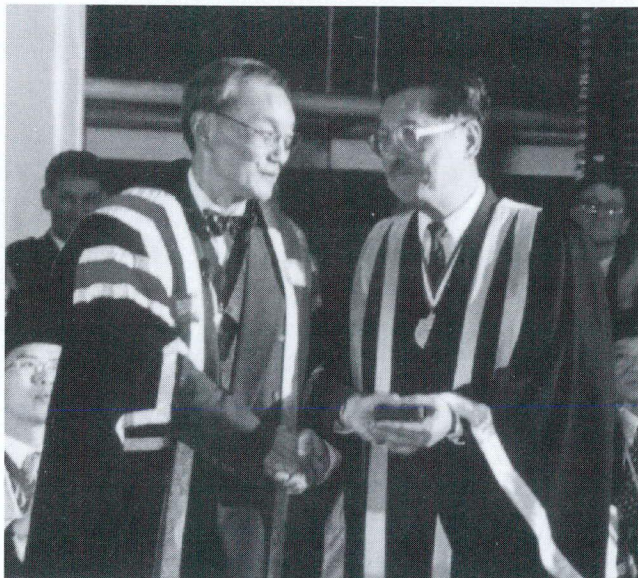
Archie Brain has held appointments in a number of London hospitals as well as an academic appointment at the Institute of Laryngology, University of London. Conferment of Honorary Fellowship by our College is in recognition of Archie Brain's contributions to research and teaching about his inventing the Laryngeal Mask Airway (LMA), the most significant advance in airway management since the Guedel airway and

the endotracheal tube. It could be said that the Laryngeal Mask Airway is the most recent quantum leap in the practice of anaesthesia. The inventiveness and persistence in development of the LMA, aimed at improved patient care, has been based on anatomical studies at the Institute of Laryngology in London, and at the Texas University Medical Center in Houston. However, not being satisfied with an invention that so revolutionised anaesthetic practice, he has continued to develop the Laryngeal Mask Airway with advancements such as the flexible Laryngeal Mask Airway, the Fastrach and most recently the Proseal. Most of us, Mr President, would have been well satisfied with the first invention, but not Archie Brain. He has also been honoured by the Royal College of Anaesthetists, the Association of Anaesthetists of Great Britain and Ireland, and the German Society of Anaesthesiologists.

Dr Brain has contributed over 70 publications to the literature, including the first textbook on the LMA, in collaboration with Dr Joe Brimacombe of Cairns. He has given over 150 presentations on the subject in 31 countries, delivering these in English, French, Spanish, Dutch and Italian, in all of which he is fluent. He is currently studying Japanese and Arabic. Despite these extraordinary talents, I can personally vouch that this is a most modest man.

Mr President, Dr Brain's contributions to airway management will be recorded in history with those of Guedel, Magill and Macintosh.

Mr President, I have the honour to present Archibald Ian Jeremy Brain for conferment of Honorary Fellowship of our College at the first meeting of our College with the Hong Kong College of Anaesthesiologists.



Australian and New Zealand College of Anaesthetists' Medal

Citation — Lim Say Wan

'The Australian and New Zealand College of Anaesthetists Medal is awarded at the discretion of the Council of the College in recognition of major contributions to the status of anaesthesia, intensive care, pain medicine or related specialities.'

Mr President, it is my privilege to present to you, Lim Say Wan, for the award of the Australian and New Zealand College of Anaesthetists' Medal.

Lim Say Wan was born and educated on the island of Penang in Malaysia. He was an excellent student and sportsman. In 1957, he was the Penang State Scholar in Medicine and commenced as a medical undergraduate in the University of Malaya in Singapore, graduating in 1963. During his undergraduate years, he continued to pursue his sporting interests excelling particularly in badminton where he won multiple singles and doubles championships.

Dr Lim returned to Penang for his house officer year in Penang General Hospital, followed by two years as a medical officer in the Malaysian Ministry of Health.

In 1966, as a Colombo Plan Scholar in Anaesthesia, he moved to Liverpool, UK, to pursue further training in anaesthesia. In a busy 1967, he was awarded DA London, FFARACS Ireland and FFARACS England. In 1968, he returned to University Hospital in Kuala Lumpur as a specialist anaesthesiologist. He was awarded Fellowship of the Faculty of Anaesthetists of RACS in 1974 and FANZCA in 1992. Since 1970, Dr Lim's major professional clinical activity has been in private practice. He has maintained his academic associations since that time both as an Honorary Lecturer in Anaesthesiology and as an

Examiner for the Final Examination for Master of Medicine (Anaesthesia) in the Universiti Kebangsaan Malaysia.

Dr Lim is best known for his contributions to major professional bodies both within his own country and internationally. Within Malaysia, he has held senior office in the Malaysian Medical Association, the Malaysian Society of Anaesthesiologists, the Academy of Medicine of Malaysia, the Malaysian Medical Council and the College of Surgeons of Malaysia and its Faculty of Anaesthesiologists. He was a major force in the establishment of the Asian and Oceanic Society of Regional Anaesthesia (AOSRA) in 1989 and was its founding President.

Dr Lim's commitment to the World Federation of Societies of Anaesthesia began in 1976 when he joined the Membership Committee. He was elected to the Executive Committee in 1980, Chairman of the Executive Committee in 1984, Secretary in 1988 and WFSA President from 1992 to 1996.

Dr Lim is a tireless and highly respected member of the international anaesthesia community. He has been honoured by many professional medical societies and Colleges for his contributions to the specialty and to medicine in general. He has been invited to present papers and orations at numerous scientific meetings in many countries on a wide variety of scientific and medico-political topics. His contribution to anaesthesia, particularly in our Asia Pacific region has been enormous. He is indeed a true giant of our specialty.

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

Hong Kong CSM and the Satellite Beijing Meeting

MAY 2001

The CSM with the Hong Kong College of Anaesthesiologists (HKCA) was held from 5-9 May 2001 at the magnificent Hong Kong Convention Centre. This was the venue where Britain officially handed over Hong Kong to the People's Republic of China (PRC) at midnight, 1 July 1997. Located on the island waterfront, the Centre offers a panoramic vista of the choppy harbour, with jostling ferries, barges, ships, and sampans against a backdrop of skyscrapers on the Kowloon side.

The Opening Ceremony was held in the Grand Foyer of the Convention Centre. A wall of glass with the harbour beyond provided the dream stage set of every stage manager. The stage party of ANZCA, the Faculties, HKCA, and officers of Hong Kong Colleges and the Academy looked resplendent in their robes. Dr EK Yeoh, Hong Kong's Secretary for Health and Welfare, opened the meeting. The two Colleges, without any earlier rehearsal, admitted Fellows, presented reports, and awarded honours in, paradoxically, record time. It had the appropriate ceremonial pageantry and was not, as one cynic cruelly said, bigger than *Ben Hur*. ANZCA awarded the ANZCA Medal to Dr Saywan Lim from Malaysia and conferred Honorary FANZCA to Dr Archie Brain from the UK. Assoc Prof. Peter Kam FANZCA from Sydney was admitted to Honorary Fellowship by the HKCA. The ANZCA Oration was delivered by Professor Arthur Li, a surgeon and Vice Chancellor of the Chinese University of Hong Kong. His oration, "Hong Kong at the Crossroads", illustrated profusely by *PowerPoint*, gave a thought provoking history of the former colony. After such a splendid start and good *fung shui*, and with about 1,000 registrants, nothing could go wrong.

The scientific program was put together by no less than six brains, chaired by Dr Tony Weeks (VIC). The theme was "Anaesthesia, Intensive Care and Pain Medicine – The Next Generation". Professor Martin Tramèr (Switzerland) was the ANZCA Foundation Visitor and he spoke on "Evidence and Anaesthesia: Where are We Going?" The FIC Foundation Speaker was Professor Laurent Brochard (France, "Optimal Management of ARDS") and for the FPM, Professor Troels Jensen (Denmark, "Acute to Chronic Pain – Neurobiological Aspects"). Dr Charles Minto (NSW) was the Australasian Visitor who spoke on "Every Anaesthetic is a Drug Experiment". The HKCA invited speakers were Professors Adrian Gelb (Canada, Anaesthesia), Randall Chestnut (USA, Intensive Care), and Michael Ashburn (USA, Pain Medicine). Their Foundation Visitor was Professor Ronald Miller (USA)

who delivered an interesting but pessimistic "Anaesthesia for the New Millennium". Delegates found the scientific program consistently innovative and practical in all disciplines. The workshops were popular, a testament to their quality. I observed a number of workshops, trying my hand in, and thoroughly enjoyed, the Airway Workshop. Dr Joe Novella's Virtual Congress impressed European and Canadian visitors. Lunches were extraordinarily good. Overall, it has to be one of the best scientific programs of an ASM or anaesthesia meeting in my memory.

As if to acknowledge our historic joint meeting, a global economic forum was also staged at the Convention Centre, starting on the last day of the CSM. This attracted its share of protesters and VIPs, including Bill Clinton and Jiang Zemin, the President of the PRC. Security was proverbially tight. Police – SWAT style – abseiled walls, "swept" the complex, and sealed off roads and entries, causing some mayhem. Water police launches formed a cordon to seal off approaches to the Convention Centre by water. Protesters were kept at bay *two* streets away from the entrance to the Centre, but Jiang Zemin made his entry from the harbour, in a glorious cavalcade of VIP launches flanked by patrol boats and black commando inflatables. Water traffic was diverted, ferries were delayed, and commuters were not impressed. This was not your everyday ASM.

The social program catered literally to most tastes. A noisy lion dance opened the Health Care Industry Cocktail Reception. There were tours to sights, shops and markets. Dinners served seafood, western and, of course, Cantonese cuisine. The College Dinner saw about 600 guests served a 12 course Chinese banquet. You have to wonder how they managed that in the kitchen. The Gilbert Brown Prize was awarded to Dr Anna KS Lee and Dr Winifred Burnett (VIC) was the recipient of the Formal Project Prize. Professor John Norman, a Fellow recently retired from the Chair in Southampton UK, presented a silver goblet to the College. Dr TW Lee, President HKCA, presented a crystal model of a sailing junk. The College presented gifts to the HKCA, Dr John Low the Convenor, and Ms Susanna Pang, the head of the PCO Team. Towards the end, we were treated to a fireworks display on the harbour, a fitting finale to a grand occasion. No one minded sharing that distinction and the fireworks with the economic forum.

There was ample opportunity for Fellows and partners to flash the plastic or test the strength of the battered Aussie and Kiwi

dollars. Exploits of hard core shoppers bargaining at Temple Street, Stanley markets and the like were rife, and legends were born. Many delegates could be seen sporting new suitcases to carry home the spoils. On an excursion to Stanley markets, some College staff and delegates met an American who was accompanied by a bunch of men in black, complete with shades. Afterwards, several photographs emerged with our staff and delegates beside the former President of the USA, Mr. Bill Clinton.



Professor Ailun Luo

A smaller group of about 90 delegates, including a dozen Hong Kong colleagues, then flew to Beijing for a post CSM satellite meeting, a brainchild of our retiring ASM Officer, Ian Rechtman. The historic one-day meeting of ANZCA, HKCA, and the Chinese Society of Anaesthesiology (CSA), the equivalent body of the PRC, was held at our hotel in a conference auditorium for about 250 people. At the opening banquet, we were welcomed by Professor Ailun Luo, President of the CSA and Professor of Anaesthesia at the Peking Union Medical College, the internationally renowned medical school. The meeting was made up of a range of topics presented by eight speakers from all three bodies. Drs John Russell (SA), Bill Shearer (VIC) and Stephen Swallow (TAS) were the ANZCA speakers. All talks were presented in English, in blocks of sentences which were immediately translated into Mandarin. Three young anaesthetists, freshly returned from Fellowships in prestigious North American institutions, provided the translation. They flawlessly translated faster than my brain could digest the same information in spoken English. About 150 delegates were from the PRC, including some who had come from afar, such as Shanghai. All of their Professors and many of their young specialists there spoke English, some fluently. I apologised for my inadequacies in not knowing Mandarin. To the Chinese, the value of the meeting was the opportunity to make contact with ANZCA and Australasian anaesthetists,

and they expressed their appreciation to me. Professor Luo hoped that contact between ANZCA and the CSA would flourish.

The other two days in Beijing were crammed with tightly scheduled tours. The Great Wall, one of the wonders of the world, took 2,000 years to build at a cost of countless lives. Tourist hordes now replace the Mongolian hordes it was intended to repel. A hawker confided to Dr Phil Ragg (VIC) that he was a nephew of the last Emperor *Pui Yin*. The ex Royal of the Kingdom of Heaven was now eking a living selling his calligraphy to tourists. One might expect Phil to have marked his respect by buying the works of the noble nephew. The Forbidden Palace, the winter residence of the rulers of the *Ming* and the *Qing* dynasties, was the location where the film *The Last Emperor* was shot. In summer, the Royal entourage moved to the Summer Palace, complete with an extensive man-made lake – not your Anglesea weekend beach cottage. Tiananmen Square was massive, with a large mural of Chairman Mao at one end, just like on TV.

Beijing surprised our ANZCA delegation, being more modern, western, and developed than expected. We travelled on excellent new roads and highways, and saw new high rises and building activity everywhere. English was displayed on road signs and many buildings. Beijing and its surrounds were astonishingly very clean. We saw no litter, and thousands of new trees had been planted in the city and surrounding countryside. This might be due, in no small part, to Beijing's current bid for the 2008 Olympics. Roads were congested with late model cars but traffic flow was uninterrupted. Bicycles (considerably less in numbers than I remembered eight years ago) were confined by barriers to the sides. Unlike other Asian cities, motorcycles were banned. Motorists considered red traffic lights and pedestrian crossings simply as invitations to stop. Crossing roads appeared to be a lottery – you kept your life if you won. Rapid progress was evident but its aftermath, a pollution haze, hung over the city like a cloak of conscience.

The CSM was the first time that ANZCA held its ASM outside Australia and New Zealand. It was also unique in holding a meeting jointly with a sister college. The satellite Beijing meeting was also ANZCA's first contact with the sister body in the PRC. Apart from their landmark occasions, both meetings were useful, educational, and enjoyable. It gave many Australians and New Zealanders an insight into China and Hong Kong. More importantly, we made friends. Our grateful thanks go to the CSM Convenor Dr John Low, President Dr TW Lee and the HKCA, ASM Officer Dr Ian Rechtman, the CEO, Dr Tony Weeks, all members of the Organizing Committee, the PCO, and our colleagues in Hong Kong and Beijing.

TEIK E. OH

Papua New Guinea Progress in Anaesthesia, Intensive Care and Pain Medicine

The College has had a long history of involvement in educational activities in Hong Kong, Singapore and Malaysia but little official engagement in the South Pacific. Australian and New Zealand anaesthetists have contributed on an individual basis to teaching, and to provision of anaesthesia for surgical teams in PNG for many years. The ASA established the Diploma of Anaesthesia in Fiji and the Fiji School of Medicine remains the base for training of anaesthetists for the South Pacific islands. This short article summarises the situation in Papua New Guinea, Australia's closest island neighbour, with a population of some 5 million people.

The Past

The first general anaesthetic was probably given in 1880 (Anaesthesia and Intensive Care, 1997;25:286-288). The reliance on expatriate anaesthetists led to the establishment, over 30 years ago, of a one year course for nurses and health extension officers, who became Anaesthetic Technical Officers (ATOs), providing anaesthesia in hospitals with anaesthetists, then eventually in hospitals where they worked alone. Over 12 years ago a decision was taken to establish a Master of Medicine in Anaesthesia, with an exit point of Diploma in Anaesthesia.

The Present

Undergraduate and postgraduate training in PNG are the responsibility of the School of Medicine and Health Sciences, University of Papua New Guinea (UPNG). The medical course began graduating doctors with an MB,BS in 1973, and has had a number of curriculum changes since then. The most recent one was introduction of a Problem Based Learning (PBL) approach in 1998.

Medical students are exposed to anaesthesia, intensive care and pain medicine via PBL cases in all years of the new course, and through an attachment to anaesthesia and intensive care in Year 4. Anaesthesia is a "major discipline", alongside the traditional major clinical disciplines of Medicine, Surgery, Obstetrics and Gynaecology, and Paediatrics. The College awards a prize to the student reaching the highest standard in anaesthesia in fourth year.

Medical graduates have a two month rotation to anaesthesia and intensive care as part of their teaching hospital commitments, prior to undertaking two service years before commencing postgraduate specialty training. Traditionally, service years were spent in the major clinical disciplines, and Anaesthesia and Intensive Care has now been added.



PNG Consultants Meeting – Port Moresby – March 2001

There are Masters of Medicine (M.Med) programs in all the major clinical disciplines. The M.Med in Anaesthesia is a four year course. At the end of first year there is a Diploma of Anaesthesia examination, aimed at producing a registrable to enter further training. The second year provides consolidation of Year 1, with emphasis on the basic sciences, and their application to clinical work. The M.Med Part I examination has core components common to all M.Med programs, and specialty components relevant to Anaesthesia.



Airway Workshop with ATOs – Medang, March 2001

Two further years of advanced training lead up to the M.Med Part II examination in all aspects of Anaesthesia, Intensive Care and Pain Medicine. The final examination has written papers, vivas, long and short cases. A thesis and satisfactory in-training assessments are required before the examination can be sat. The College awards a prize to the candidate who achieves the highest standard in the Final examination.

Until recently, registrars have spent 6-12 months in their 3rd or 4th year in a post in Australia or New Zealand. This process was interrupted recently, but will be re-established from 2002.

Anaesthesia in PNG is provided by nine specialists, supported by 50 Anaesthetic Technical Officers. There are currently nine Registrars in training, with Government approval to increase intake into anaesthesia to meet the demands from the procedural specialties.

Educational assistance to Anaesthesia, Intensive Care and Pain Medicine is provided by individuals, by anaesthetists visiting with surgical teams, and by a number of aid agencies. The bulk of Australian aid comes from AusAID via two projects, one concentrating on surgical visits and administered by RACS, the other concentrating on education and administered by MONAHP - the Medical Officer, Nursing and Allied Health Project. The lead member of the consortium is RACP, and Flinders Medical Centre is a member.

College Council passed the following resolutions at the end of 2000:

1. That the College offer educational assistance to the University of Papua New Guinea for undergraduate and postgraduate programs in anaesthesia, intensive care and pain medicine.
2. That the College make available to the postgraduate training program in anaesthesia, intensive care and pain medicine at UPNG access to the College library resources, web-based educational material and CME material.
3. That the College support teaching visits to the Department of Anaesthesia and Intensive Care, UPNG, in conjunction with AusAID, via MONAHP.
4. That the College support clinical placements in Australia and New Zealand for 6-12 months, for selected registrars from PNG, in conjunction with AusAID, via MONAHP.
5. That the College support attendance of a PNG anaesthetist at its ASM periodically.

Workshops and courses have been conducted in PNG for several years. The RACS provides an annual EMST course, with a majority of instructors being local. Dr Roger Goucke conducted a workshop for ATOs in 1997. This has been followed by a workshop for ATOs by Garry Phillips and Alistair Norton in 1999, and two workshops - one for ATO's and one for Registrars by Garry Phillips, Val Followes and Rik Fronsco in 2001.

Questions

Questions often asked by anaesthetists interested in teaching or providing anaesthesia in PNG include :

1. *Is it safe?* My reply is "Yes", provided some precautions are taken. Lawlessness has increased over the years, but cautious risk taking is part of life. There are many places in the world I would feel safer, and many more places where I would feel less safe.
2. *What about leisure time?* There are many parts of PNG open to the adventurer, and to the holiday maker. Parts of PNG are a tropical "paradise", and diving is well organised in key locations.
3. *What about equipment?* Anaesthesia equipment is modern, with a mixture of Ohmeda and Ulco machines. There has been a gap in maintenance for several years, now being addressed by an AusAID project which is also replacing obsolete machines. Monitoring is improving, with pulse oximetry the most universal. Consumables are in variable supply, with periodic shortages, creating practical difficulties with issues such as infection control.
4. *What about drugs?* Again, a variable supply being addressed by a review of the Pharmaceutical Catalogue and supply system. The commonly used agents are thiopentone (some

Propofol), morphine, pethidine, fentanyl, midazolam, ketamine, halothane (some enflurane, isoflurane), pancuronium, vecuronium, cis-atracurium. Nupercaine has been used until recently for spinals, gradually being replaced by bupivacaine. Epidurals are performed in some centres.

5. *What about Intensive Care?* This comes under the aegis of Anaesthesia. The unit at Port Moresby has 6 beds and a step-down unit. Ventilators include Servo and Bird. Units are being developed in other regional centres.



Airway Workshop with ATOs – Medang, March 2001

6. *What about Pain Medicine?* Again, Anaesthesia is responsible for most difficult pain problems, but manpower is insufficient to cope with what is required. The mainstay of pain relief for acute severe post-operative analgesia remains intramuscular or subcutaneous morphine.
7. *What about out-of-theatre anaesthesia?* There is currently limited demand. Manpower has not allowed establishment of epidural services in labour wards. There are very few imaging facilities, and limited endoscopy. Medical retrieval

is provided by private companies, although there is some excellent regional “flying squad” activity by motivated individuals.

8. *What about blood transfusion?* This varies from centre to centre. In some regions, anaemia in the population precludes donation from many people, and relative donation is relied upon.

The Future

Papua New Guinea will need assistance in developing a sustainable profile for anaesthesia, intensive care and pain medicine for the foreseeable future. Input will come from many sources, both individuals and organisations, under different banners, working through a variety of aid agencies. All of this needs to be coordinated through the key contacts in PNG:

Dr. Gertrude Didei, Senior Specialist Medical Officer in Anaesthesia, and Dr. Harry Aigeeling, Lecturer in Anaesthesia, UPNG. Both are contactable via the Department of Anaesthesia, Port Moresby General Hospital, Boroko, National Capital District, Papua New Guinea.

Garry Phillips can provide more information –
Phone (08) 8339 3532;
Fax (08) 8339 4969;
Email : gphillip@medeserv.com.au.

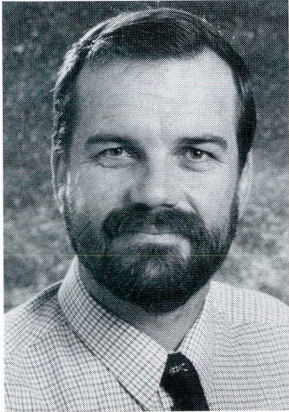
MONAHP is contactable at
PO Box 1141,
Canberra City 2601 ACT
Phone (02) 6248 0421;
Fax (02)6247 1803;
Email : p-watters@adfa.oz.au.

AusAID, via both the MONAHP and the THS (RACS) will provide support for anaesthetists wishing to work and teach in PNG for periods of 1–12 months.

GARRY PHILLIPS

Report of the Classification Update Forum on Anaesthetics

NATIONAL CENTRE FOR CLASSIFICATION IN HEALTH



Greg Knoblanche

GENERAL ANAESTHESIA

1) GENERAL ANAESTHESIA

- includes gaseous and/or intravenous

2) SEDATION FOR A SURGICAL PROCEDURE

- has no induction, vapours or artificial airways

3) SEDATION FOR A DIAGNOSTIC OR THERAPEUTIC

- has no induction, vapours or artificial airways procedure
- e.g. dressing, endoscopy xray
- often outside operating theatres
- often not an anaesthetist

4) MONITORED CARE

- part of a continuum of care
- e.g. continuous ventilating support associated with ICU, investigations or resuscitation

CONDUCTION ANAESTHESIA

1) NEURAXIAL BLOCK

- spinal, epidural or caudal

2) REGIONAL BLOCK

- all named nerves
- will be sub classified into
 - cranial
 - upper limb
 - trunk
 - lower limb

3) INFILTRATION BLOCK

- effected at tissue level
- includes topical (e.g. eyes), EMLA and Biers block etc

NOTES

Hierarche

The coding will be hierarchal with the first code only being used. For example if a procedure starts with sedation but proceeds to general anaesthesia only anaesthesia will be coded or if a spinal is used and the surgeon infiltrates local anaesthetic only the spinal will be coded.

ASA Status

ASA Patient Status will be coded for all codings. The last two digits will contain the ASA coding for 1 to 5 and emergency.

VENTILATION

I was unable to convince the forum to code for ventilation. The coding would not have been difficult, however, there are only 20 codes available for any episode of care (hospital admission). Therefore there is always going to be a compromise that will consider the value of information gained.

INDUCTION

I was unable to get the induction coded for gaseous and intravenous. This is for the reasons above and the belief that it would be primarily only of interest in paediatrics.

PRACTITIONER

It is extremely difficult to code for practitioner especially outside operating theatres. Furthermore, it is NCCH policy to code for the procedure NOT the practitioner. Therefore there will be no coding as to practitioner, however sedation for diagnostic procedures may give some insight into this area.

AGENT FOR CONDUCTION BLOCK

This coding will not discriminate between Local Anaesthesia, Narcotic or other therapeutic substance.

ANALGESIA

Whilst tidying up anaesthesia it became apparent that this would impact on de facto coding of post operative analgesia. The codes for Regional anaesthesia are currently coded for injection or infusion and pre, intra or post operative. All of these were impossible for the coders to identify and they will

be deleted from the codes. It thereby became necessary to code for analgesia and the following was proposed and accepted.

ANALGESIA

- 1) POST OPERATIVE NEURAXIAL BLOCK
 - must have a catheter
 - must have a chart for top up or infusion
 - spinal, epidural or caudal
 - any agent (local, narcotic or other)
- 2) POST OPERATIVE REGIONAL BLOCK
 - must have a catheter
 - must have a chart for top up or infusion
 - Named Nerve
 - any agent (local, narcotic or other)
 - sub classified:
 - cranial
 - upper limb
 - trunk
 - lower limb

- 3) POST OPERATIVE PATIENT CONTROLLED ANALGESIA (PCA)
 - must have a PCA device
 - must have a PCA chart
- 4) NEURAXIAL BLOCK FOR VAGINAL DELIVERY
 - spinal, epidural or caudal
 - local anaesthetic and/or narcotic

Note

Chronic pain has not been addressed in this Forum but does require substantial revision. I have discussed this with Professor Cousins (as well as the above classification). I have suggested to Professor Cousins that a submission to NCCH re Chronic Pain be made by the Faculty.

GREG E KNOBLANCHE

Primary Examination

MARCH/APRIL 2001

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

The viva examination was held at The College Headquarters in Melbourne and the Hong Kong Academy of Medicine in Hong Kong.

SUCCESSFUL CANDIDATES

M J Alter	VIC	B L Cartwright	NSW	C W C Fong	NSW
Lee Hon Ming	HKG	A J Olney	WA	J E J Tan	SING
Z Ansari	VIC	W P Chan	TAS	V J Fraser	NSW
B S Lim	MAL	J E Paver	NZ	N L T Tan	VIC
G Arnold	NZ	K N Charbucinska	QLD	M R Grill	SA
A F Lovegrove	WA	V M Payne	NSW	Tan Khong Cheong	MAL
C L Ashley	NSW	Cheah May Hong	MAL	C M Hellier	QLD
G R Lowry	SA	K Pennington	NSW	P Thalayasingam	WA
R Atan	MAL	Cheung Ning Michelle	HKG	A R Hill	NSW
D B Lu	NSW	J Poulos	NSW	K Todd-Menzel	SA
L Aykut	NSW	S L L Ching	SING	J C Hoppe	VIC
L K H Lum	SA	S Sarantopoulos	VIC	S Totonidis	TAS
M Balenovich-Kordich	NZ	K W Chong	SA	C Hoy	VIC
S L Maconachie	QLD	M O Schultz	VIC	L Truong	SA
F L Barry	VIC	E M Christiansen	NZ	V Hua	NSW
N N Marshall	NSW	Divya-Jyoti Sharma	WA	R M Vassiliadis	NSW
E J Bendall	VIC	Chu Suk Yi	HKG	A H Jackson	NSW
A L Martin	NZ	W L L Sin	HKG	S A Wan	NSW
S Bhonagiri	VIC	E J Cook	NSW	Z M Karim	NZ
S J Mitchell	QLD	Siow Yew Nam	SING	J W Watts	VIC
B J Bigwood	NZ	C C Crowe	QLD	E A Kayak	VIC
K E Morgan	NSW	P J Squire	VIC	S J Willis	SA
M S Bishay	NZ	J C W Desforges	NZ	B M Kienzle	QLD
C M Nethery	NSW	T Stavrakis	NSW	Wong Chau Ping	HKG
M Bohm	NSW	D Dimovski	VIC	K Krueger	NZ
S M Nobre	NZ	L C Stephens	ACT	T D Wright	NZ
S L M Burrows	NZ	S M Eaton	NZ	B W La Ferlita	VIC
S J Nutter	VIC	J A Symons	VIC	S Yogalingam	SA
D Carman	SA	T R Eggleton	SA	B A Langley	VIC
L J O'Halloran	VIC	N Taghizadeh	VIC		

RENTON PRIZE

The Renton Prize for the period ending 30th June 2001 was awarded to **Dr. Andrew Hugh Jackson** of New South Wales.

Final Fellowship Examination

APRIL/MAY 2001

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

The Viva Examination in anaesthesia and medicine was held at College Headquarters and the Alfred Hospital, Melbourne.

SUCCESSFUL CANDIDATES

C Antoniou	VIC	Y L Chin	SIN	K E Hillier	SA
H S Lim	HKG	I D C Miller	QLD	E L Trent	NZ
G W Baker	NZ	GR Clery	NSW	M Hondronicola	NSW
S M Lim	WA	K Parry	SA	A G Usher	NZ
P K Bhabha	NZ	J C Coldrey	SA	L J Horrell	NSW
P Liston	NSW	J E Ritchie	NZ	G L Van Essen	VIC
C W Birch	NZ	B S Cowie	VIC	J J Imrie	NZ
D R G McAdam	VIC	F E Russell	NZ	M G F van Gulik	NZ
R O Breadsell	QLD	P J Craft	QLD	K N Jayanthi	NSW
C B McFadyen	NSW	J D Salter	WA	A W Vulcan	VIC
C M Brooksbank	QLD	T R Crofts	VIC	S A Jenkins	SA
A D McGeorge	NZ	N J Scurrah	VIC	D J C Ware	VIC
N W Brown	NSW	C I Desouza	NSW	R A Jones	VIC
C A McInerney	NSW	C L Service	TAS	J Wells	WA
M M Buckham	NSW	G R Devine	NSW	A M Kirkman	NZ
N P McKinley	QLD	M P Shaw	NSW	G T C Wong	NSW
A L Carrozzi	NSW	J G Faris	NZ	N C K Lam	WA
D W McLeod	NSW	C W Smit	WA	B Yim	VIC
Chan Lim Sun, Derick	HKG	N J Forbes	NZ	B H S Lee	WA
M J McNamara	QLD	J Tomlinson	VIC	A R Zimmermann	SA
E H Chin	NSW	C B Gourlay	TAS	J M L Liew	NSW
P M Mezzavia	VIC	R J Townsend	QLD		

Cecil Gray Prize

The Court of Examiners recommended that the Cecil Gray Prize for the half year ended 30th June, 2001 be awarded to Dr. Brian Cowie of Victoria. Dr Cowie was awarded the Renton Prize in September 1998.

Fellowship Status and Recertification

1. Introduction

ANZCA supports holders of its diplomas for specialist registration and vocational registration in Australia and New Zealand. In the near future, renewal of specialist recognition and registration in Australia is likely to be based on revalidation. This is the process of recertification, which will be introduced by the Australian Medical Council (AMC). Details of recertification, when it will be introduced, and the roles of the AMC, medical boards, and Colleges, are yet to be clarified. The AMC is likely to use compliance with Maintenance of Professional Standards (MOPS) programs as the main prerequisite of recertification. The Colleges will be required to monitor compliance with MOPS and any other requirement, so that medical boards may re-register anaesthetists. Also, a single register of specialists may be introduced in all Australian States. If so, registration as a specialist in two disciplines (e.g. anaesthesia and intensive care) may not be permissible. Nonetheless, those practising in two disciplines with dual diplomas, may seek recertification in both disciplines independent of specialist registration (for example to be accredited at their hospitals of practice). Participation in MOPS is currently required for continuing vocational registration by the New Zealand Medical Council.

This paper outlines ANZCA's policies on the anticipated process of recertification, especially in relation to MOPS participation and Fellowship subscriptions. The policies may need to be reviewed when recertification is introduced by the AMC and medical boards.

2. Recertification

2.1. Fellows with FANZCA who practise anaesthesia – ANZCA will endorse recertification of specialist registration in Australia or vocational registration in New Zealand in anaesthesia, a Fellow who:

- 2.1.1 is registered by his/her respective State Medical Board or New Zealand Medical Council; and
- 2.1.2 has paid all due ANZCA fees and subscriptions; and
- 2.1.3 satisfies ANZCA's anaesthesia MOPS requirements for that year; or
- 2.1.4 satisfactorily completes Professional Practice Review (see below).

2.2 Non FANZCA anaesthetists who practise anaesthesia in Australia – ANZCA will endorse recertification of specialist registration in anaesthesia, an anaesthetist who:
2.2.1 is registered by his/her respective State Medical Board; and

2.2.2 has been supported as a specialist anaesthetist by ANZCA; and

2.2.3 has paid all due ANZCA fees for MOPS and recertification assessment; and

2.2.4 fulfils ANZCA's anaesthesia MOPS requirements for that year.

2.3 Non FANZCA anaesthetists who practise anaesthesia in New Zealand –

ANZCA will endorse recertification of vocational registration in anaesthesia, an anaesthetist who:

2.3.1 is registered by the New Zealand Medical Council; and

2.3.2 has paid all due ANZCA fees for MOPS and recertification assessment; and

2.3.3 fulfils ANZCA's anaesthesia MOPS requirements for that year.

2.4. Fellows with FANZCA and FFICANZCA or FPPMANZCA who practise anaesthesia and a second discipline –

ANZCA will endorse recertification of specialist registration in Australia or vocational registration in New Zealand in anaesthesia, a Fellow who:

2.4.1 is registered by his/her respective medical board; and

2.4.2 has paid all due ANZCA and respective Faculty fees and subscriptions; and

2.4.3 satisfies ANZCA's anaesthesia or FIC or FPM MOPS requirements for that year. (Some Fellows may also participate in the anaesthesia and their Faculty's MOPS programs); or

2.4.4 satisfactorily completes Professional Practice Review (see below).

2.5 Fellows with FANZCA and FFICANZCA or FPPMANZCA who do not practise any anaesthesia –

Such Fellows may wish to resume part time or full time anaesthesia practice after a period of absence. ANZCA will recommended for recertification of specialist registration in Australia or vocational registration in New Zealand in anaesthesia, a Fellow who:

2.5.1 is registered by his/her respective State Medical Board or New Zealand Medical Council; and

2.5.2 has paid all due ANZCA and respective Faculty fees and subscriptions; and

2.5.3 has completed the ANZCA Practice Re-Entry Program (see below)

3. ANZCA MOPS Program

- 3.1 MOPS is a prerequisite of recertification as a specialist in anaesthesia.
- 3.2 Non Fellows will pay fees to participate in the ANZCA MOPS program.
- 3.3 For a Fellow who practises anaesthesia full or part-time, but who did not participate in MOPS in the past year, ANZCA will endorse recertification in anaesthesia, if he/she
 - 3.3.1 is registered by his/her respective medical board; and
 - 3.3.2 has paid all due ANZCA fees and subscriptions; and
 - 3.3.3 satisfactorily completes Professional Practice Review as described in the MOPS Manual.
- 3.4 Such a Fellow will meet the full cost of Professional Practice Review since it is a service for Fellows outside the MOPS program.
- 3.5 Non Fellows who are not registered for anaesthesia MOPS are not eligible for Professional Practice Review.

4. Subscriptions

- 4.1 Fellows with dual diplomas of FANZCA and FFICANZCA or FFPMANZCA are required to pay two subscriptions, with possible concessions for the discipline of lesser practice for anaesthesia and intensive care. ANZCA will withdraw FANZCA from Fellows who fail to remit their FANZCA subscriptions for two successive years. Such practitioners will no longer be Fellows of ANZCA and will be ineligible to quote FANZCA as a qualification or to participate in the Practice Re-Entry Program. If they continue to practise anaesthesia, they may participate in the ANZCA MOPS program as a non-Fellow under 2.2. FANZCA that was withdrawn because of outstanding subscriptions may be reinstated following restitution of all outstanding dues and subscriptions as indicated in the relevant ANZCA regulations.

5. ANZCA Practice Re-Entry Program

- 5.1 This program is an educational service by ANZCA for Fellows to re-enter specialist anaesthesia practice after an absence of more than 12 months in practising clinical anaesthesia. It involves participation in a program that offers a renewal of experience in anaesthesia.
- 5.2 The program is conducted for Fellows and is eligible only to holders of FANZCA. Those who have had their FANZCA withdrawn must seek re-conferment of FANZCA to be eligible to participate in the program.

- 5.3. The program requires supervised experience in clinical anaesthesia in a hospital or practice, for a duration that is appropriate for the participant. This duration will normally be 4 weeks for every year of absence from clinical practice, up to a maximum period to be determined by the supervisor in 5.4.3.
- 5.4. The participant must submit an individual program for prospective approval by the Assistant Assessor. The program must:
 - 5.4.1 nominate the hospital department or anaesthesia practice that he/she wishes to undertake Practice Re-Entry; and
 - 5.4.2 provide details of the clinical experience to be undertaken; and
 - 5.4.3 enclose an endorsement of the program and its duration by the Head of the nominated department or a senior specialist anaesthetist in the nominated practice.
- 5.5 At the completion of the program, the Head of department or specialist anaesthetist in 5.4.3 will confirm to the Assistant Assessor in writing that the participant has satisfactorily completed the program. ANZCA will then endorse the participant for recertification of specialist (or vocational registration in New Zealand) in anaesthesia.

Recertification Requirements

For support by ANZCA for Specialist Registration in Australia or Vocational Registration in New Zealand

Practising Clinical Anaesthesia

	FANZCA	Non FANZCA In Australia	Non FANZCA In New Zealand	FANZCA + FFIC or FPPM
Medical Board Registration	+	+	+	+
ANZCA Support as Specialist	NA	+	NA/NE	NA
Payment ANZCA subscriptions	+	NA	NA	+
Payment MOPS fees	NA	+	+	NA
MOPS Compliance	+	+	+	+
PPR in lieu of MOPS	+	NE	NE	+

Not Practising Anaesthesia (for over 12 months)

	FANZCA	Non FANZCA (includes those with Fellowship withdrawn)
Practice Re-Entry Program	+	NE

- + Mandatory requirement
- NA Not applicable
- NE Not eligible
- PPR Professional Practice Review

TEIK OH

Highlights of Council

FROM THE APRIL 2001 COUNCIL MEETING

WELCOME

In opening the meeting the President noted it was the first meeting to be held in the Council Room of the new building. The President extended a welcome to Dr Malcolm Futter, Chairman, New Zealand National Committee.

COLLEGE AWARDS AND ELECTION

ANZCA Council Citation

ANZCA Council Citations were awarded to
Dr David McCuaig (Vic)
Dr Robert Wong (WA)
Mr W H (Bill) Woodhouse (Vic)

Presentation of these citations will take place at appropriate Regional meetings.

PROFESSIONAL

Submission to Commonwealth Government for Assistance with Rural Projects

Council noted that, to date, there has been no response from the Minister or his Department with regard to the College submission to fund the proposed projects to assist rural areas.

COMMUNICATIONS

Council established a Working Party to review communications with Fellows. It is proposed that a workshop be held, including representatives of the Faculties, in particular to review the format of the *College Bulletin*. Any suggestions or requests from Fellows with regard to the *Bulletin* would be most welcome.

INTERNAL AFFAIRS

Fellowship Status and Recertification

Following amendment, Council agreed to accept this process with regard to Fellows and other specialist anaesthetists participating in the College MOPS Program. Full details are published elsewhere in this *Bulletin*.

Criteria for Foundation Fellowship of the Joint Faculty of Intensive Care

Council supported the proposed criteria for Foundation Fellowship of the proposed Joint Faculty of Intensive Care Medicine based on the criteria which has been applied since 1995 by the Joint Specialist Advisory Committee – Intensive Care with regard to specialist recognition in intensive care.

1. FICANZCA or FRACP (with two years training in intensive care accredited by SAC-IC or JSAC-IC).

2. Persons who commenced specialist training before 1989 or specific training in intensive care before 1995 and who have the qualifications FANZCA or FRACP when the applicant has:

- (a) spent two years in a training capacity in intensive care units (ICUs) approved by FICANZCA or the RACP (SAC-IC) for core training purposes, OR
- (b) practised as a specialist in ICUs approved by FICANZCA or the RACP (SAC-IC) for core training purposes, full time for 5 years or more, or the sessional equivalent at 5/10ths or more over a longer period (example, full time for 5 years, 5/10ths for 10 years), OR
- (c) trained in intensive care outside of Australasia, provided that the training was equivalent in duration, structure and content, assessments and supervision to that required by the Australasian intensive care training bodies.

Following acceptance of these criteria by the Royal Australasian College of Physicians, the Regulations governing the Joint Faculty will be drafted.

Courses Sub-Committee

Council established a Courses Sub-Committee under the chairmanship of Dr Wally Thompson. This Committee is comprised of three Fellows, the Chair of Education and Training and the Chair of CE&QA.

Drs Brendan Flanagan (Vic), Jennifer Weller (NZ) and Leonie Watterson (NSW) have accepted an invitation to join this Committee. This Committee will oversee current courses and initiate new courses

Regulation 6.3 – Admission to Fellowship by Election

Regulation 6.3 relating to admission to Fellowship by Election has been approved and is published elsewhere in this *Bulletin*.

ANZCA Certificates

Following input from Regional and National Committees, the process was accepted by Council.

Director of Professional Affairs

Professor Garry Phillips has been reappointed Director of Professional Affairs for a further period of two years. This is a part-time appointment.

Organisational Chart and Titles of Officers

The chart and process was approved by Council and is published elsewhere in this *Bulletin*.

FINANCE

Treasurer's Report

The Treasurer's Report distributed at the Annual General Meeting is also published elsewhere in this *Bulletin*.

The Annual Accounts to which this Report relates have already been distributed to Fellows in accordance with the requirements of the Australian Securities and Investments Commission.

EDUCATION

Pilot EMAC Course

A very successful pilot of the proposed Effective Management of Anaesthesia Crises (EMAC) Course was conducted recently at Monash Medical Centre. It is now proposed that a further pilot will be carried out with trainee participants who have successfully completed the Primary Examination. It is proposed that this pilot will be conducted at the Royal North Shore Hospital in early July. Whilst numbers will be restricted, the pilot will be available to all trainees on a 'first come first served' basis.

Attendees at this pilot will be exempt from completion of the EMST Course.

Currently it is proposed that the EMAC Course will be offered to trainees as an option to the completion of the EMST Course as from 1st June 2001.

Report on the Forum on the Future of Specialist Medical Training

Council noted that this Forum, convened by the Commonwealth Department of Health and Aged Care, had considered ways to move the training of medical specialists out of hospitals and into the community. Objections to the principle of 'unbundling' had been raised regarding its inability to accurately derive the cost of training in teaching hospitals and the failure to account for the fact that trainees provide a service as part of their training. It was noted that New Zealand had previously considered this concept and the Forum thought it would be unworkable. No resolutions were made on this matter.

Education Unit

Council agreed that consideration be given to allocation of resources to the Education Unit and that the administrative requirements be determined within the next six months in order to resource the projects that Council endorses as having the highest priority.

Supervision and In-Training Assessment

The Director of Education, Dr Russell Jones, and Assistant Director, Dr Mary Done, conducted a session during the Annual Scientific Meeting in Hong Kong. The two main issues for this session were:

1. How Supervisors can teach - communicating effectively with trainees and providing feedback.
2. A global view of the role of Supervisors.

New FANZCA Program

The Working Party was established at December Council to progress this matter. The timescale for this review is 10-18 months to complete the draft program with an implementation time of 6-12 months.

Currently there is input from Fellows in various Regions with an interest in this area. Council supported the Education Committee's recommendation that support in principle be given to the concept of basic and advanced training.

Communication Skills

The Director of Education is currently pursuing various communication providers to ascertain material of value and interest to trainees and Fellows with regard to communication skills.

Self Development Modules/Train the Trainer

The Effective Teaching Techniques in Anaesthesia course, under the direction of Dr Barrie McCann will be held at Couran Cove from 8-11 June. It is proposed to produce a generic structure for a 'Train the Trainer' course. Dr Mike Martyn, Communications Officer, has agreed to look into the possibility of incorporating such a course on the internet.

Personal Professional Performance Monitoring Project

The PPPM Pilot Study, with regard to specific data collection from first year trainees at three centres in Australia and New Zealand, has now been completed. This initiative has come from members of the Department of Anaesthesia at Geelong Hospital who are currently evaluating the pilot study.

IT COMMITTEE

On-Line MOPS Program

Council agreed to proceed with implementing the MOPS Diary on-line to be available from the beginning of 2002, in addition to the availability of paper Diaries.

PROFESSIONAL

Professional Documents

Professional Document TE1 '*Guidelines for Hospitals Seeking College Approval of Posts for the First Four Years of Vocational Training in Anaesthesia*'

Professional Document TE1 '*Guidelines for Hospitals Seeking College Approval of Posts for the First Four Years of Vocational Training in Anaesthesia*' was reviewed and accepted and is published elsewhere in this *Bulletin*.

Professional Document PS9 '*Guidelines on Conscious Sedation for Diagnostic, Interventional Medical and Surgical Procedures*'

Professional Documents PS9, P19, P21, P24 and P36 which relate to sedation and anaesthesia for various procedures have been reviewed with the intention of the documents being amalgamated. Currently some of these documents are joint documents with other professional bodies and it is now

planned to approach these other organisations with a view to reviewing the document in line with the proposed document, *PS9 Guidelines on Conscious Sedation for Diagnostic, Interventional Medical and Surgical Procedures*. Council accepted this document for consultation with relevant bodies.

Professional Documents T1 and T2 '*Requirement for Anti-Hypoxia Devices on Anaesthesia Machines*'

Council considered requests from Fellows with regard to the implementation date for the inclusion of anti-hypoxia devices on anaesthetic machines from January 2002.

Council noted that two years notice had been given for this requirement and that there is an Australian Standard also requiring this device to be available at the beginning of 2002. Council confirmed that the implementation date should stand.

Clinical Practice Guidelines on Appropriate Use of Blood and Products

Council endorsed the proposed recommendations in the NHMRC Clinical Practice Guidelines on the Appropriate Use of Blood and Blood Products.

National Centre for Classification in Health: ICD-10-AM Anaesthetic Coding

Following the confusion with regard to the coding for anaesthesia procedures recently prescribed, a review has now occurred resulting in anaesthesia having three codes, one each for general anaesthesia and sedation, conduction anaesthesia and analgesia. An outline of the updated coding, which will commence from July 2002, is included in this *Bulletin*. ANZCA will now seek a formal nominee to the Coding Panel.

RESEARCH

Award of Research Grants/Fellowships for Projects carried out by Fellows/Trainees who are temporarily overseas

Council resolved that funding be made available for research

conducted either in part or whole overseas by College Fellows/ Trainees under the following conditions:

- A Fellow must have a certified ongoing appointment in Australia or New Zealand while overseas.
- A Trainee must return to Australia or New Zealand to complete their training program or return to a guaranteed specialist appointment.
- The applicant must be a principle investigator in the proposed research.
- The research proposed would normally be completed during the tenure of the Research Grant.
- The applicant must demonstrate in the application how the project will benefit research in Australia and New Zealand.

Research support for Fellows/Trainees resident in Hong Kong, Singapore or Malaysia

On the recommendation of the Research Committee, Council agreed that industry be approached to fund a Research Fellowship/Project Grant for Fellows/Trainees resident in Hong Kong, Singapore or Malaysia. The Fellowship/Project Grant is to be available for research in anaesthesia, intensive care or pain medicine.

Dr John Boyd Craig Annual Bursary

Council accepted a proposal from Dr John Craig to amend certain aspects of this award.

It has been agreed that the prize will be called the 'Dr John Boyd Craig Annual Prize' with the allocation to be made to Western Australian projects where possible and worthy. Funds from this prize may be combined with other funds.

Deaths

Council noted with regret the death of the following Fellows:

Emeritus Professor Arthur Barclay Bull (South Africa) – Honorary FFARACS 1977, Honorary FANZCA 1992

Dr Marie Margaret Simpson (NZ) – FFARACS 1968, FANZCA 1992

Dr Annie Winifred Wall, OAM (SA) – FFARACS 1955, FANZCA 1992

Recent Coronial Report

The Tasmanian Coroner has made a number of recommendations following an inquest into the death of a patient in a post-operative ward. The coroner found that the patient died as a consequence of the inadvertent administration of a level of drugs via an epidural infusion far greater than was prescribed. This caused a cardiac arrest. The drugs were bupivacaine 0.125% with fentanyl 5 micro-grams per millilitre.

The recommendations made by the coroner related to the following matters:

- Availability of relief to nursing staff, particularly night duty staff, so that relief is available as a matter of course, as opposed to being only on request, to enable staff to take regular breaks.
- Implementation of protocols for the recording of information on patient files such that nursing staff be required to record as close to contemporaneously as possible observations of patients and any treatment of them.
- Cessation of use of the GRAZEBY 3M 3000 Modular Infusion Pump for the infusion of any fluid, the significant overdose of which could cause death. Where this pump is used for any purpose the lock out switch should be utilised.
- Use for epidural infusions of the Abbott Pain Management Provider or a similar device with the same safety features.
- Clear labelling of the pump, the line to it and the container sourcing the pump either by a coloured label or the overall colour to clearly distinguish the arrangement as being for an epidural infusion.
- Implementation of a nursing staff awareness program to highlight to staff on a regular basis the need for extreme care and caution in the management of the infusion of any medication to a patient.
- Awareness by hospitals of the potential dangers existing for patients where multi use infusion pumps are in use. It should be recognised that human error occurs and that appropriate steps should be taken to minimise the likelihood of such errors having tragic consequences.

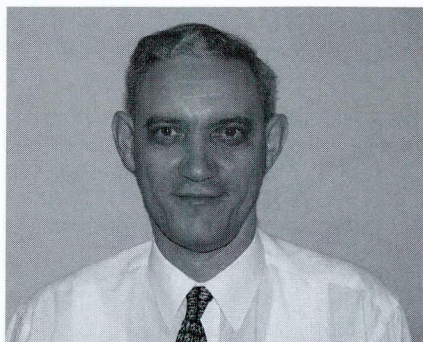
Quality Patient Care and Sedation

From time to time the College is made aware of patient morbidity or mortality associated with sedation for procedures, particularly relating to the use of anaesthetic agents by non-anaesthetists, or sedation by proceduralists without appropriate assistance.

In order to clarify thinking on this issue, the College has updated its Professional Documents in the area. Refer *PS9 Guidelines on Conscious Sedation for Diagnostic, Interventional Medical and Surgical Procedures*, and *T2 Recommendations on Minimum Facilities for Safe Anaesthesia Practice Outside Operating Suites*.

These documents may be relevant to day surgery units, office-based surgical units, and facilities where procedures such as cardioversion, endoscopy and imaging are carried out.

Effective Management of Anaesthetic Crises



Dr Wally Thompson

In 1999, Dr. J. Weller submitted to the College a 'blueprint' for a simulation course, directed at anaesthesia trainees in order to enhance the management of crises occurring during anaesthesia. The concept had been developed by Dr. Weller and the group at the Wellington Simulation Centre.

The College at that time was aware that a number of courses were that coming on stream and which potential applicability to junior trainees. A Courses Working Party (CWP) was established in order to review what was then available and to determine the need for an anaesthesia based course. The CWP recommended to Council that the EMAC proposal be developed and directed at trainees who has passed the Primary Examination. It also recommended that when developed the EMAC Course should be an alternative to the EMST Course for anaesthesia trainees. Council accepted these recommendations.

The course has been further developed by the CWP with input from the existing simulation centres. The course is run over two and a half days and is composed of 5 modules as follows:

1. **Airway Management.** The aim is to teach trainees to effectively manage the patient with a difficult airway. The module covers the assessment of potential airway problems, systematic approaches to the difficult airway patient, planning for expected and unexpected airway problems and techniques to cope with the difficult airway.
2. **Human Performance.** This module will provide understanding on the performance of anaesthetists both as individuals and as part of the healthcare team. It will also demonstrate how behavior and performance impact on patient care. The module will deal with such issues as the principles of crisis prevention, the psychology of human error, performance shaping factors and the development of a systems approach to patient safety.

3. **Cardiovascular Emergencies.** This module is centred on the general and specific therapies for dealing with perioperative cardiovascular emergencies. The module will deal with emergency vascular access, cardiac dysrhythmias, myocardial ischaemia, cardiac arrest and care of the post arrest patient.

4. **Anaesthetic Emergencies.** This module will aim to teach strategies for dealing with emergencies. Trainees will develop systematic approaches to identifying and managing life threatening emergencies, consider the use of algorithms and cognitive aids to problem solving, develop effective behavioral strategies, enhance their ability to work in teams and gain insight into their own behavior during crisis situations.

5. **Trauma Management.** The module is centred on the anaesthesia aspects of the resuscitation and management of the trauma patient in the perioperative period.

Trainees will understand the process of early evaluation and resuscitation of the trauma patient, learn to effectively review the trauma patient on handover, learn to evaluate evolving injuries during anaesthetic care and to co-ordinate the management priorities. The management of specific problems and effective team behaviors will be stressed.

Pilot courses are being conducted in order to refine the content and logistics of running the courses. The first pilot course was run at the Southern Health Simulation Centre, Monash Medical Centre in March and an evaluation undertaken with the assistance of the Education Department. The second pilot course will be run in June at the Royal North Shore Simulation Centre in Sydney. Trainees undertaking the pilot courses will have them accredited to their training.

It is hoped that the refinement and review process will be completed by the end of the year. An EMAC Committee of the College has been established and that will accredit centres to run the EMAC Courses. The plan is to have the course available at simulation centres in 2002. It has been recognised that in due course it may be possible to spin off certain aspects of some modules to skills centres, that do not have high fidelity anaesthesia simulators. That matter will be reviewed once the course has been bedded down in the current format.

W.R. THOMPSON
CHAIR, COURSES WORKING PARTY

Report from the President to Fellows of the Australian and New Zealand College of Anaesthetists

AS AT THE 8th MAY 2001

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

GENERAL

The Mission Statement of the College is “*To serve the community by fostering safety and quality patient care in anaesthesia, intensive care and pain medicine*”. Hence the core business of the College is in Education and Professional Standards. These encompass training, teaching, continuing professional development, standards of practice, credentialling and certification. Council worked to fulfil these activities, but identified four areas to focus on: elevating the delivery and quality of education, increasing education and services to rural communities, increasing education and professional involvement with Asia-Pacific neighbours, and improving communications with the Fellowship.

EDUCATION AND TRAINING

Education Unit

A Director of Education, Dr Russell Jones was appointed Director of Education in January 2001. Dr Mary Done was appointed Assistant Director on a half-time basis. They form the Education Unit to assist Council Committees and Fellows to develop, revise, review, and evaluate College education programs and continuing professional development programs.

Supervisors of Training

Supervisors of Training are corner stones of the FANZCA Program. A workshop for Supervisors of Training was held in 2000 at Ulmaroa. The College is keen to support and teach Supervisors of Training in education principles and in implementing the FANZCA Program, and this is being developed by the Education Unit. Principles on “teaching the teachers” are further considered in the forthcoming June 2001 workshop to be conducted by Dr Barrie McCann, Chair of the Medical Education SIG. I wish to thank all College Supervisors of Training. They are the quiet achievers of the College and their work is very much appreciated.

Trainees

The handbook on *Objectives of Training* in anaesthesia was revised. The College aims to graduate generalist specialist anaesthetists capable of delivering safe and quality anaesthesia

care. Our training program imparts to trainees the attributes of an anaesthetist and the standards of practice of a specialist anaesthetist.

A *Selection of Trainees* process in anaesthesia was developed according to the recommendations of the MTRP’s Brennan Report for use by Hospitals in their appointments. This sets out guidelines on selecting trainees according to set criteria and with transparency, procedural fairness, and natural justice.

A new course was developed for anaesthesia trainees, to be offered as an alternative to the EMST course from June 2001. This is the Effective Management of Anaesthesia Crises or *EMAC Course*, which uses modules including simulation, to teach skills and crisis management. A trial course for senior trainees was successfully conducted in Melbourne in March 2001 and another will be held in Sydney in October 2001. This trial will be open to all trainees on a first-come, first-served basis.

Revisions to the FANZCA Examinations were made (see below). A revision of in-training assessment of trainees (ITA) is being undertaken by the Education Unit. A working party of Professor TE Oh, Associate Professor Peter Kam, Dr Ed Loughman, Dr Lindy Roberts, Dr Tony Weeks, Dr Leona Wilson and the Education Unit was endorsed by Council to review the FANZCA Program. This is anticipated to take 18-24 months to complete.

College *Guidelines on Assisting Trainees with Difficulties* were developed and promulgated. The College contributed to the *Anaesthetics Framework for PGY1 and PGY2 Clinical Training Portfolio* developed by Queensland’s Postgraduate Medical Committee for application nationwide.

CONTINUING PROFESSIONAL DEVELOPMENT

Maintenance of Professional Standards

Participation in the MOPS Program was undertaken by a majority of Fellows. As part of the MOPS process, an audit of returns by some participants chosen at random was undertaken by the MOPS Committee. Results of compliance and integrity of returns were pleasing.

Self-Development Modules

A scheme for developing CME modules and Self-Development Modules for Fellows was framed last year. It is intended that these modules be developed and made available for Fellows

to use as teaching material or self-development in print form and on the internet. I am hoping that the first of an ongoing series will be available later this year.

Preoperative Care Clinical Practice Guidelines

The College formed a Committee under T E Oh to produce clinical Guidelines on Preoperative Care using an evidence-based medicine approach. The project is progressing.

Annual Scientific Meetings

The 2001 ASM is being held with the Hong Kong College of Anaesthesiologists as a Combined Scientific Meeting at the Hong Kong Convention and Exhibition Centre from the 5th to the 8th May. The Foundation Visitors to this Meeting are Professor Martin Tramèr from Switzerland and Professor Ronald Miller from the United States. The Ellis Gillespie Lecture was delivered by Professor Tramèr, and Professor Miller delivered the HKCA Foundation Visitor's Lecture. Dr Charles Minto (NSW) delivered the Australasian Visitor's Lecture.

A full report of the 2001 Combined Scientific Meeting, including the award of the Gilbert Brown Prize and Formal Project Prize, will be announced later this evening during the Dinner and will be noted in the *ANZCA Bulletin*. I thank the Organising Committee and the Hong Kong College (many Fellows of which are also Fellows of our College) for this immensely successful joint venture.

The 2002 ASM will be held in Brisbane and the 2003 ASM in Hobart. Since the Melbourne ASM last year, the Virtual Congress is now a popular and vital part of our scientific meeting. I thank Dr Joe Novella for driving this so successfully.

Australasian Anaesthesia

The fifth issue of *Australasian Anaesthesia*, *Australasian Anaesthesia 2000* was published early this year. This is the fifth in a series produced every two years. This 'blue book' is a showpiece of Australasian anaesthesia, intensive care and pain medicine practice. Our congratulations and thanks are due to the Editors Drs John Keneally and Michael Jones, and to the sponsors Abbott Australasia.

PROFESSIONAL AFFAIRS

Rural Education and Services

A College delegation met with Dr Michael Wooldridge, Minister for Health and Aged Care, to discuss among other matters, funding for initiatives to increase anaesthesia services and education to rural regions. I met and communicated a number of times with the officers of the federal Medical Specialists Outreach Assistance Program. All these discussions resulted in a College submission to the Commonwealth for funding on rural initiatives. At the time of writing this report, the submission is being considered. The College continues to receive good feedback on education and professional matters in rural regions from the Rural SIG.

Areas-of-Need

The College met with representatives from the Australian Medical Council (AMC), Australian Medical Boards, Australian State and Federal Governments, and other medical Colleges a number of times in the past year to formulate common processes to provide medical services to areas-of-need (AON) in Australia. The College introduced its process *Anaesthesia Services for Areas-of-Need in Australia* along the lines of the AMC template. The process fast-tracks an applicant for an AON post and provides a follow-up assessment. This AON assessment is related to, but separate from, assessment of overseas-trained specialists (OTS) see below.

Assessment of Overseas-Trained Specialists

Following a number of meetings in the past five years with representatives from the AMC, Australian Medical Boards, the New Zealand Medical Council, Australian State and Federal Governments, and other medical Colleges, the College promulgated its *Overseas Trained Specialists – Assessment Process* last year. This complies with the AMC template for OTS. The process assesses an OTS for equivalence to an Australasian specialist in terms of training received and clinical ability, through three components; an interview, a clinical examination (Performance Assessment) and a Clinical Practice Assessment.

AMC Accreditation and Recertification

The AMC will accredit medical Colleges for their delivery of training and education. Accreditation of the Colleges of Radiologists and Surgeons is being currently undertaken. Our College is preparing the documentation for our accreditation, which we wish to take place next year.

The AMC has flagged its intention to introduce mandatory annual recertification based on participation in MOPS. I am confident that AMC will approve our MOPS program for this purpose. Indeed, New Zealand introduced mandatory annual re-registration recently, based on demonstration of "competence", and accepted compliance with ANZCA MOPS as a satisfactory qualifier.

Asia-Pacific

The College joined with the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists to form an Overseas Liaison Committee to co-ordinate education, aid, and professional development programs in Asia and the Pacific region. Our Asia-Pacific Committee participated in programs in Papua-New Guinea and Fiji last year. A joint delegation with the Australian Society of Anaesthetists met with officials of AusAid in Canberra to explore how the two organizations might effect aid to Asia-Pacific countries, but met with little success. The College recognizes the selfless work of individual Fellows who participate in the aid programs of other bodies.

AWARDS, HONOURS AND APPOINTMENTS

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

- **Dr Peter D Pullen** (NSW) was invested as a Member of the Order of Australia (AM).
- **Dr Roger A Capps** (SA) was invested as a Member of the Order of Australia (Military Division) Reserve Forces Decoration (AM, RFD).
- **Dr Kevin Baker** (NSW) was awarded a Public Service Medal (PSM) in the Australia Day Honours List.
- **Professor Guy Ludbrook** (SA) was appointed Professor of Anaesthesia at the University of Adelaide, Royal Adelaide Hospital.
- **Dr Hugo Van Aken** (Belgium) was elected President of the European Academy of Anaesthesiology
- **Dr George Merridew** (Tas) was elected to the Council of the Australian Resuscitation Council.
- **Professor G A (Don) Harrison** (NSW) was added to the Roll of Honour, Australian Resuscitation Council.
- **Professor Teik E Oh** (WA) was elected to Fellowship, Academy of Medicine of Singapore.
- **Professor Anthony J Cunningham** (Ireland) was elected President of the Royal College of Anaesthetists in Ireland.
- **Dr Kester Brown** (Vic) was elected President of the World Federation of Societies of Anaesthesiologists.
- **Dr Richard G Walsh** (NSW) was awarded Honorary Fellowship of the Royal College of Anaesthetists in Ireland, elected Treasurer of the World Federation of Societies of Anaesthesiologists, and appointed as Adjunct Associate Professor, Department of Anaesthetics, University of Sydney, Royal Prince Alfred Hospital.
- **Dr Peter M Kempthorne** (NZ) was elected to membership of the Executive Committee of the World Federation of Societies of Anaesthesiologists.
- **Dr John Crowhurst** (UK) was admitted to Fellowship, Royal College of Anaesthetists.
- **Dr Michael J Hodgson**, AM (Tas) was elected President of the Australian Society of Anaesthetists.
- **Dr John Warden** (NSW) was appointed Chairman of the Australian Day Surgery Council.
- **Dr Ian McDonald** (Vic) was awarded Honorary Life Membership of the Melbourne Cricket Club.
- **Dr John G Roberts** (SA) and **Dr Greg P Wotherspoon** (NSW) were granted Life Membership of the Australian Society of Anaesthetists.
- **Dr Robert Wong** (WA) was appointed to the Editorial Board of *Undersea and Hyperbaric Medicine*.
- **Dr Leona Wilson** (NZ) completed a Postgraduate Diploma in Public Health, University of Otago, awarded with distinction.
- **Professor Bruce F Cullen** (USA) was elected President of the American Board of Anesthesiology.
- **Dr Jerrold Lerman** (Canada) was appointed to the Siemens Chair in Paediatric Anaesthesia, University of Toronto, Hospital for Sick Children.
- **Dr S (Butch) Thomas** (USA) was elected to Fellowship of the Royal College of Anaesthetists.

- **Professor Tess Cramond** (Qld) was awarded an Honorary Doctorate of the Australian Catholic University.
- **Dr Mary Done** (Vic) was awarded the Vice-Chancellor's Teaching Award 2001, University of New South Wales.
- **Dr Patricia Mackay** (Vic) received the AMA – Woman in Medicine Award

HONORARY FELLOWSHIP

Honorary Fellowship was conferred on Dr Archibald Ian Jeremy Brain (UK) and the new Fellow gowned during the College Ceremony in Hong Kong.

ANZCA MEDAL

It gave me great pleasure to present the ANZCA Medal during the College Ceremony to **Dr Lim Say Wan** (Malaysia).

ANZCA COUNCIL CITATION

The ANZCA Council Citation was established by the College in December 2000 to recognise significant contributions to particular activities of the College.

Citations were awarded to ANZCA Fellows **Dr David McCuaig** (Vic) and **Dr Robert Wong** (WA), and to **Mr Bill Woodhouse** (Vic). Presentation of these citations will take place at appropriate Regional meetings.

DEATH OF FELLOWS

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

- Emeritus Professor Arthur Barclay Bull (South Africa) –
Honorary FFARACS 1977, Honorary FANZCA 1992
- Dr James Edward Field, Vic – FFARACS 1975, FANZCA 1992
- Dr Grant James Freear, SA – FANZCA 1999
- Dr Daniel Brodie Hogg (Qld) – FFARACS 1963, FANZCA 1992
- Dr Peter William Padbury (Vic) – FFARACS 1979,
FANZCA 1992
- Dr William James Pryor, OBE (NZ) – FFARACS 1955,
FANZCA 1992
- Dr Marie Margaret Simpson (NZ) – FFARACS 1968,
FANZCA 1992
- Dr Mark Graham Somerville (NZ), FFARACS 1984,
FANZCA 1993
- Dr Annie Winifred (Win) Wall, OAM (SA) – FFARACS 1955,
FANZCA 1992

RESEARCH

Dr John Boyd Craig Annual Bursary

Council accepted a proposal from Dr John Craig to amend certain aspects of this Award. It has been agreed that the prize will be called the "Dr John Boyd Crain Annual Prize" with the allocation to be made to Western Australian projects where possible and worthy. Funds from this prize may be combined with other College Research funds.

Research Grants for 2001

Sixteen applications were received with one withdrawn prior to the review process. Total funding requested by the 15

applications was \$469,671, with \$363,550 available for allocation. A total of \$363,476 was awarded. All applications were perused by the Research Committee according to NHMRC guidelines and reviewed by two to three external Reviewers with recognised expertise in the area of the project.

Harry Daly Research Fellowship

On the recommendation of the Research Committee, the Harry Daly Research Fellowship for 2001 was awarded to Dr Mark Fajgman for his project "*Should pregnant patients have open or laparoscopic surgery? Effect of laparoscopy on fetal well being.*"

Florence Marjorie Hughes Research Award

On the recommendation of the Research Committee, the Florence Marjorie Hughes Research Award was awarded to Dr Des McGlade for his project "*The comparative effects of two analgesia techniques on outcome from lower limb vascular bypass surgery.*"

Douglas Joseph Professor 2001

The Douglas Joseph Professorship was awarded to Professor Guy Ludbrook (SA) for research into "*Safer induction of anaesthesia through simulation.*" Dr Ludbrook will present the Australasian Visitor's Lecture at the 2002 Annual Scientific Meeting in Brisbane.

ADMISSION TO FELLOWSHIP BY ELECTION

The following were elected to Fellowship of the College:

Under Regulation 6.3.1(a)

A/Prof Stephen Bolsin, Vic
A/Prof Ian Power, UK

Under Regulation 6.3.1(b)

Dr Philip Allen, Qld
Dr Lakshman Sunil Amarasena, Qld
Dr Nanda Bellum, NZ
Dr Mark Bukofzer, NZ
Dr Martin Louis Carter, NT
Dr Clive Dominy, NZ
Dr Peter Donahue, Qld
Dr Gillian Hood, SA
Dr Martina Meyer-Witting, Qld
Dr Angus Mitchell, NSW
Dr John Andrew Rose, NZ
Dr Ponniah Sri Ragavan, NZ
Dr Philip Stephens, Qld
Dr John Storrs, Qld
Dr Pieter Van Ammers, NZ
Dr Johan Vroon, NZ
Dr Marianne Wallace, Vic

Under Regulation 6.3.1(e)

Dr John Low, HK

PRIMARY EXAMINATION

July/August 2000

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

	TOTAL No CANDIDATES	INVITED TO ORAL	APPROVED
MELBOURNE	152	113	81

The Renton Prize for the period ending 30th December 2000 was awarded to Dr Gary Lewis Hopgood of New Zealand.

March/April 2001

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

	TOTAL No CANDIDATES		INVITED TO ORAL		APPROVED	
	Pharmacology	Physiology	Pharmacology	Physiology	Pharmacology	Physiology
MELBOURNE	146	150	132	143	100	120
HONG KONG	15	15	10	11		
TOTAL	161	165	142	154		

FINAL EXAMINATION (ANAESTHESIA)

July/August 2000

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

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

Ninety-two (92) candidates presented in Melbourne and sixty-three (63) were approved.

The Court of Examiners recommended that the Cecil Gray Prize for the half year ended 30th December, 2000 be awarded to Dr Stephanie Louise Keel of New Zealand.

PROFESSIONAL DOCUMENTS

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

- PS4 – *Recommendations for the Post-Anaesthesia Recovery Room*
- PS9 – *Guidelines on Conscious Sedation for Diagnostic, Interventional Medical and Surgical Procedures*
- PS15 – *Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery*
- PS18 – *Recommendations on Monitoring During Anaesthesia*
- PS41 – *Guidelines on Acute Pain Management*
- PS42 – *Recommendations for Staffing of Anaesthesia Departments*
- PS43 – *Statement on Fatigue and the Anaesthetist*
- T1 – *Recommended Minimum Facilities for Safe Anaesthetic Practice in Operating Suites*
- T2 – *Recommendations on Minimum Facilities for Safe Anaesthetic Practice Outside Operating Suites*

- TE1 – *Guidelines for Hospitals seeking College Approval of Posts for the First Four Years of Vocational Training in Anaesthesia*
- TE6 – *Guidelines on The Duties of an Anaesthetist*
- TE18– *Guidelines for Assisting Trainees With Difficulties*

Withdrawal of Professional Documents

Professional Document P13 – *Protocol for the Use of Autologous Blood was withdrawn in May 2000.*

Following the promulgation of PM2 – *Requirements for Multidisciplinary Pain Centres Offering Training in Pain Medicine* by the Faculty of Pain Medicine, College Professional Document TE16 was withdrawn in October 2000.

At the October 2000 Council Meeting, it was resolved that the documents *Statement on Continuous Intravenous Opioid Infusions* and *Statement on Patient-Controlled Intravenous Opioid Analgesia* be discontinued.

Following the promulgation of Professional Document T2 – *Recommendations on Minimum Facilities for Safe Anaesthetic Practice Outside Operating Suites*, documents PS33, T3, T5 and T6 were withdrawn in February 2001.

COLLEGE AFFAIRS

Faculty of Intensive Care

The Faculty of Intensive Care has had discussions with the Royal Australasian College of Physicians on founding a Joint Faculty of Intensive Care of both Colleges. Much time has been expended by the Board of the Faculty and RACP representatives to consider details of the Joint Faculty, including criteria for admission as Foundation Fellows. It is anticipated that the Joint Faculty will be founded later this year, and I congratulate the Dean Dr Felicity Hawker, and the Past Deans, Drs Geoff Clarke and Alan Duncan for their stewardship of the Faculty during this exciting but often challenging time. A full Annual Report of the Faculty of Intensive Care will be presented by the Dean elsewhere.

Faculty of Pain Medicine

The Faculty of Pain Medicine continues to develop and impress. In the past year, the Faculty has conducted examinations and developed professional policies and guidelines on Pain Medicine. This is reflected in the quality of their scientific program at this Hong Kong CSM. A full Annual Report of the Faculty of Pain Medicine Care will be presented by the Dean elsewhere. I congratulate the Dean Professor Michael Cousins and his Board for their sterling work.

Fellows Communications

The College is exploring how communication between the College and the Fellowship may be improved. A review of the *Bulletin* and other possible missives such as newsletters and web communications will be undertaken. Views from Fellows will be most welcome. I have undertaken to hold regular teleconferences with the Chairs of Regional Committees and the New Zealand National Committee.

‘Ulimaroa’

The extensions to the College headquarters are now complete. We have a new building of seven stories with an underground car park. As a new Councillor in 1995, I can vouch for the diligence of Councillors then, when they reached a resolution to extend ‘Ulimaroa’, as there was no suitable building to purchase or rent, despite a considerable search. The bold decision to build to seven stories rather than a safer five, means that we now have a building which will serve our needs for a long time into the future. We also have a building we can be very proud of. I invite Fellows to visit ‘Ulimaroa’ when they have the opportunity.

College Funds

The College remains in a good financial position. A full Financial Report of the College will be presented by the Honorary Treasurer and Vice President, Dr Dick Willis.

COLLEGE COUNCIL MEMBERSHIP

Membership of the Council to take office after the Annual General Meeting, its Office Bearers and Committees will be published in the *ANZCA Bulletin*.

Council

At the Annual General Meeting Dr Ian Rechtman will retire from Council following completion of ten years on the Board of Faculty and Council. During this period Dr Rechtman served as Assistant Assessor from 1992 to 1993, and Assessor from 1993 to 1995. He was Library Officer from 1991 to 1995, Protocol Officer from 1996 to 2001 and ASM Officer from 1998 to 2001. He served on the Panel of Examiners from 1991 to 1996 and chaired the Hospital Accreditation Committee from 1993 to 1999. Dr Rechtman was a member of the Victorian Regional Committee from 1975 to 1980, and from 1982 to 1990, and served on the Committee as Honorary Secretary from 1983 to 1984, CME Officer from 1986 to 1987, Vice Chairman from 1984 to 1987 and Chairman from 1987 to 1990. He was also involved with the Victorian Chairs of Anaesthesia Appeal Committee and Advisory Committee from 1989 to 1997.

In accordance with the provisions of the Articles of Association, nominations were called for eight vacancies on Council. Ten nominations were received. Professors Michael Cousins and Teik Oh, and Drs Steuart Henderson, Diana Khursandi, Walter Thompson, Rod Westhorpe and Richard Willis were re-elected for a period of three years with a new Councillor Dr Anthony Weeks. I congratulate all serving Councillors on their re-election, and Dr Weeks on his election to Council.

The following is the result of the Ballot:

Envelopes Received	1132
Less Invalid	6
Ballots Counted	1126
Less Invalid Ballots	1
TOTAL	1125 x 8 = 9000 Votes

POSITION ON BALLOT		Votes
1.	T E Oh	1074
2.	R N Westhorpe	1044
3.	R J Willis	984
4.	W R Thompson	961
5.	R S Henderson	949
6.	M J Cousins	872
7.	A M Weeks	835
8.	D C S Khursandi	817
9.	K J Brandis	778
10.	S P Gatt	686

Regional Breakdown of Votes

REGION	Votes Received	No. of Fellows	%
Victoria	251	596	42.11
New South Wales/ACT	284	812	34.98
Tasmania	32	57	56.14
Queensland	166	404	41.09
South Australia	94	241	39.00
Northern Territory	4	10	40.00
Western Australia	82	212	38.68
New Zealand	149	353	42.21
Hong Kong	22	131	16.79
Malaysia/Singapore	11	98	11.22
United Kingdom	21	63	33.33
Other Overseas Countries	10	85	11.76
Invalid Votes	1		
TOTAL	1126	3062	36.77%

COLLEGE ADMINISTRATION

A number of College staff changes have occurred during the past twelve months. A vacancy in the position of general Administrative Assistant was filled by Miss Lisa Blackmore in May 2000. Mrs Moira Matic resigned from her position as Administrative Assistant

with the Queensland Regional Committee in December 2000 and was replaced by Mrs Anne Pike.

Mr Matthew Lowe was appointed Assistant Accountant in September 2000. Mr Bill Peachey retired from the College in January 2001 and was replaced by Mr Kim Kostos as Finance Manager. Miss Shae Benton relocated to the Examinations Department as Administrative Assistant, and following Ms Liz Sinclair's resignation in March, Miss Angela Sparano was appointed to that Department.

Mrs Lindy McPhee resigned from her position as Administrative Assistant with the Faculty of Intensive Care in February 2001, and was replaced by Mr Andrew Coghill.

In April, Mrs Sue Harrison resigned from her position as Administrative Officer to the South Australian Regional Committee and was replaced by Ms Jane Hinchey.

IN CONCLUSION

As Council has worked through the issues of this year, I have been constantly reminded that the College's fundamental strength is its Fellows, trainees and staff. I continue to be impressed by their contributions and dedication, and their continuing commitment to the College's achievements. To conclude this report, I wish to record my grateful thanks to Councillors, members of Boards of Faculties, Chairs and members of Regional Committees and the New Zealand National Committee, members of College Committees, Fellows who contributed time *pro bono* to the College, in particular Michael Gorton the College's Honorary Solicitor and the CEO Mrs Joan Sheales and all the College administration staff. Our combined efforts will provide the basis for the development and promotion of our College and specialties.

TEIK E OH
PRESIDENT
May 2001

Honours and Appointments

Council congratulated the following Fellows:

Prof Teik Oh (WA) – Honorary Fellowship – College of Anaesthetists, RCSI

Prof Pierre Coriat (France) – Honorary Fellowship – College of Anaesthetists, RCSI

Dr John Crowhurst (UK) – Elected to Royal College of Anaesthetists

Dr Ben Korman (WA) – Adjunct Professor of Anaesthesia and Pharmacology, Division of Veterinary and Biomedical Science, Murdoch University

Dr Patricia Mackay (Vic) – AMA Woman in Medicine Award

Dr Robert Wong (WA) – Appointed to the Editorial Board of Undersea and Hyperbaric Medicine

Post-Graduate Qualification:

Professor Tess Cramond (Qld) – Honorary Doctorate of the Australian Catholic University

Dr Mary Done (Vic) – Vice-Chancellor's Teaching Award 2001, University of New South Wales

Dr Leona Wilson (NZ) – Postgraduate Diploma in Public Health, University of Otago – Awarded with Distinction

Honorary Treasurer's Report

The Annual Financial Statements and Auditor's Report for the financial year ending 31st December 2000 have been circulated to all Fellows in the format required by the Australian Securities and Investment Commission (ASIC). These reports have been audited by independent external auditors and have been discussed and accepted by Council. The following comments have been prepared in order to assist with the interpretation of the financial statements.

The columns headed 'Consolidated' and 'Company' relate to the purchase in 1999 of the company name 'Australian and New Zealand College of Intensive Care Medicine Ltd' for possible use in the future.

The company did not trade during the year and the only items contained within its Financial Statements are Cash on Hand of \$2 and Issued Capital of \$2. Otherwise, the figures in each column are identical. The column 'Notes' refers to a total of 20 explanatory notes on the final 15 pages of the financial report.

Revenue and Expenditure Report

The total revenue and expenditure in the various College accounts and funds are summarised in this report. Revenue has increased by 4.2% and expenditure by 4.8% resulting in a small increase in the operating surplus.

Balance Sheet as at 31 December 2000

This summarises the assets and liabilities of the College. Reference to the numbered notes will indicate details of what constitutes the various assets and liabilities. Current assets and liabilities refer to items relevant to the current financial year. Under Current Liabilities, the item 'Other' refers to money paid in advance eg subscriptions in advance, examination fees, trainee fees and ASM registration fees. Non Current Assets are property and equipment while Non Current Liabilities refer to provision for long service leave in the future.

The most notable changes in the balance sheet from previous years have resulted from expenditure on the new building at 630 St Kilda Road. There has been a decrease in investments and cash but a matching increase in property, plant and equipment. This expenditure was planned to occur in the previous financial year. The slower than expected progress on the new building has yielded extra investment income of approximately \$0.5m. There is a \$2m increase in both Total Assets and Net Assets.

Reference to Note 4 will indicate how these investments were managed. Equity Units are valued at cost while the market value is shown in brackets and Note 18(a) indicates the interest

rates for the Bills of Exchange. Of the Net Assets of \$16.6m, approximately \$9m is in property plant and equipment.

The Equity section of the Balance Sheet shows how the Net Assets are distributed between the College Funds.

Money held in the two Foundation Funds and the Trainees' Fund is only used for related specific purposes and is not available for general expenditure.

Accounts and Funds

Subscription Account

This account shows the distribution of funds received from Fellows' annual subscription payments in the day to day running of the College. At the end of the year, the surplus in this account is transferred to the Project Fund to be added to the College cash reserves. Revenue increased by 10.9% while expenditure increased by 18.3%. The large increase in expenditure was largely due to three items: the introduction of Office 2000 software, staff salaries (within budget) reflecting higher staffing levels, and travel and committee expenses (below budget). 10% of revenue from the Subscription Account is allocated each to the Foundation Fund for research and the Project Fund for development.

Project Fund

As the major income for this fund comes from the Subscriptions' Account, the Project Fund represents the Fellows' share in the net assets of the College. Investment income also contributes to this Fund. It is used to fund major College initiatives such as the new building and to hold College financial reserves.

Foundation Funds

The Anaesthesia, Intensive Care and Pain Medicine Foundation Fund receives revenue from a 10% allocation from the Subscriptions' Account, investment income, donation income and bequests for specified purposes and interest from subscriptions paid in advance. Expenditure is for research.

The CME Foundation Fund incorporates the income and expenditure related to a variety of CME activities such as Annual Scientific Meetings, Regional CME Meetings, Special Interest Group Meetings and HELP Modules.

Trainees' Fund

This Fund is specifically for training and examinations. In recent years, the balance in this Fund has fluctuated markedly. The balance has increased significantly this year due largely to an unexpected drop in College general administration expenditure and therefore a drop in the trainee allocation to this

expenditure. Trainees Fund expenditure is for trainee activities only and is unavailable for general expenditure.

Conclusion

The impending completion of expenditure on the new building has predictably decreased the College cash reserves. However, the College has acquired a most attractive property asset. The financial status of the College remains sound as was expected. It is anticipated that financial reserves appropriate to a business of this size can be gradually restored while continuing to minimise increases in subscription and trainee fees.

The healthy financial status of the College has resulted from the ongoing work of many individuals who receive little recognition. All the College staff in Melbourne, Wellington and

the regions of Australia deserve mention but I particularly thank the following: CEO Mrs Joan Sheales, Business Manager Mr Bill Peachey (now retired), New Finance Manager Mr Kim Kostos (appointed in January 2001), Accountants Ms Vivienne Lillis and Mr Matthew Lowe.

There are many Fellows in all the Regions who give generously of their time to manage the financial affairs of the many College Committees. The College appreciates and acknowledges all their efforts.

Written comments, questions, criticisms and suggestions on any matters pertaining to these reports are most welcome.

RICHARD J WILLIS
HONORARY TREASURER

Regional Annual Reports

New South Wales

Office Bearers & Members

Chair:

Dr Frank Moloney

Deputy Chair:

Dr Michael Jones

Hon Secretary:

Dr Jenny Beckett-Wood

Hon Treasurer:

Dr Michele Joseph

Regional Education Officer:

Dr Ross Kerridge

Formal Project Officer:

Dr Richard Morris

Continuing Education Officer:

Assoc Prof Peter Klineberg

Faculty of Intensive Care Representative:

Dr Dorothy Breen

ASA Representative:

Dr Nigel Symons

New Fellows Representative:

Dr Anthony Padley



Dr Frank Moloney
Chairman



Dr Jenny Beckett-Wood
Hon Secretary

Total No. of Regional Committee Meetings for Year: 6

Committee Members:	Meeting Attendance
1 Dr Jenny Beckett-Wood	4 out of 6
2 Dr Matthew Crawford	5 out of 6
3 Dr Richard Halliwell	2 out of 6
4 Dr Michael Jones	5 out of 6
5 Dr Michele Joseph	6 out of 6
6 Dr Ross Kerridge	4 out of 6
7 Assoc Prof Peter Klineberg	4 out of 6
8 Dr Frank Moloney	6 out of 6
9 Dr Richard Morris	4 out of 6
10 Dr Michelle Mulligan	4 out of 4
11 Dr Tony Quail (Sabbatical leave)	2 out of 6
12 Dr Joanna Sutherland	4 out of 4

Financial Report – Dr Michele Joseph

As at the 30th June, 2000, all NSW accounts were transferred to Melbourne.

Education – Dr Ross Kerridge

As the largest training region, NSW has over 150 positions for Yr1 – 4 trainees, most of which are organised into nine comprehensive rotational training schemes. This does not include the ACT scheme, which is now offering comprehensive training.

Appointment to a training position is keenly sought after, reflecting the status and attractions of a career in our specialty. It is also a reflection of the high standards of teaching on the schemes, and in particular the commitment of the Supervisors of Training.

The appointment of a fulltime Director of Education by the College has been enthusiastically welcomed. There are a number of issues in the current system of training that Supervisors are keen to address. These include In-Training Assessment and feedback, trainee selection, scheme structures, and dealing with trainees with difficulties. They are looking forward to working with the Director on these issues.

The social obligation on the College to ensure a high standard of training implies a requirement to prevent specialists qualifying without adequate training or abilities. Unfortunately there are sometimes manifest difficulties in dealing with trainees who are performing suboptimally. Supervisors of Training have been reminded of the need to ensure appropriate regular and documented performance appraisal, with early involvement of the hospital's Human Resources Department, to assist in these issues.

On some schemes trainees are given a printed 'Training Contract' outlining the expectations of them, and the details of the training scheme, prior to appointment. This may prevent any subsequent misunderstandings about peripheral rotations, term allocations, etc.

An increasing number of trainees are choosing to interrupt training for family or lifestyle reasons. The option of part-time training (e.g. job-sharing) is also being taken up. Both these options increase the complexity of Scheme management.

Course Organiser Primary:

Assoc Prof Peter Kam

Course Organiser Final Fellowship:

Dr Michael Bookallil and

Dr Tim McCulloch

Representatives on External Committees:

Dr Frank Moloney

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

NSW State Committee,
Royal Australasian College of Surgeons
Joint Consultative Committee-
Anaesthesia
Executive Committee, Rural Special
Interest Group

Dr Michael Jones

Committee of Management,
Australian Society of Anaesthetists
Assistant Editor, Australasian
Anaesthesia

Dr Matthew Crawford

Peer Review Subcommittee, NSW
Council on Quality in Health Care

Dr Jo Sutherland

Scientific and Technical Advisory
Committee, Australian Red Cross Blood
Service

Ex-Officio Members:

Councillors:

Professor Michael Cousins, AM
Assoc Prof Greg Knoblanche

Regional Administrative Officer:

Ms Janice Taylor

Offices and Secretariat

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

Paediatric training has been a problem for many years but progress is being made towards a reorganisation of schemes to provide equitable training for all trainees.

The commitment of effort by the Supervisors of Training is great. There is, at times, inadequate recognition of the demands of this position by hospital administration. This is particularly the case for "Scheme" Supervisors of Training. The College has made a welcome commitment to education, by moves such as the creation of the position of the Director of Education, and increased training in education. This commitment will need to be matched by training hospitals giving increased support and recognition for anaesthetists involved in teaching and organisation of training.

Formal Projects – Dr Richard Morris

I would first like to pay tribute to the considerable efforts of Brian Horan, as my predecessor in this role.

This year twenty four formal projects were submitted with only three requiring further work before being accepted. A small but enthusiastic group of reviewers helped in their assessment.

There were also thirty three proposals submitted. A format for the submission of proposals has been instigated and this has proven useful in clarifying trainees' thoughts at the start of their projects. It consists of a two page document addressing the following headings:

Title of Project

Name of Supervisor

Project goal

Methods for attaining that goal

Application of a scientific approach including outline of statistical methods and literature review strategies where applicable

Mode of project presentation

Continuing Education – Assoc Prof Peter Klineberg, Chairman NSWACE

Year 2000 was a very busy time in Sydney with the Olympic Games and associated activities. The NSW Committee therefore decided to have only two major meetings and an Anatomical Workshop for this year. We also had broad discussions regarding the format of continuing education and strategic changes we may make. Specifically, it appears that audience participation is of fairly crucial importance to increasing quantity and quality of information accepted by the participants. The size of the groups is significant but not of overriding importance; for us this presents a major problem as we will often have upwards of 200 people attending our meetings. We acknowledge the increasingly significant role of simulation as a teaching tool and a decision was made to look for a means of incorporating simulation in our continuing education process. This led to consultation with Richard Morris and Leonie Watterson and an invitation for Leonie to join the committee. We have also asked Ed Loughman to join the committee, with his broad interest in education.

The committee was also cognizant of the increased requirements in our Maintenance of Standards Program for both CME and QA activity. We therefore decided to move towards a format allowing the awarding of QA points for our meetings, when possible.

Our first meeting was on the 13th May, 2000, at the Regent Hotel on "Anaesthesia and the Older Patient". We had 242 registrants for this meeting, covering a broad range of information including the older patient as a 'day admit' person.

Our second meeting for the year was held on the 4th November, 2000, at the University of Sydney and titled 'Bolts from the Blue' for which we had 174 registrants. This meeting was a simulator-based meeting, and was our first major attempt to

incorporate the full anaesthesia simulator as the basis of a large scale continuing education presentation. Following a broad search for a 'theatre-in-the-round' venue, we ended up in a lecture theatre at the University of Sydney and the simulator was physically moved there from the Sydney Simulation Centre base. A team of anaesthetists with a vent for acting were recruited to present rehearsed scenarios in emergency management. The audience was divided for morning and afternoon sessions. The simulator presentations with the actors were presented followed by a brief review of the scenario by an expert in the field, and then an audience participation segment allowing broad interactive discussion. During this meeting we used the 'Option Finder' audience feedback system which was well accepted by the attendees. The NSW Committee intends to look at ways of continuing to use this format at some future meetings, despite the dramatic increase in workload required.

An Anatomical Workshop was held at the University of Sydney on the 25th November, 2000, with our full complement of 60 registrants. We have developed new specimens for the Anatomical Workshop, which continues to be very well received and fully subscribed. This is a unique teaching and learning opportunity and we encourage all Fellows who have not taken advantage of this resource, to do so in the future.

The NSW Anaesthetic Continuing Education Committee consists of Matt Crawford, Genevieve Goulding, Peter Isert, Mike Jones, Michele Joseph, Peter Klineberg (Chairman), Ed Loughman and Leonie Watterson. This is a cohesive committee which has worked well to offer a forum for NSW anaesthetists to keep up-to-date with information in our area and to maintain a skills base for current practice. We also offer the opportunity for discussion and interaction amongst NSW Fellows. During 2001 we will be conducting three meetings: 19th May at the ANA Hotel in Sydney, 25th-26th August at the Fairmont Hotel in the Blue Mountains and on 3rd November at the Regent Hotel in Sydney.

Professional Affairs – Dr Frank Moloney, Chairman

The year 2000 has been a busy time for the NSW Regional Committee. Colleges are having to be aware of, and react to, outside influences such as the ACCC and NCC. As well, we must comply with legitimate regulatory bodies such as the NSW Medical Board and the Australian Medical Workforce Advisory Committee (AMWAC).

Like the obedient child, we strive to please all of these agencies, primarily by explaining the reason we exist: to develop and maintain high standards of education, training and practice in Anaesthesia.

Changes have occurred in the process for selection of trainees, peer review has been strengthened and, although AMWAC acknowledges our rural rotations, there is still pressure to address a perceived maldistribution of anaesthetic manpower.

Our Committee, through its Education Officer, has spent months negotiating with the paediatric hospitals for increased training positions by the reduction of allocated rotation periods. There is also a National Joint Paediatric & Rural Training Posts initiative, proposing co-ordinated rural rotations with extra four month paediatric postings. A combined meeting of State Education Officers at the Hong Kong ASM will address these issues.

There were significant personnel changes to the Committee through 2000. Two long-standing members, Ed Loughman and Brian Horan, completed their time on the Committee. Ed occupied multiple posts during his twelve years of service, including three years as Chairman. I acknowledge Ed's loyal and dedicated work

for the Committee. Brian Horan is well known to you all, having edited Anaesthesia and Intensive Care, served on College Council and served as the Formal Project Officer for our Committee for many years. Brian has suffered serious health problems since resigning mid-year. He has battled on with customary fortitude but as I write this, the latest reports are not good. In 1970 I was privileged to have Brian as my Best Man when I was married. Since then, I have benefitted from a long, close friendship. My thoughts are constantly with his wonderful family.

Richard Walsh retired from College Council in June after a stellar involvement in ANZCA administration. Richard's presence at our meetings will be sorely missed. I would like to personally thank him for his assistance in ANZCA rural matters and I hope he is coping with fewer trips to Melbourne.

The newly elected members replacing these stalwarts were Jo Sutherland from Royal North Shore Hospital and Michelle Mulligen from Wagga Wagga Base Hospital. Another long serving member, Tony Quail, spent the latter half of 2000 on Sabbatical leave in the USA.

Regional Committees now appoint a New Fellow annually to serve on the committee and Tony Paddy from Westmead Hospital has attended from the December meeting.

At the August meeting I succeeded Matthew Crawford as Chairman. Matthew has been an exceptional Chairman for the past three years. His rational, thorough approach to the task has been an inspiration to me. Fortunately for all of us Matthew remains on the Committee.

The major issues for debate through 2000 were changes with Peer Review, Selection of Trainees, Overseas Trained Specialists (OTD's) and Areas of Need.

Peer Review has become a 'hot' topic. The NSW Council on Quality in Health Care has been set up, essentially to scrutinise how we measure our performance. The Performance Assessment Program and Medical Practice Amendment Act No 64 of 2000 passed through Parliament mid-year. The end result for Fellows has been the NSW Medical Board attaching participation in College MOPS programs to registration. This can be circumvented by submitting practice audits, but non-compliance can result in random assessment by the Board. Matthew Crawford has been appointed to the Peer Review Sub-Committee of the NSW Council on Quality in Health Care.

Selection of trainees for all Colleges has been influenced by ACCC and NCC, the keynotes being equality and transparency. Guidelines for the selection of trainees is now available in booklet form and can be obtained on enquiry or the College Website.

ANZCA has made practical changes in the assessment and utilization of OTD's. Varying requirements for training and assessment are now in place, based on background, training and experience. Significantly, in approved locations OTDs can work in Area of Need posts while they prepare for the OTS examination.

The NSW Regional Committee received seven applications for Area of Need status throughout the State in the last twelve months. This Committee has endeavoured to advise and assist these regions with the changing regulations and the provision of essential anaesthetic manpower.

On the 12th February, Matthew Crawford attended the first meeting of the Tort Law Reform Group, convened by the AMA and UMP. Since then, the many problems in this area have received intense media attention. Although Matthew and I have been peripherally involved in this serious dilemma through the Committee of College

Chairmen, the intention of this Committee is to leave the direct action on indemnity issues to the ASA.

Mid-year, Nigel Symons succeeded Genevieve Goulding as ASA State Chairman. I would like to thank both of them for their regular attendance and comprehensive reporting of ASA matters. This has been appreciated by all Committee members, and as we continue gratefully to use ASA facilities for our meetings, I look forward to a closer liaison with the ASA in the future.

Hospital inspections occurred at St George, St Vincent's and Wagga Wagga Base Hospitals. 2001 requires more of us in this sphere with upcoming inspections at Campbelltown, Canterbury, John Hunter, Lismore, Manly, Mona Vale, Royal Newcastle and Royal North Shore Hospitals.

In conclusion, I would like to thank all members of my Committee for the assistance they provide, with some specific acknowledgements. Richard Morris for his work on Formal Projects, Michele Joseph for her 'never say no' approach and work as Treasurer, Peter Klineberg for his long tenure as head of ANZCA's most productive CME Committee, Jenny Beckett-Wood for her work as Secretary and confidante, Ross Kerridge who works tirelessly as Education Officer to improve the lot of Trainees and their Supervisors, Greg Knoblanche and Michael Cousins as our learned Council members who provide essential information and support to our meetings and Deputy Chair Michael Jones who, along with our Regional Administrative Officer Jan Taylor, makes it possible to Chair this Committee from a rural base.

FRANK MOLONEY
CHAIRMAN

Queensland

Office Bearers & Members

(* denotes co-opted members)

Office Bearers and Members

Chair:

Dr Kerry Brandis

Vice chair:

Dr Bob Whiting

Honorary Secretary:

Dr Geoffrey Gordon

Honorary Treasurer:

Dr Patricia Goonetilleke

Regional Education Officer:

Dr Kerry Brandis

Formal Project Officer:

Dr Gerard Handley

Continuing Education Officer:

Dr Peter Moran

Committee members:

Dr Michael Beem

Dr Stephen Bruce

Dr Julia Byatte

Dr Ian Cameron

Dr Anton Loewenthal

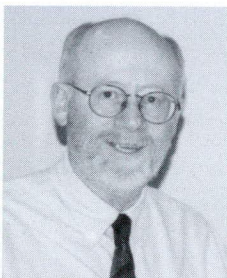
Ex-officio Members:

Dr Di Khursandi (Councillor)

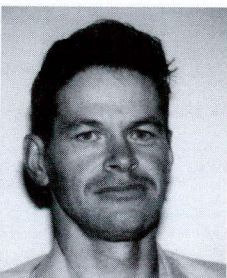
Prof John Gibbs (Councillor)

Dr Ranald Pascoe (Faculty of Intensive Care Representative)

Dr Tim Wong (ASA Representative)



Dr Kerry Brandis
Chairman



Dr Geoffrey Gordon
Hon Secretary

Representatives on External Committees:

Dr Kerry Brandis

ANZCA/RACS Building Committee

Dr Robert Whiting

Advisory Panel to Health Rights Commission

Committee of Queensland Medical Colleges. Medical Workforce Specialist Working Party

Staff Panel of Peers, Senior Staff Specialist Status, Queensland Health

Dr Jennifer Parslow

Chair, Queensland Health Theatre Utilisation steering Committee

State Health Departments Committee Elective Surgery Project

Ministerial Task Force on Elective Surgery

Dr Peter Moran

Editorial Committee Representative "Australasian Anaesthesia"

Postgraduate Diploma in Anaesthetic Nursing, Queensland University of Technology

ANZCA/RACS Building Committee

Dr Bart McKenzie

Medical Workforce Specialist Working Party

Queensland Ambulance Medical Advisory Committee

Dr Mark Gibbs

Queensland Committee to Investigate Perioperative Deaths

Dr Geoffrey Gordon

Emergency Services Specialist Advisory Panel

Dr Di Khursandi

Medical Advisory Committee of Queensland

Post-graduate Medical Education Committee, University of Queensland

Dr Alison Holloway

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

Dr Ian Stephens

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

Dr Paul Mead

Australian Resuscitation Council

Dr Ken McLeod

Queensland Council for Rural Medicine, Rural Specialists Steering Group

Dr Norris Green

RACS Queensland Trauma Committee

Total No. of Regional Committee Meetings for Year:

April 2000 to March 2001 = 8 meetings

Attendances of Elected Members (No. of Meetings)

Dr Michael Beem	6:7	Dr Kerry Brandis	8:8	Dr Stephen Bruce	7:7
Dr Julia Byatte	5:7	Dr Ian Cameron	8:8	Dr Patricia Goonetilleke	6:7
Dr Geoffrey Gordon	7:8	Dr Gerard Handley	4:7	Dr Anton Loewenthal	5:8
Dr Peter Moran	7:8	Dr Robert Whiting	5:8		

Financial Report

The accounts of the QRC have been moved to Melbourne with the introduction of the GST. These centralized accounts remain with sufficient funds for the anticipated operating activities of the committee.

Queensland (continued)

Co-Opted New Fellows' Representatives:

* Dr Daryll Koch

Course Organisers:

Primary Short Course

Dr Kerry Brandis

Primary Long Course

Dr Cameron Hastie

Part I Practise Viva Sessions

Dr Rhonda Boyle

Final Fellowship Short Course

Dr Stephen Bruce

Final Fellowship Long Course

Dr Kerry Brandis

Part II Practise Viva Sessions

Dr Peter Moran

Regional Administrative Officer:

Ms Joyce Holland

Administrative Assistant:

Ms Anne Pike

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

Major purchases this financial year included a digital camera for the recording of committee activities, and the purchase of some additional texts for the regional reference library. Additional AV equipment was also purchased, and this has been an asset to our courses and educational activities.

Education

Trainees

The number of accredited trainees (AVT years 1-4) in Queensland for 2001 is 79. The trainees are organised into 2 rotational training schemes known as the Northside Scheme (40 trainees) and the Southside Scheme (39 trainees).

Three month sub-speciality rotations in Intensive Care, Paediatric Anaesthesia, Obstetric Anaesthesia and Cardiothoracic Anaesthesia are currently adequate for the number of trainees. Experience in Neurosurgical Anaesthesia is obtained at 6 hospitals on the rotations. Involvement in Acute Pain services is widely available but opportunities for experience in Chronic Pain is more limited.

Recommendations for trainee selection have been determined at an annual meeting to which the Director of Anaesthesia and the Supervisor of Training from each of the 19 hospitals with trainees are invited. The selection process is merit-based and scored against Selection Criteria. It is intended to move to a more structured and transparent process for 2002.

Provisional Fellows this year total 14.

Registrar Training Courses

Three types of courses are available for registrars:

- Hospital Departmental meeting programs
- Long Courses
- Short Courses

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

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

The Long Part 2 Course is a series on tutorials on Thursday nights in the College building.

The Short Primary Course is a two week full-time course held bi-annually. These courses are organised by Dr Kerry Brandis.

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

Other Training Issues

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

Other Training Matters:

The Queensland Regional Committee has been tasked by the College Council with the trial of a log book for trainees. Wide consultation and a trial of a PDA log book is being produced for Council.

Continuing Education

The 4th Annual CME meeting was held on the 8th July 2000 at the Noosa Lakes Resort. Major themes of the meeting included Obstetric Anaesthesia, Paediatric Anaesthesia, the Management of Anaesthetic Crises and the Assessment of Outcomes. Dr Paul Myles from The Alfred Hospital in Melbourne was the interstate guest speaker. 153 delegates with 134 Fellows and 19 Registrars attended the meeting which was well supported by the trade. The successful meeting was concluded with an evening Dinner Dance attended by 91 registrants. The meeting was convened by Dr Darryl Koch.

The 4th Combined ANZCA-ASA Annual Registrars' Meeting was held at College House in Brisbane on the 11th November 2000. Dr Pearl Cheung was the recipient of the Tess Cramond Prize for Formal Projects presented on that day.

Preparations are well advanced for the 2002 ANZCA Annual Scientific Meeting which will be held at the Brisbane Convention & Exhibition Centre from the 11th to the 15th May.

Acknowledgements

The Queensland Regional Committee once again would like to acknowledge the extraordinary contribution made to the activities of the Committee, Fellows and trainees in Queensland by Joyce Holland, the Regional Administrative Officer. Without her organization, thoughtfulness, forbearance and management skills, we would not be able to engage ourselves in the range of activities that are currently available to the Fellows and trainees in Queensland. We also wish to acknowledge the countless and undocumented hours spent on College affairs by Queensland Fellows over the past year.

Admission to Fellowship

BY EXAMINATION

BURGESS	Neil David	NSW	ISMAIL	Mohamed Hilmy	NZ
FOUND	Philip William	UK	KHOO EN SZEE		SA
GIBSON	Stephen Bruce	NSW	MURPHY	Edward John	SA
GILLIES	Robyn Louise	VIC	POON	Anthony Bruce Yew Wai	VIC
HALLIDAY	Emma Louise	NSW	PRICE	Darcy John	NZ
HAUGHTON	Andrew John	VIC	SEPPELT	Ian Mark	NSW
HENDERSON	Gary Paul	NSW	SHEARER	Virginia Maria	QLD
HUNT-SMITH	Julian John	VIC	STRYKOWSKI	Rodney John	NSW
ILLINGSWORTH	Anna Lynda	QLD			

Victoria

Office Bearers:

Chairman:

Kate Leslie

Deputy Chairman:

Rowan Molnar

Honorary Secretary:

Peter McCall

Honorary Treasurer:

Mark Fajgman

Continuing Medical Education / IT:

Joe Novella

Education - Anaesthesia:

Mark Buckland

Paramedical Personnel:

Philip Ragg

Formal Project Officer:

Winifred Burnett

Safety Officer / Social:

Beth Ashwood

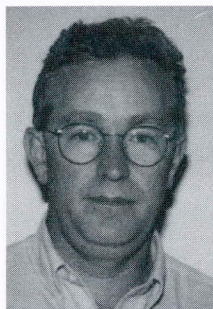
Victorian Medical Postgraduate

Foundation:

Steve Chester



Dr Kate Leslie
Chairman



Dr Peter McCall
Hon. Secretary

Total number of Regional Committee Meetings for Year: 2000 = 11
2001 = 3

Attendances of Elected Members:

Dr Ashwood	9/11	Dr Buckland	9/11	Dr Burnett	6/9	Dr Chester	4/11
Dr Fajgman	7/11	Dr Iatrou	6/9	Dr Leslie	8/11	Dr McCall	6/11
Dr Molnar	11/11	Dr Novella	9/11	Dr Ragg	10/11	Dr Tuck	9/11

Introduction

The major focus of the Regional Committee in 2000 was the Annual Scientific Meeting of the College, which was held in Melbourne from May 6th - 10th. The Meeting was attended by more than 1000 participants and was acclaimed by all as a fabulous success. The Convenor, Dr Philip Ragg, and his Committee (which comprised VRC Members and other Fellows of the College) are to be congratulated on a job well done!

Following elections in May, the new Committee was formed in July 2000 for a two-year term. I would like to welcome Drs Winifred Burnett and Colin Iatrou to the Committee and thank Drs Graeme Cannon and Brendan Flanagan for their contribution as retiring Members. The Committee also welcomes Dr Craig French, Co-opted Faculty of Intensive Care Representative, and Dr Antony (Tony) Leaver, Co-opted New Fellow. The new Committee has continued with its core business: conducting CME meetings for Victorian Fellows, organising courses for trainees, and advising and assisting Council with their Victorian affairs, ably assisted by our Administrative Officer, Ms Corinne Millane.

Consultative Council on Anaesthetic Mortality

In the year 2000 the Council met on 10 occasions and reviewed 115 cases of perioperative mortality and 48 cases of significant morbidity related to anaesthesia. A significant number of these cases related to 1999 cases and there are still a considerable number of cases from 2000 to be reviewed.

In May 2000 the triennial report to parliament was distributed to all Victorian Medical Practitioners as well as to Colleges and other Quality Assurance organisations. In December a further Information Bulletin was issued to Victorian anaesthetists, highlighting concerns arising from more recent reports.

During 2000 the Council suffered a serious setback during a departmental reorganisation within the Department of Human Services, which resulted in a temporary withdrawal of support services. The activities of the Council were able to continue but there was a regrettable delay in feedback to reporting anaesthetists. However the Council is now receiving significant support from the government and hopefully there will now be stability of the organisation.

The term of the current Council expires in July 2001 when the Minister will appoint a new Council. There will be some additional terms of reference for the new Council which will include participation in the evaluation of mandatory reports of selected sentinel events where these are relevant to anaesthesia and closer liaison with other Consultative Councils, including the yet to be established Surgical Consultative Council. In addition to reporting to the Minister the Council will also be required to report to the new statewide Quality Council and to respond to specific matters referred to the Council by the Minister. However it is emphasised that strict confidentiality will continue to be maintained and no material identifying the patient, hospital or practitioner will be revealed to any other Council. It is also expected that the legal issues covering indemnity will be clarified in the forthcoming year.

Victoria (continued)

Assistant Education Officer:

Mark Tuck

Assistant CME Officer:

Colin Iatrou

Ex-Officio Members:

Councillors:

Dr Ian Rechtman

Dr Rod Westhorpe

Co-opted:

Royal Australasian College of Surgeons

Prof Paddy Dewan

Consultative Council on Anaesthetic

Mortality and Morbidity

Dr Patricia Mackay

Australian Society of Anaesthetists

Representative

Dr Simon Reilly

Faculty of Intensive Care Representative

Dr Craig French

New Fellow

Dr Antony (Tony) Leaver

Administrative Officer:

Ms Corinne Millane

Education

The Victorian Regional Committee ran the usual courses leading up to the Primary and Fellowship Examinations. They were very popular and successful. The Annual Registrars' Scientific Meeting was hosted in August on the eve of the 21st Combined ANZCA/ASA Continuing Medical Education Meeting, and once again proved a success.

After an interval of several years, a meeting of Victorian Supervisors of Training was held. This was an excellent opportunity to introduce the Supervisors to the newly appointed Dr Russell Jones, Director of Education and Dr Mary Done, the Assistant Director of Education, and enabled a wide range of issues to be discussed. Dr Jones is very enthusiastic about working with the Supervisors of Training in all regions, and I think will offer them excellent support in what at times is a very challenging job. The group agreed to meet six monthly in the future, and look forward to updates in areas such as In-Training Assessment.

Finance

All the bank accounts run by Regional Committees were closed as part of the management changes required within the College following the introduction of the GST. The additional record keeping is now centralised to the College's accounting department.

Our first and second part training courses have again been held off sight due to the continuing building activities at Ulimaroa. The Committee has funded the additional cost associated with these courses.

Paramedical Personnel

The Victorian Society of Anaesthetic Technicians courses will no longer be held at Barton College and anaesthetic training would, in future, be done by correspondence from New South Wales.

Following nurses' award negotiations with the State Government, the wording of the After Hours Call and Requirements in Theatre has been revised, and quite specifically states that for minor cases after hours now requires three nurses in theatre, four for major cases. The award hasn't taken into account hospitals using anaesthetic technicians as their anaesthetic assistant, and some hospitals have already advised technicians they would no longer be doing After Hours Call. Because of this anomaly Commissioner W Blair has called a meeting of interested parties to discuss this issue.

Continuing Education

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

- | | |
|---------------------|---|
| 4th -5th May 2000 | New Fellows' Conference, The Cumberland, Lorne |
| 6th - 10th May 2000 | Annual Scientific Meeting, Crown Palladium, Melbourne. |
| 21st July 2000 | Annual Registrars' Scientific Meeting, Mary Aikenhead Conference Centre, Melbourne |
| 22nd July 2000 | 21st Annual Combined ANZCA/ASA CME Meeting, Hotel Sofitel, Melbourne. "Perioperative Management and Planning – an Update". Guest Speaker, Professor Bill Runciman |
| 5th December 2000 | Victorian Regional Committee CME Evening Meeting "An Update on Hyperbaric Medicine" Dr Ian Millar, Head, Hyperbaric Medicine Unit, Alfred Hospital, Melbourne |

All of these Meetings were videotaped and may be borrowed from the ANZCA Library.

The 21st Combined ANZCA/ASA CME Meeting was held on 22nd July 2000. The Meeting theme, "Perioperative Management and Planning – an Update", included areas covering: management of hypertension, cardiac disease and diabetes. Operative room distractions, patient monitoring; prophylactic antibiotics; post-operative nausea; post-operative complications and, the legal consequences of lack of management were also addressed.

The 22nd Combined ANZCA/ASA CME Meeting will be held on 21st July 2001 at the Hotel Sofitel. The theme of this meeting will be "Technology and the Anaesthetist".

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

A questionnaire was distributed in late November 2000, seeking feedback on the format, timing and content on future CME Meetings, as well as feedback on the VRC Website. The results will be included in the minutes of the March VRC Committee Meeting.

Victorian Medical Postgraduate Foundation Inc.

In spite of withdrawal of government funding in 2000, the VMPF continued to organise metropolitan postgraduate education meetings, a gynaecological pathology conference and a limited country education program. Negotiations are currently occurring for funding for a more extensive country education program. The Careers Expo Day for medical undergraduates and residents was again very successful and will be held on 7th July 2001.

Electronic Media And Web Page

The year has been spent enhancing the website. We now have application forms available online for primary and final examination short courses. Dr J Novella has continued his involvement in the organisation of the Virtual Congress 2001. The ANZCA CSM in Hong Kong will be brought back to Australia and New Zealand via an online website <http://virtualcongress.anzca.edu.au>.

Rural Activities

No new issues arose during 2000. The year's events were dominated by the ASM in Melbourne. The Rural SIG held a well attended workshop during the conference which highlighted the issues of recruiting to rural centres, CME/MOP's in the rural environment, an overview of the development and implementation of RARS and the ongoing issue of training for rural GP's involved in the delivery of anaesthesia. Debate was interesting and encouraging. Council's proposed forays into rural scholarships, rural/paediatric rotations and the development of a more formalized relationship between the central resource hubs and peripheral/rural departments, all hold much promise. The challenge will be to enhance the training for, and attractiveness of, a non-CBD career without compromising the current level of exposure and competence in essential subspecialty areas for the majority of trainees.

Safety

The Safety Officer of the Committee is responsible for monitoring drug and equipment issues, which are important to Victorian patients. Fellows are invited to contact the Safety Officer with issues or problems regarding safety.

Formal Projects

Victorian trainees have produced some interesting Formal Projects this year. Many were presented at the Annual Registrars' Scientific Meeting organised by the Regional

Education Officer, Dr Elizabeth Ashwood. Several trainees presented their projects at national meetings, whilst others submitted published work.

Dr Patricia A Newell	Post-operative epidural analgesia in ASA III & IV patients undergoing general surgical operations: A retrospective cohort study
Dr Robyn L Gillies	The use of a PACU score to aid PACU discharge
Dr Frank G P Raymond	Attitudes and Practices of Victorian Anaesthetists with Regard to Brachial Plexus Blockade
Dr Greta M Palmer	Use of the Bispectral index monitor to aid titration of Propofol during a drug assisted interview/neuropsychiatric evaluation
Dr Antoinette M Brennan	Myocardial Ischaemia and Infarction in Pregnancy
Dr Dayalan Ramasamy	Transient radicular irritation after spinal anaesthesia with 2% isobaric lignocaine
Dr Julian J Hunt-Smith	Safety and efficacy of target controlled infusion (Diprifusor) vs manually controlled infusion of propofol for anaesthesia
Dr Robyn F Chirnside	Tidal volume ventilation induction of anaesthesia with 8% sevoflurane, with and without nitrous oxide
Dr William J Hoffmann	Extra Corporeal Membrane Oxygenation at Frankston Hospital ICU
Dr Craig A McCutcheon	Systemic Reperfusion Injury During Arm Replantation Requiring Intraoperative Amputation
Dr Raymond B-K Tam	Raised Pulmonary Vascular Resistance Index (PVRI) – Identification and Stratification by means of Cardiopulmonary Exercise Testing
Dr Peter T J Girdlestone	The Laryngeal Tube – a viable alternative?
Dr Justin W Watts	Cardiac Investigations and Referrals Ordered from the Pre-Admission Clinic
Dr Christopher J Reid	Video Assisted Thoracoscopic Surgical Pleurodesis for Persistent Spontaneous Pneumothorax in Late Pregnancy
Dr James A Mitchell	Patient Monitoring in Anaesthesia: a Review of the On-line Literature
Dr Elli Tutungi	Carotid endarterectomy: anaesthetic management of the patient
Dr Neil R Orford	Effect on Anaerobic Threshold of Electrical Cardioversion of Atrial Fibrillation to Sinus Rhythm
Dr Penelope J Clunies Ross	Assessing the patient with perioperative coagulopathy – with reference to the coagulopathy associated with liver transplantation
Dr Sue Ho	Persistent Pain Following Cardiac Surgery – retrospective study
Dr S Dishan P Chandrasekara	Suspected Haemaccel Reaction in an Obstetric Patient – Case Report and Review
Dr Mae F Chen	A Comparison of Carbon Dioxide Monitoring and Oxygenation Between Facemask and Divided Nasal Cannula
Dr David K Clarke	High Dose Oral Dextromethorphan as an Adjunct to Analgesia with Morphine after Knee Surgery
Dr Andrew C Schneider	Local anaesthetic infiltration may not be necessary prior to intrathecal anaesthesia for elective Caesarean section
Dr Tyron R Crofts	Bilateral Frontal Haemorrhages Associated with Continuous Spinal Analgesia

Finally, the Victorian Regional Committee would like to thank all the staff at “Ulimaroa” for their valuable assistance during the year. We extend our particular thanks to our Administrative Officer, Ms Corinne Millane for her excellent support.

KATE LESLIE

South Australia

Office Bearers and Regional Committee Members

Chair:

Dr. A. Rainbird (until May 2000)
Dr. M. Wiese (from June 2000)

Vice Chair:

Dr. M. Wiese (until May 2000)
Dr. M. Cowling (from June 2000)

Hon. Secretary/Treasurer:

Dr. M. Cowling

Committee Members:

Dr. N. Maycock (until May 2000)
Dr. J.D. Richards (until May 2000)
Dr. A.R. Laver
Dr. P.C. Woodhouse (until May 2000)
Dr. L. McEwin
Dr. R. Singleton (until May 2000)
Dr. L. Rainey (from June 2000)
Dr. J. Harding (from June 2000)
Dr. A. Norton (from June 2000)
Dr. C. Higham (from June 2000)
Dr. R. Limb (from June 2000)

Formal Projects Officer

Prof. D. Moyes

Northern Territory Representative

Dr. D. Catt

Faculty of Intensive Care Representative

Dr. S. Peake



Dr Margaret Wiese
Chairman



Dr Margaret Cowling
Hon. Secretary/Treasurer

Total No. of Regional Committee Meetings for Year: 7

Attendances of Elected Members

Dr Margaret Cowling	6 of 7	Dr Alisteir Norton	2 of 6
Dr Chris Higham	0 of 6	Dr Alan Rainbird	1 of 1
Dr Tony Laver	7 of 7	Dr Lynne Rainey	5 of 6
Dr Robin Limb	4 of 6	Dr John Richards	0 of 1
Dr Neil Maycock	2 of 4	Dr Robert Singleton	1 of 1
Dr Lisa McEwin	6 of 7	Dr Margaret Wiese	7 of 7
Professor Don Moyes	4 of 6	Dr Peter Woodhouse	2 of 4

The Annual General Meeting of the South Australian Regional Committee was held on Wednesday, 5th April 2000 prior to the CME meeting at Wakefield Hospital.

Continuing Education

Continuing Education Meetings - The South Australian Regional Committee thanks the Combined ASA/ANZCA CME Committee for organising the following meetings throughout 2000/early 2001:

1. **1st March 2000** - "Risk Management and Legal Issue for Anaesthetists" Speaker: Ms Tracey Nelson, Risk Management Officer, Medical Defence Association of SA
2. **5th April 2000** - "Anaesthesia and Morbid Obesity" Speakers: Drs Simon Macklin, Grant Carr, Andrew Puddy and Tony Burke
3. **7th June 2000** - "Perioperative Arrhythmia Diagnosis and Management" Speaker: Dr Glenn Young, Adelaide Cardiology
4. **5th July 2000** - "Oh! Is he a Bleeder?" Speaker: Dr Doug Coghlan, Haematologist, FMC.
5. **19th-20th August 2000** - "The Grand Update - 2000" Visiting Speakers: Associate Professor Richard Moon, Dr Di Khursandi
6. **18th October 2000** - "Preoperative Assessment and Planning" Speaker: Professor Bill Runciman
7. **22nd November 2000** - "Registrars Scientific Evening" Presenters: Dr T Strong, Dr A Hackland, and Dr E Hewitson. The Registrars Prize was presented to Dr Erica Hewitson. ANZCA Prize presentation to Dr Lucy McKinnon
8. **21st March 2001** - "Cleft Palate Repair: East Timor Style" Speakers: Dr Tim Semple and Mr Mark Moore ANZCA Prize presentation to Dr Andrew Lok

Perioperative Mortality Committee

As the College now provides a collated report from the regions of Anaesthesia Related Mortality in Australia only a brief summary of our local committee's activities is provided here.

101 cases were considered in the year ending 31 December 2000. This is close to 100% of perioperative deaths requiring review in our region due to the excellent cooperation of the SA Coroner's Office. In 2001 there may be some delay in considering cases as the only access to coronial data now is by application to the Monash University National Coroner Information System. The Perioperative Mortality Committee Report form is being modified to make it more user friendly.

Anaesthetic Museum

The Regional Committee has decided to name our collection "The Bill Fuller Collection" in recognition of Bill's major contribution to South Australian anaesthesia activities. Other contributors to the collection, in particular Maurice Sando, will be noted in the way the collection is presented.

Faculty of Pain Medicine Representative

Dr. P. Macintyre

Younger Fellows Representative

Dr. T. Jaensch (until July 2000)

ASA Representative

Dr. N. Maycock (from Oct 2000)

Ex Officio Member of Council

Dr. R.J. Willis

Directors Representative

Dr. P. Lillie

Regional Education Sub-Committee:

Chairman - Regional Education Officer:

Dr. Peter Woodhouse (until Oct 2000)

Dr. Glenys Miller (from Nov 2000)

Organiser - CME

Dr. Lisa McEwin

Course Organiser - Primary

Dr. Grace Koo

Course Organiser - Final Fellowship

Dr. David McLeod

Regional Administrative Officer

Ms Sue Harrison (until April 2001)

Ms Jane Hinchey (from April 2001)

Training Issues

A decision was made to provide both Primary and Second Part Courses at no cost to our local trainees during the year 2000. A fee of \$100 per semester has been reintroduced for the Primary Course this year. The Second Part Course has been changed to an annual course with core topics rather than a two-year program. The Regional Committee, on behalf of our trainees would like to thank all the Supervisors of Training, our Coordinator of Training (Dr Neil Maycock) and the Primary (Dr Grace Koo) and the Second Part (Dr Dave McLeod) Course Organisers for their considerable efforts.

The members of the Regional Education Sub-Committee are looking forward to the attendance of Dr Russell Jones, the newly appointed ANZCA Director of Education, at one of their meetings later this year.

Dr Kym Osborn, the Supervisor of Training in Women's Anaesthesia at the Women's and Children's Hospital, organised a combined ANZCA & RACS Registrar Seminar ("How to Deal with Conflict in Theatre") which was very well received by the registrars who attended. A similar session, accessible to Fellows is being planned for a local CME meeting as there was a considerable interest from this group in the topics covered at the seminar (Life Stresses, Communication with Colleagues and Patients, Bullying and Harassment, Conflict Resolution: Assertiveness, Negotiation and Dealing with Difficult People).

The Alice Springs rotation has been suspended due to several difficulties, the final one being lack of nursing staff to provide other than emergency services.

A survey of trainees, who participated in this rotation, is being assessed. The situation will be reviewed later in 2001.

Regional Committee

The Regional Committee would like to thank all Fellows who have contributed to the various activities of the College in South Australia throughout the past year. The South Australian Secretariat is very capably managed by Ms Sue Harrison. I would like to thank her for the excellent support she has given me and the efficient and pleasant way she has assisted us all throughout the year.

MARGARET WIESE

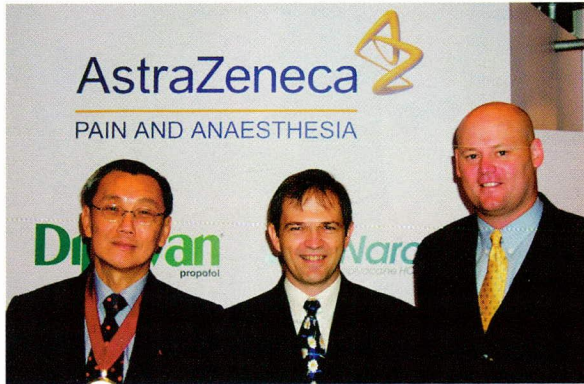
CHAIRMAN



Dr Winifred Burnett, Vic received the Gilbert Brown Prize from Vice President, Dr Richard Willis



Right: Dr Anna Lee with the Vice President following the presentation of the Formal Project Prize



Right: Dr Charles Minto, NSW (centre) Australasian Visitor with Prof Teik Oh, President and Mr Lincoln Clifford, Product Group Manager, AstraZeneca



Dr Garry Hopwood, NZ, Renton Prize Winner August 2000 with President, Prof Teik Oh



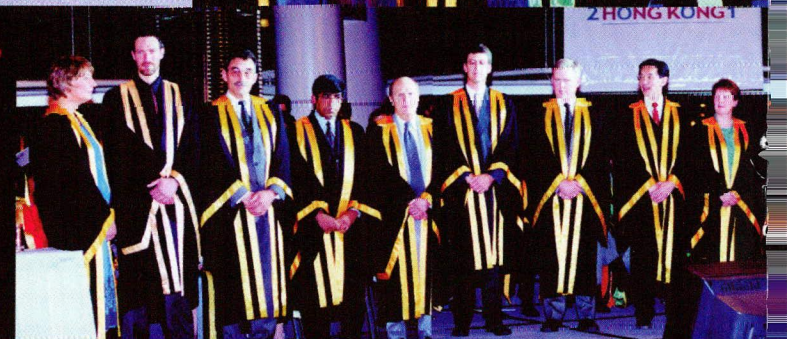
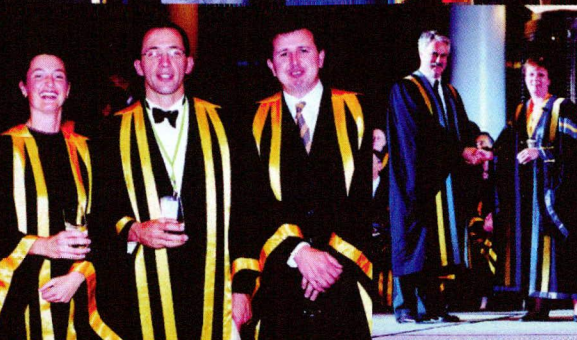
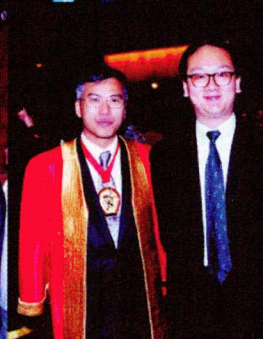
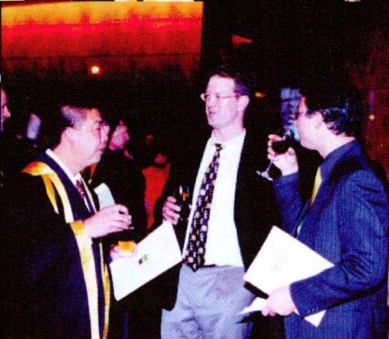
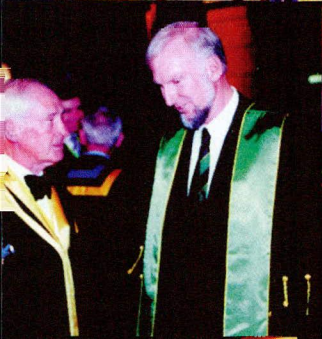
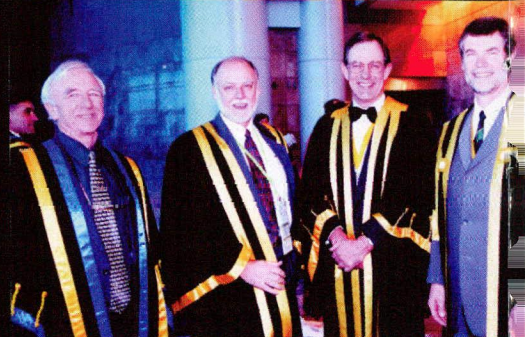
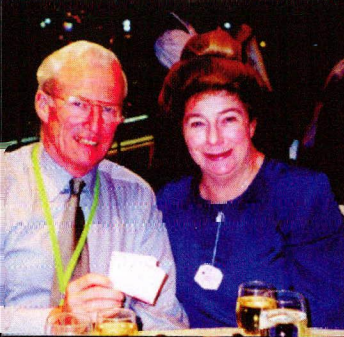
Dr Stephanie Keel, NZ was awarded the Cecil Gray Prize August 2000



Dr Paul Wrigley, NSW presented with the Barbara Walker Prize for Excellence in Pain Medicine, 2000 by Prof Michael Cousins



Dr Simon Townsend, Qld received the Cecil Gray Prize at the Final Examination from the President. Dr Townsend also received the Renton Prize in September 1993





Tasmania

Office Bearers and Members:

Chair:

Dr Margaret Walker

Deputy Chair:

Dr Phil Browne

Secretary/Treasurer:

Dr Richard Smith
(Resigned March 2001)

Dr Daniela Eugster
(from April 2001)

Regional Education Officer:

Dr Mike Grubb

Committee Member:

Dr Richard Waldron

Ex Officio:

Dr Mike Martyn, Councillor

New Fellows Representative:

Dr Mike Grubb

Representatives on external committees

Ambulance Clinical Council:

Dr Daniela Eugster (to Jan 2001)

Dr Marcus Skinner (from Jan 2001)

Post-Graduate Medical Committee:

Dr Michael Hodgson

Australian Resuscitation Council:

Dr Malcolm Anderson

School of Medicine Advisory Committee:

Dr Malcolm Anderson

Australasian Anaesthesia Sub-Editor

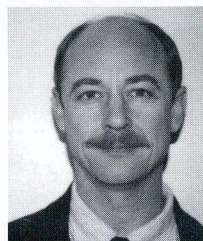
Dr Colin Chilvers

Younger Fellows Conference:

Dr Mike Grubb



Dr Margaret Walker
Chairman



Dr Richard Smith
Secretary/Treasurer

Total Number of Regional Committee Meetings for Year: 4

Attendance of elected members

M Walker	4 of 4	M Martyn	3 of 4
R Smith	2 of 4	R Waldron	4 of 4
P Browne	4 of 4	M Grubb	2 of 4

Financial Report:

The TRC Accounts were centralised at the Melbourne office upon implementation of the GST to simplify our accounting processes. The State Annual Scientific Meeting covered its own costs, and a second meeting held for registrars in Launceston was fully sponsored.

Education

Successful exam candidates for 2000

Primary: Andrew Ottaway, Tony Keeble, Ravi Walpitagama

Final: Simon Morphet

The College requested that an "Advisor for Candidates for Anaesthesia training" be appointed in each state. The role of this person is to advise candidates wishing to enter the scheme or to return to training after a period of absence. Dr John Hickman agreed to take on the role for the whole state, as he had already been effectively filling this role in an unofficial capacity for some time.

Dr Peter Lane has been appointed Supervisor of Training at the Royal Hobart Hospital.

Continuing Education

The Tasmanian Regional ASM was held at Freycinet Lodge in February 2001, with a theme of "Pain management". A registrars meeting was held in Launceston in November 2000, with a theme of "Planning for life after training". Both meetings were well attended.

The highly successful "Anaesthesia for remote situations and difficult circumstances" course was held in April 2001 at Royal Hobart Hospital, co-ordinated by Dr Haydn Perndt. The Regional Committee congratulates Dr Perndt on this highly successful course, which may become a second-yearly event.

Hobart has been selected as the Host City for the ANZCA ASM in May 2003. The venue will be the Hotel Grand Chancellor Convention Centre.

The Organising Committee so far consists of:

Convenor:	Dr Richard Waldron
Deputy Convenor:	Dr Margaret Walker
Scientific Convenor:	Dr Phil Browne
Social Programme:	Dr Peter Sayers
Workshops and Problem Based Learning:	Dr Malcolm Anderson
Trade Liaison:	Dr Colin Chilvers
Audio-visual:	Dr Jeremy Wallace
Faculty of Intensive Care Representative:	Dr Stuart Miller

The Faculty of Pain Medicine will advise us of their representative in due course. Penny Archer of Conference Design has been appointed as the Professional Conference Organiser, and we look forward to a busy couple of years.

Professional Affairs

The issue of problems in attracting people to participate in the workings of the Regional Committees remains a perpetual problem, especially in the smaller states like Tasmania, where a small number of volunteers end up doing all the work all the time. Dr Richard Smith has resigned from the Regional Committee. We wish to thank him for his valuable contribution as Secretary/Treasurer. The Committee has Co-opted Dr Daniela Eugster to replace him in the interim until the next elections are due.

MARGARET WALKER
CHAIRMAN

Annual Report New Zealand – National Committee

Office Bearers and Members

Chairman

Dr Malcolm Futter

Deputy Chair

Dr Sharon King

Honorary Secretary

Dr Vaughan Laurenson

Honorary Treasurer

Dr Peter Cooke

Education Officer

Dr Hugh Spencer

Formal Project Officer

A/Prof. Michael Harrison

Committee members:

Dr Sandy Garden (resigned, March 2001)

Dr David Jones

A/Prof. Alan Merry

Dr Tom Watson

Dr Jennifer Weller



Dr Malcolm Futter
Chairman



Dr Vaughan Laurenson
Hon Secretary

Total number of committee meetings for year – 3

Attendance of Elected members

November 2000: Dr Weller (overseas), Dr Cooke, apologies for Saturday absence; July 2000: apologies from Dr Weller for Friday absence; March 2001: Apologies from Dr Cooke for Friday absence, and from A/Prof Merry for Saturday absence

CHAIRMAN'S REPORT

New Zealanders are yet again grappling with further name changes to our hospitals. We are now known as DHBs (District Health Boards) instead of HHSS, CHES or prior to that Area Health Boards.

The Medical Practitioner Act 1995 requires by 1 July 2001 for vocationally registered medical practitioners to be enrolled in an approved Maintenance of Standards Program. The Medical Council of New Zealand will begin to audit individuals' compliance in three years time.

The Honourable Ken Shirley has successfully taken his private member's Bill – *The Medical Practitioners (Foreign Qualified Medical Practitioners) Amendment Bill* to the Select Committee stage. It proposes that assessment of suitability for registration of overseas trained doctors be removed from the Medical Council of New Zealand and be given to the New Zealand Qualification Authority. This is indicative of the political climate in New Zealand where the Colleges are viewed as protectionist. Also it is an attempt to address the embarrassment of the mid 1990's immigration policy which granted residency to medical practitioners who in fact did not meet the expected standards required by the Medical Council of New Zealand for registration. During verbal submission to the Parliamentary Select Committee, the Committee was clearly of the opinion that our College is the most protectionist.

Medical adverse events have dominated in the headlines – with at least three high profile incidents relating to anaesthetists – syringe reuse, ice on the breast and tiredness to name a few. Helen Cull QC has made recommendations for significant changes to the reporting and investigation of adverse events which include mandatory reporting, the ability for the Medical Council to stand down a medical practitioner before investigations are complete and to allow the different agencies which may be involved to share the information.

Recruitment of trainees and retention of anaesthetists in New Zealand is a growing concern. Enticing offshore rewards grow stronger and local student debt appears to be growing, with University funding by Government diminishing each year.

Changing junior doctors' hours of work and study leave are making it increasingly important for the College to maintain a close eye on trainee experience, particularly with regard to subspeciality areas and the proportion of training that is supervised.

Liaison with the New Zealand Society of Anaesthetists continues to be mutually beneficial and consolidates the close working arrangement the New Zealand National Committee has through CECANZ. This is evidenced by the three offices now located in the same building.

The NZ National Committee continues to support the need for a close relationship with the Australian part of the College, particularly Council. The New Zealand Chairman has attended College Council Meetings when appropriate and the Committee waits to welcome the Executive to a New Zealand meeting in the near future.

I would like to thank all the members of the NZ Committee for their continued commitment and the administrative staff for their gentle reminders about deadlines.

Councillors

Dr Steuart Henderson

Dr Leona Wilson

Faculty of Intensive Care Representatives

Dr Ross Freebairn Chairman, FIC, NZ

Dr Jack Havill BOF

NZSA representative :

Dr David Chamley

Administrative Officer

Lorna Berwick

Administrative Assistant

Jan Graham

2001 ANNUAL REPORT: EDUCATION OFFICER, NZ

Advisors of Candidates for Anaesthetic Training

Dr Alan MacKenzie, a former member of the NZNC has undertaken this role.

Changes to training numbers

The number of year 1-4 trainees in the NZ scheme has been slightly increased – Auckland (3), Waikato (2), Christchurch (4). More PFY posts have also been approved in the Northern scheme. However, it is generally difficult to fill all the PFY positions in NZ and this has caused some concern.

Hospital inspections

Whangarei, New Plymouth, and all the South Island hospitals were inspected in this period.

Annual trainee placement teleconference

This was conducted by Dr Vaughan Laurenson. With the formalising of a national registrar employment system amongst the hospitals, the Trainee placement efforts by NZ centres, co-ordinated by the NZNC, will run comfortably in parallel.

South Island Rotation

Since September 2000, the education officer has been able to visit all the hospitals of the new Southern Rotation. It is clearly a viable rotation which covers all aspects of anaesthesia training with a more than adequate availability of sub-speciality opportunity.

Training in pain management

As with many other rotations within Australia, incorporation of considerable resources of pain management training into trainees' programs is inconsistent and insufficient in many NZ centres.

Demographics of training

There has been growing concern in NZ about the loss of senior trainees abroad. It is not known how many trainees registering for T1 in NZ, who complete the Fellowship, remain in or return to NZ as specialists. An investigation has been requested of Melbourne to track the fate of T1 registrants at years T4, PFY, and post-fellowship years 1, 3 and 5 starting from the 1990 T1 year.

This should enable the Committee to gauge the problem and consider ways to deal with it should it prove to be as serious as is suspected.

Co-ordination of appointments process

A letter has been sent to all hospitals requesting that a nationally standard process of appointment of anaesthesia registrars be agreed to, based on the College document *Guidelines for the Selection of Trainees* (Nov 2000). It was also suggested that to align the dates of appointment with Australia made sense in an Australasian College, because of the importance of examination results for appointment.

Courses

Primary courses were held in Hamilton (June) and Christchurch (February) and the Finals course took place in Auckland (July).

Education Sub-committee meeting (NZ)

This was held on 22 March by teleconference and was attended by Dr Russell Jones. Matters discussed included the new rotations which were working well; national standardisation of appointment processes; trans-Tasman trainee flight; inadequacies of pain management training; Dr Jones's aims and priorities.

HT SPENCER

NEO, NZ

Treasurer's Report
Year ending 31 December 2000

New Zealand Fellows continue to pay annual subscriptions in Australia whilst New Zealand trainees' fees have been paid to the New Zealand office. This arrangement seems to be suiting all parties.

GST is payable on fees. The GST percentage payable is calculated each year proportional to an estimate of the amount of goods and services provided to Fellows and trainees within New Zealand versus that provided from Australia.

Income and expenditure for the activities of the New Zealand committee varied little from the previous year.

The CME account benefited from return of conference seed money from the 1999 Wellington conference and very modest profits were banked from the Invercargill 1999 conference and the 1998 Dunedin conference. A payment of \$16,253 was made from the account to CECANZ. This amount represented the College's share of CECANZ income requirements for a two year period.

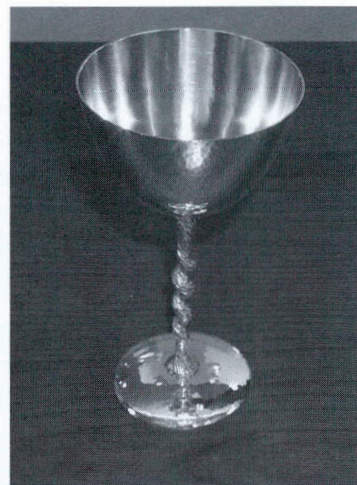
The NZ committee is an active member of the Council of Medical Colleges of New Zealand. The annual levy to support the activities of this council is \$8,505

PETER COOKE
HONORARY TREASURER

Gifts to the College



Crystal Junk presented by the Hong Kong College of Anaesthesiologists



Hand made Sterling Silver Goblet with gold gilding designed by Stuart Devlin and presented by Prof John Norman, UK

Separating the Armstrong Twins – A Team Effort

Scott Campbell has given a lot of media interviews since he successfully separated Siamese twins Tay-lah and Monique Armstrong, but the Brisbane neurosurgeon is very quick to share the credit.

Mr Campbell and a team of 25 people including anaesthetists, neurosurgeons, plastic surgeons, paediatric surgeons, theatre nurses and technicians were prepared for every aspect of the world-first operation at Brisbane's Royal Children's Hospital in October.

They had two models made to ensure each step of the operation went smoothly.

"We knew the operation would be awkward because of the way they were joined. So we practised with the dummies to make sure we could flip them over safely. We also practised on the babies themselves, so there were no mishaps," Mr Campbell said.

For Mr Campbell, the operation began after obstetric ultrasound specialist Gary Pritchard picked up the abnormality during a routine ultrasound and was able to provide very accurate details of the twins as early as 14 weeks.

From there, Mr Campbell counselled the girls' parents Pacquita Armstrong, 21, and Shane Conyard, 23, telling them how rare the condition was and discussing the process.

"They were given the option of going ahead with the pregnancy and they made their decision based on their own ethical and social values," he said.

The babies were born at 33 weeks - seven weeks premature. Tay-lah initially had a heart problem, a coarctation of the aorta, and had open-heart surgery at four days of age. She also developed renal problems and later developed cerebral palsy.

Mr Campbell said the twins' condition, craniopagus occurred once in every two to five million births, but that this type of case - where they were joined upside down and back-to-front - had not been recorded in the published literature.

Mr Campbell said the operation's best chance for success was if it was performed on the twins when they were aged between six and 12 months.

"If we did it too early there may have been complications ... we had to make the operation as safe as possible and we believed six to seven months was the correct time. We had to build up their blood supply and their immunity," he said.

Mr Campbell said he consulted Sydney paediatric neurosurgeons Professor Michael Besser, of the New Children's Hospital and Dr Ray Chasling of Westmead Hospital. He also sought advice from Dr Gordon Stuart, of Royal Brisbane Hospital and Dr Michael Weidman, of Princess Alexandra Hospital in Queensland.

The team of 25 were all from the Herston Complex, the Royal Women's, Royal Children's and Royal Brisbane Hospitals in Brisbane.

The operation lasted 12 hours. It carried a 70 per cent chance that one would die.

Mr Campbell said the twins were joined by a sliver of bone at the back of their skulls. "It was a very complex anatomy because there was a hole between the two skulls and part of Monique's cerebellum was protruding through."

"There were major problems because the conjoined area is the part of the brain where the superior sagittal sinus and the left and right transfer sinuses are located."

"The blood flow builds up as the veins drain ... if you occlude any of the draining veins there you can cause a stroke. If you cut them and they bleed, the patient can potentially bleed to death. But we were able to navigate our way through and preserve both twins' sinuses. It basically meant that we did not have to make a decision about which twin's sinuses to keep and we were able to treat them both equally."

The babies were removed from ventilators the day after the operation and moved into the hospital's general ward a day later. Monique went home about four weeks after the operation and although struggling with some feeding problems is progressing well.

Tay-lah, as expected, developed moderate to severe cerebral palsy and is still in hospital. Mr Campbell said her heart problem meant that she would probably need more surgery and she was also likely to undergo an anti-reflex operation.

Royal Children's Hospital, Brisbane – Team Involved in Armstrong twins' surgery

Surgical Team Dr Scott Campbell, staff neurosurgeon Dr Richard Theille, lead plastic surgeon Dr Gordon Stewart, Director of Surgery, Royal Brisbane Hospital Dr Peter Catt, plastic surgeon	Anaesthetists Dr Phil Stevens Dr Bob Reith-Muller Dr Lyndall Patterson Dr Cameron Hastie Registrars Dr Eddie Cheng, neurosurgery Dr Juantia Ling, plastic surgery	Paediatricians Dr David Slaughter Dr Bruce Goodwin Paediatric Intensivists Dr Greg Delbridge Dr Julie McEniery Paediatric Renal Physician Dr John Burke	Neo-natal Intensivists Dr David Cartwright Dr Tim Donovan Paediatric Radiologist Dr Kieran Frawley	Operating Room Registered Nurses Judith Hewett Vicki Livett Peta McIntyre Janet Roper Natalie Snide Tracy Button Amanda Duncan Kristine Neufeld Natasha Calif Alison Walmsley Kellie Williams	Wardsperson Ken Diggelmar Cardiologist Dr Christopher Whight, Prince Charles Hospital Cardiac Surgeon Dr Peter Pohlmen, Prince Charles Hospital	Obstetric Ultrasound Consultants Dr Gary Pritchard, Royal Women's Hospital Dr Stephen Sinnott Obstetrician Dr John Wilson, Royal Women's Hospital
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Obituaries

Professor Arthur Barclay Bull

South Africa - FFARACS 1977, FANZCA 1992

Professor Arthur Bull died on 3 March 2001 at the age of 80 years. He had enjoyed 20 happy and active years of retirement from the Chair of Anaesthesia at the University of Cape Town, having been its first incumbent. His father, Dr AB (Pop) Bull was a General Practitioner in Simonstown. Arthur was the second of three children all of whom graduated MBChB from the University of Cape Town, Arthur in 1943.

Arthur enlisted in the SA Medical Corps, serving until the end of World War II. It was his experience during this time that first stimulated his interest in clinical anaesthesia. In 1948 he joined the staff of the Department of Anaesthetics of Groote Schuur Hospital as a Registrar. He rounded off his training with a period of post graduate study in England in 1953 during which he obtained the DARCP(S)(Ire), later becoming a foundation FFARCS(Ire).

The most formative period of his career followed in 1954 when he was selected as Nuffield Dominions Trust clinical assistant in the Oxford University Department of Anaesthetics for two years.

Professor Bull returned to Cape Town in 1956 to head the Department of Anaesthetics at the newly opened Red Cross War Memorial Children's Hospital. Thereafter his selection in 1960 as World Health Organisation Travelling Fellow as a fitting prelude to his appointment as head of the UCT Department of Anaesthesia in 1961. Promotion to Associate Professor followed in 1963 and appointment as the first incumbent of the Chair of Anaesthesia at UCT in 1965.

As professor, Arthur Bull applied himself to the creative building of his Department into a sound service and teaching unit capable of meeting the clinical challenges imposed by the cutting edge of surgical advance. During his tenure the staff establishment grew from 20 members responsible for 20,000 anaesthetics per year to 63 responsible for 50,000 anaesthetics per year together with involvement in the developing sub-specialty services such as respiratory intensive care, trauma unit and pain therapy.

Arthur Bull was inherently a quiet man who had a generally 'laid back' approach to life which enabled him to get things done with a minimum of fuss. In the operating theatre he eschewed histrionics and radiated an air of purposeful calm. As Head of Department he was popular with his staff, rapidly attaining 'Father Figure' status because of his approachability and readiness to provide sage advice and support when needed. Behind all, was a ready wit and a dry sense of humour.

Of his own contributions to anaesthesia, I think Professor Bull would most wish to be remembered for the part he played in the development of paediatric and neonatal anaesthesia in South Africa. Major improvements in these anaesthetic techniques followed from his introduction into clinical practice in South Africa of halothane, having been involved in investigations of this new anaesthetic agent while at Oxford.

Pari passu he pioneered the use of halothane in anaesthetic techniques applied to the nascent cardio-pulmonary bypass surgery. As important was his work in association with Professor Pat Smythe in the successful development of the use of prolonged neuromuscular blockade together with intermittent positive pressure ventilation in the management of neonatal tetanus – a world first. Another such innovation resulted from his collaboration with the Department of Electrical Engineering which resulted in the design of a novel apparatus capable of warming units of cold stored blood pre transfusion by means of electromagnetic radio frequency induction. Developed commercially at the Taurus Blood Warmer, this apparatus is still in standard use today.

Professor Bull also influenced greatly the direction and development of anaesthesiology in the national arena. This followed from his long service to both the College of Medicine of South Africa and the South African Society of Anaesthetists.

For his leisure he had a hobby that afforded him great pleasure – silver. He was a collector, valuer and skilful silversmith.

Arthur's family life was happy and stable, his marriage to Esme passing its Golden Jubilee. They had three sons, the eldest following his father's choice of career. There are four grandchildren. To all of these, we extend our condolences and sympathy for their loss of a truly grand old man who enlightened and enlivened the lives of so many of us.

Gaisford G Harrison

Dr William James Pryor

New Zealand –FFARACS 1955, FANZCA 1992, OBE 1986

Bill Pryor was born in 1922 and educated at Nelson College, New Zealand between 1936 and 1940. He graduated from the Otago Medical School of the University of New Zealand in 1947. During 1948, he was a Medical Officer in the RNZAF being posted to Japan. As with many New Zealanders, he then went to Britain to undertake his postgraduate medical education. His colleague and friend, Bill Utley, remembers that his initial intention was to train as an orthopaedic surgeon but he soon transferred to anaesthesia. He spent time on the staff of the London Hospital and in 1954 completed the Fellowship in the Faculty of Anaesthetists, Royal College of Surgeons. That year, he returned to Christchurch to take up a position as Anaesthetic Registrar at Christchurch Hospital. In 1956, Bill became a Fellow of the Faculty of Anaesthetists, Royal Australasian College of Surgeons and was forthwith appointed as visiting anaesthetist to the North Canterbury Hospital Board.

Within a year or so, he had published *A Manual of Anaesthetic Techniques*. My own copy of the second edition (signed by the author) dates from March 1959. This small book was aimed at 'House Surgeons and Registrars commencing the practice of anaesthetics'. It was a down to earth text containing much wisdom and common sense which I came to recognise in later years as a hallmark of its author. To a very junior – and largely self taught – anaesthetist, Bill's text was a lifesaver. It is an honour to be able to pay this belated tribute to him. His book went through a number of editions, later in association with Dr David Bush as a co-author. As well, Bill published a text on *Anaesthesia and Sedation for Dentistry*.

Bill continued as a visiting anaesthetist to the Christchurch Hospitals with a particular interest in thoracic anaesthesia. He and the late Heath Thompson were New Zealand pioneers in the technique of bronchial lavage for the treatment of severe asthma. Bill had interests in many professionally associated areas. He was a member of the Dominion Committee (now New Zealand National Committee) of the Faculty of Anaesthetists and was its Chairman in 1972. He served the Canterbury Division of the British Medical Association (now New Zealand Medical Association) for many years, and was national President in 1979. Bill was one of a number of well known Cantabrians who worked towards the establishment of the Christchurch School of Medicine which became a reality in 1973. He was a supporter and friend during my early days on the staff of the School in 1974. While being an active supporter of the Clinical School and the Christchurch Hospitals, Bill was also an active private anaesthetist and worked tirelessly towards the development of St George's Hospital. He was a long-time member of its Board of Management. In later years, Bill served on the North Canterbury Hospital Board, the Christchurch Clinical School Council and the Canterbury Medical Library.

After retiring from anaesthetic practice, Bill turned his energies to Age Concern, Canterbury and was an active member of that organisation for a number of years. Bill had strong family support. His wife Molly predeceased him. His second wife Dorothy cared for him during his final illness which he tolerated with courage and patience. Bill's son, Peter, has followed in his father's footsteps and is a prominent member of the Christchurch anaesthesia community.

It was a privilege to have known and worked with Bill. He was a skilled, competent and caring anaesthetist who contributed much to his colleagues and to the community. His passing is a loss to us all.

John M Gibbs

The 5th National Forum on Prevocational Education

HELD AT FREMANTLE, 16-17 NOVEMBER 2000



Dr R S Henderson

This Forum is an annual event organised by the Confederation of Postgraduate Medical Education Councils. The Fremantle meeting also brought together representatives of the Australian and New Zealand Medical Schools, the Colleges, the Australian and New Zealand Medical Councils, industrial bodies representing junior doctors on either side of the Tasman, and junior doctors themselves.

The theme for the Forum was *The Human Dimension*. Keynote speakers were Ian Hart, Professor of Medical Education at the University of Ottawa and perhaps best known as the inventor of the OSCE, and Dr Kwee Matheson from the United Kingdom, the current President of the National Association of Clinical Tutors and an anaesthetist.

1. Professor Hart gave a very interesting presentation on *Best Evidence Medical Education* (BEME). Medical education practice has largely been empirically based and underpinned by tradition, anecdote and the consensus of experts. The lack of rigorous evidence from randomised controlled trials (as in Evidence Based Medicine) does not however absolve us from using the best evidence available in planning the components of clinical training. The Campbell Collaboration (a spin-off from Cochrane) is attempting to bring an evidence-based approach to education and other social sciences. A recent (1998) international collaborative approach within medical education has led to the development of BEME, which attempts to establish rules for valuing the best evidence appropriate to the educational context. The rules of BEME

are still under development and currently address questions of: quality, utility, extent, statistical strength, target, and setting. BEME will be the focus of a major international meeting in Berlin in September 2001.

There is strong resistance in many quarters to changing traditional educational practice, with a reluctance to invest time and resources in this area or to accept the evidence when it is available. Teachers and departments have enjoyed a traditional autonomy and do not welcome a new accountability. There are however likely to be strong external pressures to move in this direction.

The BEME Collaboration has established a series of international review groups (one of which is looking at simulators and simulations). The web-site can be located at: www.bemecollaboration.org All eight major medical education journals are supporting the project. BEME reviews will be published in one or more of these journals as they are completed. See IR Hart and RM Harden, *BEME a plan for action, Medical Teacher* (2000), 22(2): 131-135.

2. Professor Hart also led a workshop on the *assessment of clinical competence*, analysing competence in terms of the familiar triad of knowledge, skills and attitudes. He emphasised that clinical memory is more strongly related to clinical experience than to content knowledge and stressed the importance of trainee exposure to prototype cases. Assessment via standardised patients or OSCEs enables the focus to fall on practice measures (what is actually done), whether the assessment is to be used for formative or summative purposes.

Defensible judgements in assessment require objective criteria. Such test criteria must be reliable, valid and practical. Examinations can achieve acceptable validity and reliability and can test knowledge, skills and also knowledge of expected attitudes. They can however never measure many important professional behaviours. In-training assessment (ITA) is the only way to evaluate actual performance and should focus particularly on (non-cognitive) professional behaviours. While having high validity, ITA reliability is poor and this inevitably limits its usefulness, particularly for summative purposes. Simulation may enable both improved learning and improved reliability and validity of assessment. However much work remains to be done in this area.

3. Dr Matheson addressed the topic: *How do we create an ideal educational environment?* She painted a rather depressing picture of recent UK experience, with widespread disillusionment on the part of many senior staff, numbers of whom have elected early retirement. Trainees have higher expectations and greater cynicism than their predecessors and tend to see medicine less as a vocation and more as a job. A successful program is one where trainees enjoy both learning and their service contribution. Attention needs to be directed to *personal factors* that facilitate self directed learning, *support systems* that provide constructive feedback, an *organisational culture* that values staff, an *adequate infrastructure* eg safe rostering, and *social support*, especially for the overseas doctor.

4. A joint session by Dr Matheson and Professor Hart addressed *Who Needs Appraisal?*

"Appraisal" was defined in the UK context as synonymous with "formative assessment". There is some evidence that such appraisal can significantly improve performance. Appraisal in the UK however tends to be a rather autocratic, negative, and intimidating process (eg anaesthesia trainees repeatedly front up to a panel of eight appraisers to receive feedback and redefine goals). Formal annual appraisals for senior doctors will become mandatory in the UK during 2001.

The term "appraisal" is little used in Canada, except as an informal component of daily clinical teaching. "In-training evaluation" (comparable to ITA) is however an important formal component of almost all specialty training programs, and trainees can be prevented from sitting examinations on the basis of a negative evaluation.

Such evaluations have high validity but poor reliability. Validity can be maximised by the use of prototype cases and learning portfolios. Recent literature reveals however that the reliability of the data is poor, with inadequate sampling, a typical separation of documentation from observation, and low inter-rater reliability. These issues of reliability can be only partially addressed by such measures as "training the trainers". Well used formative evaluations do stimulate learning and provide progressive feedback. There is evidence of benefit in sourcing feedback from the whole team (including nurses, secretaries etc) and especially from colleagues who are only a little senior to the individual being evaluated.

It was stated that log books have now been abandoned as a waste of time virtually everywhere in both Canada and the United States.

5. An international panel discussed *Separating the Cost of Teaching and Training from Patient Care*. With the exception of a representative of the WA Health Department there was general agreement that such a separation was a misguided exercise that ignored how health care is actually delivered and in practice tended to increase total costs while aiming to reduce them. Activities can be unbundled only if they have single rather than multiple outputs (eg lecture versus ward round). There is evidence that the increased cost of teaching hospitals relates more to case complexity and its flow on consequences than to teaching as such. Unbundling leads to cost shifting where activities such as clinical audit are not regarded as an integral part of clinical care. Trainees themselves also do a lot of teaching of both other trainees and other health professionals. This tends to be ignored in costing.

The differing experiences in New Zealand, the United Kingdom, the United States and Canada were seen as confirming this general viewpoint.

6. The junior doctors held their own mini forum and reported back concerns in a number of areas. These included feedback, mentoring, information technology (access and training), safe hours, and rural practice issues.

7. The Forum concluded by passing four resolutions:

- i) This meeting opposes separation of teaching and training from clinical practice, as this will affect continuing medical education, quality improvement, and risk management.
- ii) This meeting supports the provision of medical education by practising clinicians who have appropriate support from professional educators, and access to professional development of teaching skill.
- iii) This meeting recommends that each primary allocation centre should develop at least one rotation to a community or rural practice.
- iv) This meeting resolves to promote increasing involvement of junior doctors in all aspects of post graduate medical education.

STUART HENDERSON



Dean's Message

Felicity Hawker

I believe the Faculty of Intensive Care Meeting held as part of the Combined Scientific Meeting in Hong Kong last month was the best since the Faculty was formed. The scientific program was excellent, the highlights being the Foundation Visitor's Lecture on 'Optimal Management of ARDS in 2001' given by Professor Laurent Brochard and Professor Randall Chestnut's presentation on 'Severe Head Injury Management in the Year 2001'. These, as well as many other presentations were polished, based on solid scientific evidence and with important practical, clinical messages. As usual the audience in the intensive care concurrent sessions frequently exceeded 150 despite the smaller but growing number of 'intensive care only' registrants.

Certainly the meeting was made more memorable by the fact that it was held offshore. Much of the magic was the result of the way aspects of Chinese culture were woven into the scientific as well as the social program. Many of us have listened to pro-con debates at Intensive Care Meetings and some of us may even have heard a pro-con debate on the subject of human albumin administration. However, the way Dr Hing-Yu So used ancient Chinese stories to illustrate his argument against giving albumin to critically ill patients was very effective and refreshingly different.

Despite being held outside of Australia and New Zealand and in a land of contrasting culture, this meeting was very much a meeting of the Faculty of Intensive Care, ANZCA. There are now 14 Fellows in Hong Kong and 11 Faculty trainees – sufficient numbers to support the equivalent of a Regional Committee. This situation has taken many years to develop and we hope has fostered a lasting legacy for high standards of intensive care practice in Hong Kong. In fact, the Faculty of

Intensive Care has very strong international ties across the globe. One in six Fellows lives and works outside of Australia and New Zealand, mostly in the United Kingdom and Hong Kong but also in Ireland, Canada and the United States. This is due in no small measure to the reputation of the Faculty training program and to the high regard in which the qualification FICANZCA is held.

In considering the future directions of the Faculty, I believe it is vital to foster and build on these international links, particularly in the Asia-Pacific region. Although the Faculty has not so far been involved in intensive care training in Singapore, the Singapore Ministry of Health has indicated that it would like to further discuss this possibility later in the year. This is clearly an opportunity the Faculty must grasp.

The experience in Hong Kong has shown that it is possible for the Faculty to administer an intensive care training program in which a part or all of training is undertaken in another country, with enormously positive results – although clearly it is the commitment, enthusiasm and ability of both supervisors and trainees that make the program work. I hope that in time we will have the opportunity to develop similar positive relationships with other countries, particularly our Asia-Pacific neighbours.

A handwritten signature in black ink, which appears to read 'Felicity Hawker'. The signature is stylized and fluid.

Retirement of Dr Geoffrey A Barker



Dr Geoffrey Barker

On March 31, 2001 a formal dinner was held in Toronto, Canada to celebrate the accomplishments of Geoff Barker following his recent retirement as Chief of the Department of Critical Care Medicine at The Hospital for Sick Children, Toronto.

This dinner was hosted by the Hospital for Sick Children as part of their "Legends of Care Program". The program aims to recognise individuals who have dedicated their careers to the hospital and who also embody the spirit of the original founders of the hospital whose mission it was to make "Sick Kids" the best Children's Hospital in the world.

Geoff Barker is the first current leader at the Hospital to be so honoured. At the dinner, the Hospital also announced the creation of a professorial chair in Geoff's honour to be known as The Geoffrey Barker Chair in Paediatric Critical Care Medicine

Geoff has been Chief of the Department of Critical Care at The Hospital for Sick Children for 20 years as well as Professor of Critical Care Medicine, Anaesthesia and Paediatrics at the University of Toronto. He remains the president of the World

Federation of Paediatric Intensive and Critical Care Societies and has received international recognition for the clinical service and educational programs he developed at "Sick Kids". Graduates of his clinical fellowship program staff paediatric critical care units world wide.

Geoff has had a major influence on the development of paediatric critical care in Australasia. He graduated from the University of Melbourne in 1966, trained in Melbourne teaching hospitals and obtained the FFARACS in 1971, FANZCA 1992 and was elected FFICANZCA in 1994.

At the Royal Childrens Hospital, Melbourne, he came under the influence of the late John Stocks who was pioneering paediatric intensive care both in Australasia and indeed in the world. Following John Stock's tragic early death in 1974 Geoff was appointed the first full time Director of Intensive Care at the Royal Childrens Hospital and was at this time the first full time director of a paediatric intensive care unit in Australasia.

Geoff moved to "Sick Kids" Toronto in 1976 and became Chief of Critical Care Medicine in 1981. During his tenure at "Sick Kids" he developed close links with all the paediatric critical care units in Australasia. All the units in Australasia have staff who have graduated from his fellowship program and most paediatric intensivists in Australasia have visited his department. Many fellows of our College are indebted to Geoff for his encouragement, support and friendship.

Geoff is a superb ambassador for paediatric critical care medicine and will remain so as president of the World Federation of Paediatric Intensive and Critical Care Societies. His hospitality, good humour, humility and air of aristocratic melancholy endear him to all his friends and colleagues around the world. A professorial chair in paediatric critical care medicine named in his honour is a most fitting recognition of his achievements.

Combined Scientific Meeting, Hong Kong

5-7 MAY 2001

The recent Combined Scientific Meeting held in Hong Kong showcased one of the best scientific programs for intensive care in recent years.

Faculty Scientific Convenor Tom Buckley put together a high quality program featuring three international speakers: Prof Laurent Brochard from the University of Paris who expounded on recent developments in the management of ARDS and non-invasive ventilation; Mitchell Levy from Rhode Island Hospital in Providence, USA who presented on tissue oxygenation in sepsis in the intensive care program and also contributed his theories on evidence-based medicine at the informatics session, and Randall Chesnut from Portland Oregon who reviewed recent advances in the management of traumatic brain injury and spinal cord injury. The latter two visitors were kindly sponsored by the Hong Kong College of Anaesthesiologists. Other features of the scientific program included an informative debate on the Human Albumin controversy, organ donation, nutrition in sepsis and Asian

ethical issues. An interesting collection of free papers was also welcomed.

Some of these sessions commanded upwards of 180 attendees, as well as some lively debate.

The opening ceremony held at the Hong Kong Convention Centre, provided a truly glamorous backdrop to a wonderful evening concluded by a potted history of Hong Kong, given by Professor Arthur Li, Vice-Chancellor of the University of Hong Kong.

Many interesting social tours were available that enabled delegates and associates the chance to sample all that Hong Kong has to offer, including a satellite tour to Beijing.

This was a highly successful meeting which enabled long overdue interaction with our Asian counterparts.



Dean Dr Felicity Hawker awards Professor Laurent Brochard the Foundation Visitor's Medal for 2001



Education Officer Jack Havill congratulates fellow New Zealanders on their admission to Fellowship, Craig McCalman and wife Jacquie and John Torrance



Dr Wally Thompson presents his paper on head injuries



The "Three Deans" Drs Geoff Clarke, Alan Duncan and Felicity Hawker at the Opening Ceremony Reception

Items of Interest

FROM THE MARCH 2001 BOARD MEETING

EDUCATION AND TRAINING

Guidelines for the Selection of Trainees

The Board approved a document on fair and transparent process for the Selection of Trainees, which will be circulated to Hospitals, Directors and Supervisors. This policy was introduced following recommendations from the Medical Training Review Panel Report on Medical Workforce Training and Employment.

Logbooks

The Board noted that the Committee had reviewed the results of further trials undertaken in 2000 and their lack of success. It was agreed that an electronic version will be promoted and available to Regional Committees, Directors, Supervisors of Training and Trainees, but will not be mandatory.

Revised Notes for Candidates

The document 'Notes for Candidates' was revised to incorporate greater detail regarding the pass/fail criteria, which was previously not included. This document is circulated to candidates prior to sitting the Examination. Copies of the revised document will also be circulated to all Supervisors of Training for information.

Change in Examination Process

The Board considered a proposal to modify the Examination format, by separating the Written and Oral Sections and creating two modules. Each module could be taken at the same sitting or at different times in the candidate's career, and once passed, a module would not need to be sat again. The Written Module would not be a 'gate' to the Oral section, rather each section being seen as separate and independent. It was suggested that the Written Section can be viewed as a pretest and early stimulus to accumulating core knowledge and the Clinical Section as assessing progress in the core years of intensive care training. Preparation for the Oral Section would be better performed without the distraction from clinical experience of the Written Section.

In view of the impending establishment of a Joint Faculty, and changes made to the Exam format recently, it was agreed to defer any action with this proposal.

Ongoing Vocational Branch Recognition and Recertification

The Medical Council of New Zealand has sought the opinion of the Faculty with regard to the minimum amount of time

spent in active practice required to maintain clinical competence, and what audit mechanisms are in place. The Board believed specifying minimum requirements for maintaining clinical competence was inappropriate at present, however it is noted that ANZCA is developing a system of practice re-entry, and the Faculty may develop a similar system.

Role and Function of JSAC-IC

This will be examined upon the establishment of the Joint Faculty, and it was suggested these functions may be converted to an Education Committee, for overseeing training and education.

Accreditation of Private Intensive Care Units

The issue of accreditation of private intensive care units was examined to be more consistent. At present some co-located units are accredited as part of the public unit, whilst others are accredited independently. A further issue of whether a trainee can rotate to a co-located private unit during their continuous year was considered. It was agreed that an appropriate solution was to assess the private unit independently, however training may be combined at the public and private ICU during the trainee's continuous year, with the time accredited at the private hospital limited to that defined by its accreditation status, that is, 3 or 6 months. Specific criteria would need to be met. A further proposal and a decision on current accreditation of private ICUs will be considered at the next meeting of the Board.

A Joint Faculty of Intensive Care Medicine

A Working Party made up of representatives of the Faculty, ANZCA and the RACP has been established to develop criteria for admission to Foundation Fellowship of a Joint Faculty. The criteria have been drafted and referred to the Councils of ANZCA and the RACP for consideration.

Policy Documents

The policy document IC-6 "The Role of Supervisors of Training in Intensive Care" was revised and accepted for promulgation. A copy of this document is printed elsewhere in the Bulletin.

The following documents are under review:

- IC-10 "Minimum Standards for Transport of the Critically Ill"
- IC-11 "In-Training Assessment of Trainees in Intensive Care"
- IC-1 "Minimum Standards for Intensive Care Units" is also being reviewed to ensure that the system of classifying levels of intensive care units is consistent at a national level.

Representation on the CPMC Aboriginal Health Sub-Committee

Dr Dianne Stephens, Director of Intensive Care at Royal Darwin Hospital, was appointed the Faculty representative on this Committee.

Rural Issues

Dr Daryl Catt has established a Rural Focus Group, whose goals include identification of any rural hospitals suitable for training, consideration of the development of a locum service and provision of incentives for practice in rural areas.

Subscription Concessions for Dual Fellows Relinquishing FANZCA or FFICANZCA

The Board noted that the College has written to those Fellows opting to withdraw their FANZCA Fellowship, encouraging them to retain their dual Fellowship. Should the secondary Fellowship lapse, it is possible that Fellows would have to undertake a recertification training program, in order to be eligible to qualify for the FANZCA. This process is in development by the College.

The Board noted that in the case of Fellows wishing to re-qualify for the FANZCA Diploma, it is possible all outstanding dues for the period of non-Fellowship will be required to be paid.

New Fellows' Conference

The Board approved the following delegates:

Dr Richard Newman, South Australia
Dr John Torrance, New Zealand
Dr Michael Davis, New South Wales
Dr Anne Leung, Hong Kong

Changes to MOPS Program from 2001

The Board resolved that:

1. As from January 2001, the Faculty MOPS Program will adopt an annual cycle.
2. On receipt of an annual return which indicates satisfactory completion of the requirements, a Statement of Satisfactory Participation will be issued.
3. Where participants submit an annual return but do not meet the minimum requirements for 50 CME points and 25 QA points, a Statement of Participation will be issued verifying registration with the program only.
4. Those participants registered prior to 2000 will receive a Certificate of Satisfactory Performance upon completion of their five year program, on request.

Attendance of Regional Chairmen at Board meetings

Dr Megan Robertson, Chair of the Victorian Regional Committee, attended the Board meeting as its first Regional Chairman observer.

Staffing

The Board noted with regret the resignation of Mrs Lindy McPhee, who has left the College to have her first baby. Mr Andrew Coghill commenced in the position of Administrative Assistant in February.

Re-election of Dean

Dr F.H. Hawker was re-elected Dean for a further term, commencing June 2001.

ADMISSION TO FELLOWSHIP

The following were admitted to Fellowship by examination:

Michael John Davis	NSW
John Francis Frazer	QLD
John Edward Foy	NZ
Gerard Thomas Joyce	Vic
Craig Laurence McCalman	NZ
Priya Nair	NSW
Peter Howard Scott	QLD
Ian Mark Seppelt	NSW
Penelope Clare Huston Stewart	NSW
<i>Paediatric Intensive Care</i>	
Fiona Kristine Isôla Miles	NZ

Examination – April/May 2001



Left: *The Court of Examiners and successful candidates*

Right: *Successful Candidates of the April/May 2001 Fellowship Examination in Intensive Care:*

Foreground: *Drs Greg McGrath, Claudia Schneider, Catherine Simpson, Sathyajith Velandy Kootayi, Michael Sutherland*
Rear: *Drs Mark Daley, David Evans, Robert Plant, David Lowe and Anthony Delaney*



Faculty of Intensive Care

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

THE ROLE OF SUPERVISORS OF TRAINING IN INTENSIVE CARE MEDICINE

The Supervisor of Training is the Faculty's representative on training in accredited units. The role is an important one, and the Supervisor must have a broad understanding of Faculty affairs. The Supervisor provides liaison between trainees and the hospital authorities (in respect of matters related to training) as well as with the Regional Education Officer and the Faculty.

The primary role of the Supervisor is to provide *formative assessment* (feedback on performance). In order to do this, the Supervisor should have regular meetings with the trainee, organise an assessment based on general observation of the trainee's clinical practice (including history taking where relevant, physical examination and procedures), discuss with the trainee the interpretation of clinical findings and investigations and discuss management plans to ensure they are appropriate to the needs of the patients and carers.

The Supervisor will often also have a mentor role. This might involve discussion with the trainee regarding their future training and employment. It might also involve assisting the trainee to recognise and deal with personal problems including aspects of inadequate performance.

The Supervisor also has the responsibility to provide *summative assessment* (formal determination of competency). This involves completion of the in-training assessment form at the end of each 6 month period of training.

1. APPOINTMENT

- 1.1 The Supervisor of Training will be nominated by the Director of Intensive Care who will be responsible for notifying the Board of the recommendation. The appointment will be ratified by the Board of Faculty and both the Director and Hospital Administration will be advised of the appointment.
- 1.2 The appointee is required to hold the Diploma of FFICANZCA or an equivalent qualification acceptable to the Board, and should not be a candidate for any Faculty examination.
- 1.3 It is preferable but not mandatory that the Supervisor of Training be an intensive care specialist other than

the Director of the Unit, and to have held the Diploma of FFICANZCA or equivalent for at least three years.

2. DUTIES OF SUPERVISORS

2.1 Responsibilities to Trainees

- 2.1.1 To be familiar with the Faculty's Administrative Instructions on Training and Examinations.
- 2.1.2 To advise potential and current trainees on their training, registration requirements, fee payments, examination dates and dates of closure for entries.
- 2.1.3 To be aware of dates and other matters relevant to appropriate courses and to ensure that trainees receive this information.
- 2.1.4 To monitor supervision, experience and fair allocation of duties for trainees and if necessary, to facilitate changes.
- 2.1.5 To liaise with the Director of the Department with respect to trainee duties, supervision, working hours and study time and release for approved courses.
- 2.1.6 To ensure an adequate orientation program is available for trainees.
- 2.1.7 To ensure that there is a structured educational program for trainees.
- 2.1.8 To provide advice, supervision and support for trainees planning, executing and presenting the Formal Project. The Supervisor also has a responsibility to critically review the final manuscript to ensure its suitability for submission.
- 2.1.9 To advise and assist candidates regarding the Fellowship Examination by providing or organising tutorials and trial examinations. After the Examination, to provide feedback from the Chairman of Examinations to the failed candidate and advise on future planning.
- 2.1.10 To undertake in-training assessments in accordance with Faculty Policy Document IC-

II 'In-Training Assessment of Trainees in Intensive Care'.

2.1.11 To assist in the identification and counselling of trainees with difficulties, and to undertake remedial action.

2.2 Responsibilities to the Faculty

2.2.1 To establish and maintain liaison with the Regional Education Officer and with other Supervisors of Training.

2.2.2 To refer any difficulties in respect of training or trainees to the Regional Education Officer.

2.2.3 To ensure the Board is aware of any senior staffing or other changes in the unit likely to impact on training.

2.2.4 To attend any regional meetings or Workshops for Supervisors of Training.

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

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

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

Related Documents:

- IC-3 "Guidelines for Intensive Care Units seeking Faculty Accreditation for Training in Intensive Care"
- IC-4 "The Supervision of Vocational Trainees in Intensive Care"
- IC-II "In-Training Assessment of Trainees in Intensive Care Medicine"

Promulgated: February 1994

Reviewed: 1995

Date of current document: March 2001

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Dean's Message

Michael J Cousins, AM

The decade of pain control and research

In my last Dean's Message I referred to new USA pain assessment and management standards that are now mandatory for all healthcare facilities in the USA (JCAHO Standards – August, 1999).

At the Faculty Scientific Meeting in Hong Kong, invited speaker, Professor Michael Ashburn, current President of the American Pain Society, referred to the substantial impact that this new accreditation requirement is having upon healthcare facilities across the USA. Professor Ashburn also referred to an extraordinary development resulting from an initiative of the USA Congress, HR 3244, which President Clinton signed into law for a “decade of pain control and research” to begin on January 1 2001. This is only the second congressionally declared medically related decade, the previous one being “the decade of the brain”. The pain initiative was fostered by a coalition of the American Academy of Pain Medicine, the American Pain Society and the American Association for the Study of Headache. A key factor in motivating the US Congress to pursue this initiative was the dedicated work of Drs. Phil Lippe, Joel Saper and Michael Ashburn. A crucial aspect was the close relationship between Michael Ashburn and prominent Congressional Senator Orrin Hatch who introduced the legislation and carefully fostered its passage through Congress.

Thus the ingredients of a successful endeavour in Australia and New Zealand could be a coalition of the Faculty with the Australian and New Zealand Pain Societies. I would also suggest that we would do well to join forces with our colleagues in the newly formed Chapter of Palliative Medicine and there may be other bodies who would be prepared to join us.

Further however we will need to identify an appropriately motivated politician who would be prepared to assist us as

did Senator Orrin Hatch. The key lesson of the US initiative is to put aside any vested interests of particular groups and to focus on the wider objective of improving public awareness and perceptions about pain and its treatment, health professional education and training, undergraduate education, clinical and basic research.

The “decade of the brain”, during the 1990s has had a major impact on research and development of new knowledge about the brain and related medical conditions. There have undoubtedly been spinoffs from this decade for pain research and treatment. However a focus specifically on pain control and research should have a massive impact upon the whole field of pain medicine.

Public awareness and perceptions about pain and its management

We are still at a stage in Australia and New Zealand which is similar to that which existed in the USA prior to the JCAHO initiative and the announcement of the “decade of pain control and research”. Thus the management of pain is not on the national agendas or is it high in the awareness of State Governments. Furthermore pain is not perceived by the general public as being a major health issue or indeed as a specialty area in its own right. On the other hand it is fair to say that palliative care has achieved a level of visibility as a result of the euthanasia debate.

Sadly during this debate patients with persistent non-cancer pain of a ‘non-terminal’ type received little attention, despite the fact that many of them do contemplate suicide and would undoubtedly avail themselves of euthanasia legislation were it available. Such patients of course, vastly outnumber patients suffering with severe pain in the terminal phase of cancer; furthermore, patients with persistent non-cancer pain may

face a lifetime of pain. Thus we must acknowledge that we have as yet not taken the appropriate steps to raise the awareness of the general community and our politicians.

Although part of this situation is clearly due to the fact that the “hard yards” have not been taken, some of the problems may lie in the **perception** of the field of pain. **Chronic pain** tends to have somewhat of a negative connotation, implying that the situation is static and unchangeable and that there may be something about the patient which makes them refractory to returning to a relatively normal lifestyle. This of course is quite unfair and inappropriate. As discussed in the panel discussion in Hong Kong “Pain Clinics at the Crossroads” it may be time that we discarded the term “**chronic pain**” and replaced it with “**persistent pain**”. This would have the added advantage of allowing us to focus on the important window of opportunity when acute pain progresses to persistent pain. Our focus then should be on intervening during this transition phase so that as far as possible we should aim to eliminate the possibility of patients developing “**pain that is persistent in the long term**”. The Faculty Foundation Visitor, Professor Troels Jensen, Professor of Neurology, Aarhus University, Denmark provided us with an excellent summary of exciting new evidence concerning the neurobiological aspects of the transition from acute to persistent pain. There is now much more than a glimmer of hope that we will have sufficient understanding and interventions to practise highly effective preventative medicine in the field of pain medicine. This is a much more optimistic, proactive and exciting profile for the speciality of Pain Medicine.

Another perception that may not be helpful to Pain Medicine is the use of complex terminology such as “multidisciplinary” or “interdisciplinary”. We have made much of the importance of assessing biopsychosocial aspects of patients with complex pain problems. Quite likely, the general community and even some of our professional colleagues do not understand what we are talking about. I suspect that it may be much better to simply refer to a “**team approach**” to assessing “the whole person” in situations where pain is persistent. This concept really dates back to Dame Cicely Saunders who initiated the hospice movement and coined the term “total pain” to encompass the holistic assessment of patients with persistent pain.

Surprisingly, we have made little capital to date of the unprecedented achievement of five specialist bodies coming together to form a single training program and examination process. This should send a message to the general community and to politicians that this problem is viewed as being of sufficient importance to warrant this joining of forces of major specialist bodies.

Educational implications

The “decade of pain control and research” should serve as a potent reminder that there are currently woeful inadequacies in the education of health professionals, both at an undergraduate and postgraduate level. Although there are

undoubtedly some laudatory attempts in Australia and New Zealand to correct this situation very few medical undergraduates complete their courses with a sound understanding of the neurobiology of pain and the wide range of options for pain management. Achieving a coherent undergraduate education in pain is particularly difficult in new types of curricula where information about pain and its treatment tends to be scattered among different parts of the curriculum.

At least one medical school is now teaching an integrated pain curriculum, namely, the University of Texas which has a “Catchum Project” that is supported in principle by the American Academy of Pain Medicine. The AAPM is currently developing a model teaching program that will be available to all medical schools and should be of significant interest in Australia and New Zealand. However an even greater task will be attempting to introduce such a program into the already crowded medical school curricula, particularly those that are now of only four years in length. Nevertheless this is a challenge that we must take up since persistent pain is clearly one of the major diseases of the new millennium, particularly with recent evidence from Australia of an incidence of one in five, which is very similar to data available in the USA and Scandinavia.

Another challenge is in post graduate education in a wide range of relevant specialties such as neurology, rheumatology, rehabilitation medicine, psychiatry, orthopaedic surgery, neurosurgery and of course anaesthesia. The Faculty provides a wonderful opportunity to channel high quality post graduate educational materials through to trainees in various specialties who should have a broad understanding of pain and its treatment, even if they are not proceeding to specialty training in the Faculty’s Fellowship training program.

Research

Judging from the results of the “decade of the brain”, there will be a major impetus to both basic and clinical research during the “decade of pain control and research”. Currently in Australia and New Zealand, there is no special category for “pain research” in the NHMRC and NZMRC list of research categories. As a result of this situation, applications for basic and clinical research tend to be farmed out to a whole variety of “discipline panels” which may have quite variable expertise in assessing applications and may not assign high priority to such research. It is now essential that we do the appropriate lobbying to achieve the assignment of a major category to pain research. This is more than justified by the prevalence of persistent pain and its associated costs which are estimated to be in excess of \$10 billion per annum in Australia.



MICHAEL J COUSINS AM

Highlights from the Board Meeting

HELD ON MAY 4, 2001

The Dean commented that this was an auspicious occasion for the Board to be able to meet in Hong Kong and passed on the gratitude of the Board to the staff at Queen Mary Hospital who had assisted in the organisation of this meeting.

It was also a wonderful opportunity for Dr P P Chen, Chairman of the HKCA Pain Management Committee and Dr S L Tsui, the Hong Kong Pain Medicine Scientific Programme Convenor for the CSM, to attend the Board Meeting as observers.

Honours and Appointments

The Board noted that Professor T R Cramond AO, OBE has been awarded Doctor of the University (honoris Causa), Australian Catholic University, in recognition of her services to higher education in the discipline of medicine and her contribution to the advancement of the Australian Catholic University.

Admission to Fellowship by Training and Examination

The following trainees were admitted to Fellowship by Training and Examination:

CARTER Martin	NT	FANZCA
CLUBB Bryce	NSW	FRANZCR
PALMER Greta	USA	FANZCA
WRIGLEY Paul	NSW	FANZCA

Admission to Fellowship by Election

The following were admitted to Fellowship by Election

BURSTAL Richard	NSW	FANZCA
NOORE Faizur	NSW	FRANZCP
THOMAS Clayton	Vic	FAFRM (RACP)

Regional Education Meetings

The Board discussed the possibility of conducting regional education meetings. There will be further discussion at the next meeting of the Board.

Education

The Objectives of Training and Reading List has now been circulated to all Faculty Fellows as well as registered trainees. The Education Officer requested that all co-ordinators of the reference materials now submit their material to the Faculty

to assist the College Librarian in collating this material for distribution to the Faculty accredited Pain Management Units for use by Faculty trainees.

The next immediate issues to be addressed by the Education Committee are the updating of the Prospectus as well as updating some of the References in the Reading List.

Examination Committee

P Briscoe commented that the Examination Committee will hold its next meeting in August.

The Board noted that the Report from the 2000 Examination had now been circulated.

It was noted that candidates who were successful at examination are progressively submitting their treatise material.

2001 Examination

It was agreed that the venue for the 2001 examination be moved to the Royal Adelaide Hospital for financial reasons. Candidates for this examination will be notified of this change of venue.

Pre-Examination Short Course

This course for candidates for the 2001 examination will be held at Royal Adelaide Hospital.

Barbara Walker Prize for Excellence in Pain Medicine

Paul John Wrigley FANZCA, NSW has been awarded the 2000 Barbara Walker Prize for Excellence in Pain Medicine.

Hospital Accreditation

T Little reported that there had not been any reviews for accreditation undertaken since the last meeting of the Board.

A new questionnaire form for Multidisciplinary Pain Centres applying for accreditation has now been completed and the Board thanked P Macintyre for undertaking this task.

Recognition of Pain Medicine as a Specialty

The Dean commented that as the taskforce now has a copy of the draft submission requirements, work will now commence work on the submission.

Development of White Papers

The Board has highlighted topics and will be contacting individuals shortly to assist with the development of the white papers.

CSM, May 5-9, 2001 – Hong Kong

R L Atkinson confirmed that arrangements were now in place for this meeting.

ASM, May 11-15, 2002, Brisbane

Plans are underway for this scientific program.

New Fellows' Conference

Paul Wrigley has accepted the invitation to represent the Faculty at this conference to be held in Hong Kong.

Expressions of Interest from Fellows

The Board noted the disappointing response to a request for expressions of interest from Fellows and hoped that more Fellows would respond to assist with Faculty activities.

A meeting between the Faculty of Pain Medicine and the Pain Management Committee of the Hong Kong College of Anaesthesiologists was held after the Board Meeting.

Highlights from a Meeting between the Faculty of Pain Medicine/Pain Management Committee Hong Kong College of Anaesthesiologists

MAY 4, 2001 – QUEEN MARY HOSPITAL, HONG KONG



Dr PP Chen (left) and Dr SL Tsui meeting with members of the Board of Faculty at Queen Mary Hospital

Development of Pain Medicine in Hong Kong

The Pain Management Committee presented a summary of the development of Pain Medicine in Hong Kong over the last ten years.

Role of the Faculty of Pain Medicine in Hong Kong

Several ideas were suggested for the Faculty to provide assistance for the development of Pain Medicine in Hong Kong:

- Provide information on Faculty activities, particularly through its website
- Exchange regular dialogue between the two parties

- Provide educational materials, training and examination information
- Exchange of trainees
- Exchange of examiners to observe examinations
- Exchange of speakers at annual scientific meetings

Collaborative Research Initiatives

The possibility of collaborative research initiatives between the Faculty and the Pain Management Committee was explored.

Highlights from the Conference in Hong Kong

The Faculty and the Pain Management Committee of the HKCA held a dinner on the evening of Friday, May 4 at the Eighteen Brook Cantonese Restaurant, Hong Kong. This was a most enjoyable evening and a wonderful opportunity for everyone to chat in a relaxed atmosphere.

The Faculty's scientific program ran for two days, Saturday, May 5 and Sunday, May 6 and all sessions were well attended.



Professor Jensen presenting the "Foundation Visitor's Lecture"

Foundation Visitor

The Plenary Session for the Faculty's Foundation Visitor, Professor Troels Jensen from the Department of Neurology, Aarhus University, Denmark was held on Saturday, May 5. The topic for his lecture was "Acute to Chronic Pain Neurobiological Aspects".

Professor Jensen also gave a presentation on "Implications for Treatment: Neuropathic Pain and Mechanisms" and also contributed in panel discussions on "Opioids in Chronic Non-Cancer Pain" and "Pain Clinics at the Crossroads".

Pain Management Committee of the HKCA Invited Speaker

Professor Michael Ashburn is Professor of Anesthesiology and also the Medical Director of the Pain Management Center at the University of Utah, USA. He is also President of the American Pain Society. Professor Ashburn presented an introductory review on "Pain Clinics at the Crossroads". This was followed by a wonderful panel discussion and participation from the attendees at this session.

College Ceremony

Fellows who were presented at the College Ceremony:

Admitted to Fellowship by Training and Examination -

John Henshaw
Geoffrey Needham
Lucia Rodrigues
Paul Wrigley

Admitted to Fellowship by Election -

Guy Bashford
Julia Fleming
Dianne Pacey
Philip Siddall
Jane Trinca
Siu Lun Tsui

Barbara Walker Prize for Excellence in Pain Medicine

The Barbara Walker Prize for Excellence in Pain Medicine was presented to Paul Wrigley.

The Faculty wishes to thank all Speakers, Co-Chairmen and Panel Members for their contribution to this successful meeting.

Regulation 6.3

Admission To Fellowship By Election

PURSUANT TO ARTICLE 23.

The Council of the College may elect to Fellowship of the College without examination:

- 6.3.1 a) A Professor or other Academic Head of a Department at a recognised University or College or a Director of a Department of Anaesthesia at a University Hospital or Clinical School approved by the Council provided that the applicant holds a qualification in anaesthesia acceptable to Council; or
- b) Anaesthetists who took up permanent residency in Australia or New Zealand before 1 January 1996 and who have been assessed and supported by ANZCA as specialists. Such applicants must have practised anaesthesia in Australia or New Zealand for five years preceding application. The criteria for election to Fellowship of such applications shall be determined by Council; or
- c) In exceptional cases, duly qualified medical practitioners who have made a significant contribution to College activities and/or to anaesthesia and related disciplines.

NOTE: Any person invited to accept Fellowship by Election must notify the CEO of acceptance of this election and pay the prescribed fees within three months of invitation otherwise such invitation will lapse.

- 6.3.2 Nominations for admission to Fellowship under these Regulations shall be on the prescribed form of nomination and signed by the applicant and two members of the Council or one member of the Council and five other Fellows. No other form of recommendation is permitted.
- 6.3.3 Applications for admission to Fellowship by election shall be considered by the Executive Committee, who will, after due inquiry of the appropriate Regional

Committee, and on the evidence presented, make recommendations to the Council.

- 6.3.4 a) Nominations and/or applications for election to Fellowship under Regulation 6.3.1 may be considered at any meeting of the Council provided that nominations or applications are submitted to the CEO 60 days prior to the meeting.
- b) No late nominations or applications will be considered.
- 6.3.5 Separate lists of the nominations or applications for Fellowship under each Regulation, containing the information required on the prescribed forms, shall be sent to each Member of the Council at least fourteen days before the day of the Council Meeting.
- 6.3.6 The Council will vote on nominations and applications by secret ballot.
- 6.3.7 No nominee or applicant shall be elected to Fellowship unless three quarters of the Members of the Council present vote in favour.
- 6.3.8 If approved, the nominee or applicant shall be informed by letter and invited to accept Fellowship by election.
- 6.3.9 Those admitted to Fellowship by election shall pay the entrance fee as prescribed by the Council in addition to the annual subscription.
- 6.3.10 Fellowship will not normally be conferred in absentia.
- 6.3.11 Nominations or applications rejected by the Council may be reconsidered if formally proposed and seconded at a subsequent Council Meeting.

April 2001



Education Report

RUSSELL W. JONES, Director Of Education, ANZCA

Since taking up the position of Director of Education for the Australian and New Zealand College of Anaesthetists I have focussed upon identifying those educational issues pertinent to ANZCA. I have spoken with many office holders, Fellows and Trainees as well as met with many Committees at College, Faculty and national/regional levels. Over time I intend to meet with many more. The result of these numerous encounters, together with a review of College records in recent years, has led to the identification of a list of issues relating to education within the College. Several of these issues are described below together with some of their current concerns and suggested actions. I invite you to read the following and offer you the opportunity to provide feedback to me on any of the issues described or on any other educational issue.

Review in-training assessment

The recent workshop concerning in-training assessment cited the following objectives of ITA. Firstly, to ensure that Trainees receive regular formative assessment. Secondly, to ensure that this is conducted and documented in accordance with sound principles, in particular it was deemed essential that Trainees participate formally in the process and receive copies of all documentation.

Suggested actions

- Review the College Professional Document E14, *Guidelines for the In-Training Assessment for Trainees in Anaesthesia*.
- Consideration can be given to the formal inclusion, within the ITA process, of a requirement for Trainees to set their own training goals (in conjunction with Supervisors) and to achieving them.
- Encourage a culture of self-directed learning within Trainees with the intent that self-directed learning becomes habitual continuing into full Fellowship. This will facilitate a sound basis for ongoing CEQA.

Educational Support for Supervisors of Training

The effective supervision of Trainees is essential for the successful development of future Fellows and fulfils an important component of the College educational mission. This issue has been raised repeatedly in recent years and should be treated as an educational priority.

Current concerns

- The need for a Supervisor to be able to gradually increase Trainee responsibility as training progresses, and to concomitantly increase the extent of candidate feedback and practical advice provided by the Supervisor.
- The time commitment required by Supervisors and which is not always recognised by Departments.

Suggested actions

- Consideration be given to the Director of Education running workshops and/or seminars for Supervisors with a focus upon such issues as:
 - Developing the skills of a successful Supervisor.
 - Educational principles of effective supervision.
 - Adapting supervision for Trainees at different stages in their training.
- The Education Unit to facilitate face-to-face meetings between Supervisors with varying levels of expertise and experience to share concerns, common problems, and strategies for successfully dealing with problems.
- The Education Unit to develop materials and strategies for Supervisors. For example, proven teaching techniques, soliciting and facilitating optimal responses and reactions from Trainees, successful lecturing techniques, promoting small group discussion, assessment for Trainees and evaluation of own teaching.
- Encourage experienced Fellows to become Supervisors.

- Encourage Supervisors to prolong their appointments as Supervisors for several years.
- The active encouragement and support of Supervisors for their teaching endeavours.
- The Education Unit to offer ongoing support for Supervisors of Training.
- For departments to formally recognise Supervisors and allow the time necessary for Supervisors to optimally perform their duties.
- Consideration should be given to reviewing the incentive/reward structure for Supervisors with a view to greater acknowledgement and reward for their role.

Modular basic training (especially related to long distance learning)

A modular approach to education offers several useful features including the provision of clear course structure, reasonable flexibility, an opportunity to review and revise modules as anaesthesia and other medical fields evolve (usually this is more manageable than the review and revision of an entire course), a broad range of adaptability to available developmental resources (for example, specific modules can be developed by individuals or organisations who are part of the College, from other medical colleges, and outside organisations, etc.), the common use of modules by several medical colleges, and the provision of discreet educational goals for course participants.

Current concerns

- Many lessons/courses have been developed by individuals and organisations.
- These lessons/courses vary tremendously in quality, content, method of delivery, evaluation of Trainee mastery, and overall success.

Suggested actions

- Identify the lessons/courses currently available (this has been undertaken to some extent by the ANZCA Courses working party).
- Match these lessons/courses to the educational objectives as described in the proposed FANZCA curriculum.
- Identify gaps between the proposed FANZCA curriculum and the available lessons/courses.
- Develop a list of individuals and organisations willing to develop sound educational materials to fill the gaps identified above.
- Develop a list of current lessons/courses capable of being incorporated into the new FANZCA program (include documentation of any shortcomings these may have).
- Identify which current lessons/courses are the best and, in particular, any that would serve as exemplary educational resources upon which to model other lessons/courses.

Web-based Education (including CME)

Web-based educational resources have the potential to

positively impact many of the issues described within this report. These issues include CME, QA, MOPS, modularised basic learning, long distance learning, rural and Asia-Pacific education and even in-training assessment and the supervision of training. Web-based education resources are likely to prove particularly useful in overcoming the many difficulties associated with College Fellowship and Traineeship being spread over multiple countries and enormous distances.

Recent years have witnessed a plethora of educational resources developed for application through the Internet. The quality of these resources varies tremendously. Rather than attempt to “reinvent the wheel” it would seem worthwhile to examine the available web-based resources with the aim of incorporating useful aspects of current resources into our web-based resources and supplementing these with our own educational vision and materials.

Related issues

- The need to ensure the quality of any web-based educational resource that the College develops directly or develops in association with other organisations.
- Once developed, web-based resources can be readily incorporated into other educational resources produced by the College such as CD, Video and DVD educational tools.

Suggested actions

- Identify available clinicians with an interest in web-based learning, computers as educational tools, or education in general.
- Develop proposals for web-based educational tools incorporating:
 - Film/video clips.
 - Photographs, drawings and diagrams.
 - Text.
 - Voice-overs.
- Consideration be given to adding any or all of the following educational resources on the College website:
 - Virtual clinical situations including emergency management.
 - Case scenarios.
 - Anaesthesia, Pain Medicine and Intensive Care resource units.
 - Educational modules.
 - Guides for self-directed learning.
- Educational research has shown that maximum educational benefit is derived from the interaction of a user with the web-based resource. Hence it is suggested that these resources be made as interactive as possible.
- Develop a proposal for producing an interactive audio/visual educational resource suitable for use on, for example, CD and the web which focuses upon current events of importance to all Fellows (for example, a re-enactment of a recent anaesthetic emergency illustrating how the emergency arose and demonstrating how to effectively deal with the emergency).

Review Status and Progress of MOPS

The Maintenance of Standards Program was established in 1995 and has been revised to become the Maintenance of Professional Standards (MOPS) program introduced in 1999. MOPS functions primarily in an educational role with a particular focus on CME, QA and other self-improvement educational activities.

Research as Part of Education (CME, MOPS)

Research is widely recognised as an essential part of any medical field. Research has educational implications arising out of learning that takes place during the research process, (including the researcher increasing their understanding of their own learning process, important for life long learning, their own knowledge and the knowledge of the broader community) as well as from the resultant benefits which ripple through the field following the development and implementation of research findings.

Relevant issues

- Research focus may include research focused upon improving education.
- Many Trainees experience difficulty initiating and completing a satisfactory formal project.

Suggested actions

- Encouragement be given by the Education Unit to Fellows and Trainees interested in researching questions relating to the current educational concerns of the College.
- Particular emphasis to be placed on research into improving the delivery and quality of educational activities.
- Consideration be given to the Education Unit running research based workshops such as:
 - How to identify a suitable formal project.
 - How to write a research proposal.
 - Successfully undertaking and completing your formal project.

Rural Education

The training and CEQA of rural anaesthesia, pain medicine and intensive care specialists is an issue of concern to the College. A working party is currently being established to specifically examine rural concerns.

Related issues and possible actions

- Development of web-based and other distance learning educational materials (including CEQA modules).
- Development of a modular anaesthesia basic training distance-learning program.
- The fostering of outreach programs for specialists from larger hospitals to regularly service smaller remote hospitals.
- Rural rotations for Trainees.
- Raising the profile of the Rural SIG.
- Encouraging doctors from a rural background to complete the FANZCA training program.

- Health channel satellite link television promoting CME and health information to doctors in their homes.

Enhancing Communication

There appears to be widespread acknowledgement of the value of educating Trainees to be better communicators and to improving the communication awareness and skills of Fellows. Effective communication will facilitate the ideal two-way transmission of information between specialist and patient as well as between specialist and other medical staff, important for effective clinical practice. In addition enhanced communication will contribute to public education.

Current concerns

- A less than optimal level of communication between other members of the medical team and patients.
- Where appropriate the need to increase both the awareness of the value of effective communication and the communication skill levels of Trainees and Fellows.

Suggested actions

- The Education Unit to offer to work with the Communications Committee and CEQA Committee to facilitate improved communication.
- Emphasise the importance of both non-verbal communication (for example, dress and bearing) as well as verbal communication (for example, clarity and purpose of speech) when dealing with patients.
- Suggested two level approach introducing formal training in this area at both the postgraduate and undergraduate level.

Educating the Public

Although anaesthetists are highly skilled specialists having completed an MBBS or equivalent followed by an internship, residency and an additional four years of approved training before undertaking their provisional fellowship year, the general public seems largely unaware of the plethora of learning and experience which has taken place in order to qualify as an anaesthetist. Furthermore, despite the importance of the role of the anaesthetist in modern medicine and the extensive nature of this role, the general public remains largely unaware of what it is anaesthetists do, the complexity of the tasks undertaken by an anaesthetist, and their extensive continual involvement throughout a medical procedure.

Current concerns

- Anaesthetists have some interaction with patients and/or their families prior to a procedure, then the role of the anaesthetist largely becomes hidden from the patient and family.
- How best to educate the general public as to the complete role of the anaesthetist, their value, qualifications and extensive nature of their speciality.

Suggested actions

- Educate ANZCA Fellows and Trainees as to the importance of educating their patients in the role of anaesthesia and anaesthetists within medical procedures relevant to their patients.

- Educate ANZCA Fellows and Trainees in suitable strategies and techniques that can be used to communicate to the general public the importance of anaesthesia and anaesthetists in medical procedures.
- Incorporate components of “educating the public” into undergraduate and postgraduate teaching.

Asia-Pacific Education

Although ANZCA is willing to deal with relevant issues relating to anaesthesia, pain medicine and intensive care worldwide, the College prefers dealing with issues arising within a geographical area. This region provides a fertile ground for educational initiatives. Countries within the Asia-Pacific region with which ANZCA currently has relationships include Hong Kong, Singapore, Malaysia, Papua New Guinea, East Timor, Fiji and some other Pacific Island countries. The Strategic Planning Workshop, held 13th October 2000, focused in part upon issues pertaining to Asia-Pacific relationships.

Current concerns

- There exist widely differing needs within Asia-Pacific countries.
- Overcoming the tyranny of distance related to long distance education.

Suggested actions

- Complete a comprehensive list of those relationships, initiatives and projects that already exist between ANZCA and specific countries. These established relationships may form a useful foundation or framework for future educational initiatives.
- Develop technology based educational resources capable of delivering College education via web, CD, video or DVD.

Conclusion

Each of the educational issues identified in this report is of immediate relevance to the College. However, whereas some of the issues are less pressing, the need to address other issues is urgent. Your feedback is welcome and I can be contacted at the College or at DirEduc@anzca.edu.au.

Australian and New Zealand College of Anaesthetists

ABN 82 055 042 852

GUIDELINES ON CONSCIOUS SEDATION FOR DIAGNOSTIC, INTERVENTIONAL MEDICAL AND SURGICAL PROCEDURES

1. INTRODUCTION

Sedation for diagnostic, interventional medical and surgical procedures (with or without local anaesthesia) includes the administration by any route or technique of all forms of drugs which result in depression of the central nervous system. The objective of these techniques is to produce a degree of sedation of the patient, **without loss of consciousness**, so that uncomfortable diagnostic and surgical procedures may be facilitated. The drugs and techniques used should provide a margin of safety which is wide enough to render loss of consciousness unlikely. Loss of consciousness due to sedation has the same risks as general anaesthesia (see College Professional Document T2 *Recommendations on Minimum Facilities for Safe Anaesthetic Practice outside Operating Suites*).

These techniques are not without risk because of the:

- 1.1 Potential for unintentional loss of consciousness.
- 1.2 Depression of protective reflexes.
- 1.3 Depression of respiration.
- 1.4 Depression of the cardiovascular system.
- 1.5 Wide variety and combinations of drugs which may be used, with the potential for drug interactions.
- 1.6 Possibility of excessive amounts of these drugs being used to compensate for inadequate analgesia.
- 1.7 Individual variations in response to the drugs used, particularly in children, the elderly and those with pre-existing medical disease.
- 1.8 Wide variety of procedures performed.
- 1.9 Differing standards of equipment and staffing at the locations where these procedures may be performed.

It is important to recognise the variability of effects which may occur with sedative drugs, however administered, and that over-sedation, airway obstruction or cardiovascular complications may occur at any time. To ensure that standards of patient care are satisfactory, equipment and staffing of the area in which the patient is being managed should satisfy the requirements in the appropriate College Professional Documents.

2. GENERAL PRINCIPLES

2.1 The patient should be assessed before the procedure and this assessment should include:

2.1.1 A concise medical history, examination (including blood pressure measurement), performance of appropriate investigations and identification of risk factors. The American Society of Anesthesiologists classification system is convenient for this purpose. (See Appendix 1.) (See College Professional Document PS7 *Recommendations on the Pre-Anaesthesia Consultation*).

2.1.2 Informed consent for sedation as well as the planned procedure.

2.1.3 Instructions for preparation for the procedure (**including the importance of fasting**), the recovery period, and discharge of the patient (including avoidance of driving, other dangerous activities, undertaking responsible business).

2.2 If the patient has any serious medical condition (such as significant cardiorespiratory disease) or danger of airway compromise, or is a young child or is elderly, then an anaesthetist should be present to administer sedation and to monitor the patient during the procedure. (See College Professional Documents PS1 *Recommendations on Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia*, PS2 *Recommendations on Privileges in Anaesthesia*, PS16 *Guidelines on the Standards of Practice of a Specialist Anaesthetist*, TE3 *Policy on Supervision of Clinical Experience for Trainees in Anaesthesia*).

2.3 The practitioner administering sedation requires sufficient knowledge to be able to:

2.3.1 Understand the actions of the drug or drugs being administered.

2.3.2 Detect and manage appropriately any complications arising from these actions. **In**

particular medical practitioners administering sedation must be skilled in airway management and cardiovascular resuscitation.

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

2.4 Techniques intended to produce loss of consciousness must not be used unless an anaesthetist is present. (see College Professional Documents PS1 *Recommendations on Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia*, PS2 *Recommendations on Privileges in Anaesthesia*, PS16 *Guidelines on the Standards of Practice of a Specialist Anaesthetist*, TE3 *Policy on Supervision of Clinical Experience for Trainees in Anaesthesia*).

2.5 A written record of the dosages of drugs and the timing of their administration must be kept as a part of the patient's records. Such entries should be made as near the time of administration of the drugs as possible. This record should also note the regular readings from the monitored variables, and should contain other information as indicated in the College Professional Document PS6 *Recommendations on Minimum Requirements for the Anaesthesia Record*.

3. STAFFING

3.1 In situations other than those noted in 2.2 an appropriately trained medical practitioner other than the proceduralist should be present and be responsible for administration of sedation and monitoring the patient.

3.2 If an appropriately trained medical practitioner is not present to administer sedation and monitor the patient, there must be an assistant present during the procedure, appropriately trained in observation and monitoring of sedated patients, and in resuscitation whose sole duty shall be to monitor the level of consciousness and cardio-respiratory function of the patient.

3.3 If at any time **rational communication** with the patient is lost, both the proceduralist and assistant must devote their entire attention to monitoring and treating the patient until recovery, or until such time as another medical practitioner becomes available to take responsibility for the patient's care.

3.4 If general anaesthesia or loss of consciousness is sought for the procedure, then an anaesthetist must be present to care exclusively for the patient (see College Professional Document T2 *Recommendations on Minimum Facilities for Safe Anaesthetic Practice Outside Operating Suites*).

3.5 If major patient risk factors are identified (as in 2.2) an anaesthetist must be present to care for the patient.

4. FACILITIES

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

4.1 An operating table, trolley or chair which can be readily tilted.

4.2 Adequate uncluttered floor space to perform resuscitation should this prove necessary.

4.3 Adequate suction and room lighting.

4.4 A supply of oxygen and suitable devices for the administration of oxygen to a spontaneously breathing patient.

4.5 A self inflating bag suitable for artificial ventilation together with a range of equipment for advanced airway management.

4.6 Appropriate drugs for cardiopulmonary resuscitation and a range of intravenous equipment. (See Appendix II.)

4.7 A pulse oximeter.

4.8 Ready access to a defibrillator.

(See College Professional Documents T2 *Recommendations on Minimum Facilities for Safe Anaesthesia Practice Outside Operating Suites* and PS15 *Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery*.)

5. MONITORING

All patients undergoing intravenous sedation must be monitored continuously with pulse oximetry and this equipment must alarm when certain set limits are exceeded. There must be regular recording of pulse rate, oxygen saturation and blood pressure. According to the clinical status of the patient, other monitors such as ECG or capnometry may be required (see College Professional Document PS18 *Recommendations on Monitoring During Anaesthesia*).

6. OXYGENATION

Degrees of hypoxaemia occur frequently during intravenous sedation without oxygen supplementation. Oxygen administration diminishes hypoxaemia during procedures carried out under sedation and should be routine.

Pulse oximetry enables the degree of tissue oxygenation to be monitored and must be used on all patients during sedation.

7. DRUGS USED FOR SEDATION

A variety of drugs and techniques are available for sedation. The most common intravenous agents used are small doses of a benzodiazepine (such as midazolam) for sedation and small doses of opioid (such as fentanyl) for analgesia. Even

small doses of such drugs may result in loss of consciousness in some patients.

Intravenous anaesthetic agents such as propofol must only be used by an anaesthetist. These agents must not be administered by the proceduralist.

8. SEDATION FOR DENTAL PROCEDURES

An appropriately trained medical or dental practitioner other than the proceduralist should be present and be responsible for administration of sedation.

- 8.1 Dental practitioners who administer conscious sedation must be able to demonstrate an appropriate level of training.
- 8.2 Dental practitioners must be capable of administering the correct oral medication for conscious sedation.
- 8.3 Practitioners wishing to administer intravenous drugs for conscious sedation must attend an appropriate course. They must demonstrate competence in these techniques and the associated resuscitative measures, which must include management of artificial ventilation and external cardiac massage.
- 8.4 In areas where sedation is used, there must be appropriate staffing, facilities and monitoring available.

9. SPECIALISED EQUIPMENT FOR NITROUS OXIDE SEDATION

When nitrous oxide is being used to provide sedation, the following equipment requirements must be satisfied.

- 9.1 There must be a minimum oxygen flow of 2.5 litres/minute with a maximum flow of 10 litres/minute of nitrous oxide, or in machines so calibrated, a minimum of 30% oxygen. There must be the capacity for the administration of 100% oxygen.
- 9.2 The circuit must include an anti-hypoxic device which cuts off nitrous oxide flow in the event of an oxygen supply failure, and opens the system to allow the patient to breathe room air.
- 9.3 There must be a non-return valve to prevent re-breathing, and a reservoir bag.
- 9.4 The patient breathing circuit must provide low resistance to normal gas flows, and be of lightweight construction.
- 9.5 Installation and maintenance of any piped gas system must be according to appropriate standards.
- 9.6 Servicing of equipment and piped gases must occur on a regular basis and at least annually.
- 9.7 An appropriate method for scavenging of expired gases must be in use.
- 9.8 Risks of chronic exposure to nitrous oxide should be considered.

10. DISCHARGE

The patient should be discharged only after an appropriate period of recovery and observation in the procedure room, or in an adjacent area which is adequately equipped and staffed (see College Professional Document PS4 – *Recommendations for the Post-Anaesthesia Recovery Room*).

Discharge of the patient should be authorised by the practitioner who administered the drugs, or another appropriately qualified practitioner. The patient should be discharged into the care of a responsible adult to whom written instructions should be given.

Adequate staffing and facilities must be available in the Recovery Area for managing patients who have become unconscious or who have suffered some medical mishap. Should the need arise the patient must be transferred to appropriate medical care.

All College Professional Documents must be complied with, particularly the following:

- PS1 *Recommendations on Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia*
- PS2 *Recommendations on Privileges in Anaesthesia*
- PS4 *Recommendations for the Post-Anaesthesia Recovery Room*
- PS6 *Recommendations on Minimum Requirements for the Anaesthesia Record*
- PS7 *Recommendations on The Pre-Anaesthesia Consultation*
- PS15 *Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery*
- PS16 *Guidelines on the Standards of Practice of a Specialist Anaesthetist*
- PS18 *Recommendations on Monitoring During Anaesthesia*
- T2 *Recommendations on Minimum Facilities for Safe Anaesthesia Practice Outside Operating Suites*
- TE3 *Policy on Supervision of Clinical Experience for Trainees in Anaesthesia*

APPENDIX I

The American Society of Anesthesiologists' classification of physical status:

- Class I A normal healthy patient
- Class II A patient with mild systemic disease
- Class III A patient with a severe systemic disease that limits activity but is not incapacitating
- Class IV A patient with an incapacitating systemic disease that is a constant threat to life
- Class V A moribund patient not expected to survive 24 hours

APPENDIX II

Emergency drugs should include at least the following: adrenaline

atropine
dextrose 50%
lignocaine
naloxone
flumazenil

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

Australian and New Zealand College of Anaesthetists

ABN 82 055 042 852

GUIDELINES FOR HOSPITALS SEEKING COLLEGE APPROVAL OF POSTS FOR THE FIRST FOUR YEARS OF VOCATIONAL TRAINING IN ANAESTHESIA

1. GENERAL

- 1.1 A training post in anaesthesia is one that has been approved by the College as appropriate to be occupied by a trainee anaesthetist who is registered with the College.
- 1.2 Training posts will be approved by the College only if they are part of a recognised training program.

2. THE RECOGNISED TRAINING PROGRAM

- 2.1 A training program is a scheme of rotation between two or more hospitals such that the program can provide an appropriate range of experience of anaesthesia and its sub-specialties during the first four years of training, including:
 - 2.1.1 PAEDIATRIC ANAESTHESIA
 - 2.1.2 CARDIO-THORACIC ANAESTHESIA
 - 2.1.3 NEUROSURGICAL ANAESTHESIA
 - 2.1.4 OBSTETRIC ANALGESIA AND ANAESTHESIA
 - 2.1.5 PAIN MEDICINE
 - 2.1.6 INTENSIVE CARE
 - 2.1.7 RURAL EXPERIENCE
 - 2.1.8 DAY SURGERY
 - 2.1.9 For those programs where the subspecialty is not able to be organised into blocks or sessions, a pro-rata caseload in the specialty would be acceptable.
 - 2.1.10 At least 50% of subspecialty experience must be in-hours.

2.1.1 PAEDIATRIC ANAESTHESIA

The program must have sufficient paediatric anaesthesia so as to provide 50 sessions (half days) of experience to every trainee. Limited time in neonatal or paediatric intensive care may be included in this.

2.1.2 CARDIO-THORACIC ANAESTHESIA

The program must have sufficient cardio-thoracic anaesthesia so as to provide 50 sessions (half days) of experience to every trainee. Limited time in post cardio-thoracic surgery intensive care may be included in this.

2.1.3 NEUROSURGICAL ANAESTHESIA

The program must have sufficient neurosurgical anaesthesia so as to provide 50 sessions (half days) of experience to every trainee. Limited time in post neurosurgical intensive care may be included in this.

2.1.4 OBSTETRIC ANALGESIA AND ANAESTHESIA

The program must have sufficient obstetric analgesia and anaesthesia so as to provide 50 sessions (half days) of experience to every trainee. It is acceptable for obstetric

experience to be combined with other duties provided that obstetric experience always takes priority.

2.1.5 PAIN MEDICINE

The program must have a pain medicine service so as to provide 50 sessions (half days) of pain management experience to every trainee. While it will be acceptable for the majority of this experience to be in acute pain management, there must be some provision for chronic and cancer pain management experience for every trainee.

2.1.6 INTENSIVE CARE

The program must have sufficient intensive care services so as to provide three continuous months experience to every trainee. The intensive care unit should be accredited by the Faculty of Intensive Care.

2.1.7 RURAL EXPERIENCE

The program must include a rural hospital so as to provide the opportunity for anaesthesia experience in a rural centre.

2.1.8 DAY SURGERY

The program must have day surgery services so as to provide experience in ambulatory anaesthesia.

For those programs where the subspecialty is not able to be organised into blocks or sessions, a pro-rata caseload in the specialty would be acceptable.

At least 50% of subspecialty experience must be in-hours.

It would be unusual for a single hospital to provide up to four years of the designated five years of training from its own resources. Trainees will not normally be permitted to spend all of their training in one hospital.

- 2.3 Training programs will be regularly reviewed at intervals determined by Council. Hospitals will be visited by the College. Accreditation of Intensive Care training posts will normally be carried out by the Faculty of Intensive Care.
- 2.4 The number of posts approved within a training program will be specified with regard to the availability of anaesthetic experience and subspecialty training (see 2.1). Additional posts will not be recognised without the prior knowledge and consent of Council. This will generally require the inspection of the hospital and consideration of the effect of the increase on the training program and other training programs in that region.
- 2.5 Training programs should interact, especially with regard to subspecialty training. The advice of the relevant Regional/National Committee will be sought on the impact on subspecialty training of any additional training posts. Confirmation of the availability of subspecialty training by Regional/National Committees will usually be required before additional posts will be approved.

3. THE HOSPITAL

- 3.1 A recognised hospital must have a Department of Anaesthesia under the direction of a suitably qualified anaesthetist who is responsible for the organisation, teaching and service requirements of that Department.
- 3.2 Training posts may be full or part time but must include normal, emergency and out-of-hours duties. Part time posts are subject to the requirements of the relevant College regulations.
- 3.3 There must be adequate supervision of trainees by specialist anaesthesia staff who hold the FANZCA or another qualification acceptable to Council (see College Professional Document TE3 *Policy on Supervision of Clinical Experience for Trainees in Anaesthesia*). Specialist anaesthesia staff must be familiar with the College's training program.
- 3.4 Job descriptions for the specialist anaesthesia staff must be acceptable to the College (see College Professional Document TE6 *Guidelines on the Duties of an Anaesthetist*).
- 3.5 When specialist anaesthesia staff are appointed, the advice of a properly constituted committee capable of evaluating the applicants must be sought. See College Professional Document PS44 – *Guidelines to Fellows Acting on Appointments Committees for Senior Staff in Anaesthesia*.
- 3.6 A Supervisor of Training in Anaesthesia must be appointed by the hospital on the advice of the Department of Anaesthesia. It is not permissible for

the Supervisor of Training to be the Director of the Department of Anaesthesia. This appointment requires ratification by Council. The duties of the Supervisor of Training are specified in College Professional Document TE5 *Policy for Supervisors of Training in Anaesthesia*.

- 3.7 The hospital (and other hospitals forming part of the training program) must agree to inspection by representatives of the Council.
- 3.8 Posts approved for training in anaesthesia by the College must be advertised with that approval being noted. Where the number of training posts is less than the number of posts being advertised, the number of training posts should be specifically indicated.
- 3.9 The hospital must agree to notify Council (through the Supervisor of Training) of any changes that might affect training. Importance is placed on changes such as alterations in workload and increases or decreases in the number of senior staff working in the Department.
- 3.10 The Department of Anaesthesia must have:
 - 3.10.1 A minimum of two full time equivalent (FTE) specialist anaesthesia staff with qualifications acceptable to Council.
 - 3.10.2 No more than two FTE non-specialist anaesthesia staff (either trainees or other medical officers) for each FTE specialist.
 - 3.10.3 Sufficient FTE anaesthesia specialists to provide supervision for all trainees in accordance with College Professional Document TE3 *Policy on Supervision of Clinical Experience for Trainees in Anaesthesia*.
 - 3.10.4 Adequate secretarial staff. Most departments will require at least one full-time secretary with several being needed in larger hospitals (see College Professional Document TE7 *Recommendations on Secretarial and Support Services to Departments of Anaesthesia*).
 - 3.10.5 Adequate office space for the specialist staff.
 - 3.10.6 A suitable study room for trainees.
 - 3.10.7 Access to a suitable conference room for quality assurance, clinical review and educational activities.
 - 3.10.8 Regular programs of quality assurance and teaching appropriate to the size of the department (see College Professional Document TE9 *Guidelines on Quality Assurance*).
 - 3.10.9 Adequate library facilities with information sources appropriate to anaesthesia and its sub-specialties.
 - 3.10.10 Ready access to appropriate computer facilities for specialists and trainees.

3.10.11 Access to clinical support services appropriate to the role of the hospital.

3.10.12 Anaesthesia specialists participating in the College's Maintenance of Professional Standards Program or its equivalent.

3.11 In addition to matters noted above, the hospital and department will take note of and comply with all College Professional Documents and in particular:

- PS4 Recommendations for the Post-Anaesthesia Recovery Room
- PS6 Recommendations on Minimum Requirements for the Anaesthesia Record
- PS7 Recommendations on the Pre-Anaesthetic Consultation
- PS8 Recommendations on the Assistant for the Anaesthetist
- PS18 Recommendations on Monitoring During Anaesthesia
- T1 Recommendations on Minimum Facilities for Safe Anaesthesia Practice in Operating Suites
- T2 Recommendations on Minimum Facilities for Safe Anaesthesia Practice outside Operating Suites

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- P27 (1994) Standards of Practice for Major Extracorporeal Perfusion *Bulletin Nov 94, pg 46*
- P28 (1995) Policy on Infection Control in Anaesthesia *Bulletin Mar 95, pg 38*
- PS29 (1997) Anaesthesia Care of Children in Healthcare Facilities without Dedicated Paediatric Facilities *Bulletin Nov 97, pg 82*
- PS31 (1997) Protocol for Checking the Anaesthetic Machine *Bulletin Nov 97, pg 84*
- PS36 (1997) Sedation for Regional Anaesthesia for Ophthalmic Surgery *Bulletin Nov 97, pg 93*
- PS37 (1998) Regional Anaesthesia and Allied Health Practitioners *Bulletin Mar 98, pg 79*
- PS38 (1999) Statement Relating to the Relief of Pain and Suffering and End of Life Decisions *Bulletin June 99, pg 93*
- PS39 (2000) Intrahospital Transport of Critically Ill Patients *Bulletin July 2000, pg 84*
- PS40 (2000) Guidelines for the Relationship Between Fellows and the Healthcare Industry *Bulletin Mar 2000, pg 55*
- PS41 (2000) Guidelines on Acute Pain Management *Bulletin Nov 2000, pg 80*
- PS42 (2000) Recommendations for Staffing of Departments of Anaesthesia *Bulletin Mar 2001 pg 63*
- PS43 (2001) Statement on Fatigue and the Anaesthetist *Bulletin Mar 2001 pg 66*

FACULTY OF INTENSIVE CARE

ABN 82 055 042 852

POLICY DOCUMENTS

- IC-1 (1997) Minimum Standards for Intensive Care Units *Bulletin Aug 94, pg 44*
- IC-2 (2000) The Duties of an Intensive Care Specialist in Hospitals with Approved Training Posts *Bulletin Nov 2000, pg 53*
- IC-3 (2000) Guidelines for Intensive Care Units seeking Faculty Accreditation for Training in Intensive Care *Bulletin Nov 98, pg 70*
- IC-4 (2000) The Supervision of Vocational Trainees in Intensive Care *Bulletin Mar 2000, pg 57*
- IC-5 (1995) Duties of Regional Education Officers in Intensive Care *Bulletin Nov 95, pg 50*
- IC-6 (2001) The Role of Supervisors of Training in Intensive Care Medicine *Bulletin June 2001, pg 67*
- IC-7 (2000) Secretarial Services to Intensive Care Units *Bulletin Mar 2000, pg 58*
- IC-8 (2000) Quality Assurance *Bulletin Nov 2000, pg 55*
- IC-9 (1997) Statement on Ethics and Patients' Rights and Responsibilities *Bulletin Nov 97, pg 68*
- IC-10 (1996) Minimum Standards for Transport of the Critically Ill *Bulletin Mar 96, pg 42*
- IC-11 (1996) In-Training Assessment of Trainees in Intensive Care *Bulletin Mar 96, pg 46*
- IC-12 (1996) Examination Candidates Suffering from Illness, Accident or Disability *Bulletin May 96, pg 66*
- IC-13 (2000) Minimum Standards for High Dependency Units Seeking Accreditation for Training in Intensive Care *Bulletin Mar 2000, pg 59*
- PS38 (1999) Statement Relating to the Relief of Pain and Suffering and End of Life Decisions *Bulletin June 99, pg 93*
- PS39 (2000) Intrahospital Transport of Critically Ill Patients *Bulletin July 2000, pg 84*
- PS40 (2000) Guidelines for the Relationship Between Fellows and the Healthcare Industry *Bulletin Mar 2000, pg 55*

PROFESSIONAL DOCUMENTS

E = Educational P = Professional T = Technical

EX = Examinations PS = Professional Standards TE = Training and Examinations

- TE1 (2001) Guidelines for Hospitals seeking College Approval of Posts for the First Four Years of Vocational Training in Anaesthesia *Bulletin June 2001, pg 92*
- TE3 (1999) Supervision of Clinical Experience for Trainees in Anaesthesia *Bulletin Nov 99, pg 67*
- TE4 (1997) Duties of Regional Education Officers in Anaesthesia *Bulletin Nov 97, pg 88*
- TE5 (1997) Supervisors of Training in Anaesthesia *Bulletin Nov 97, pg 89*
- TE6 (2000) Guidelines on the Duties of an Anaesthetist *Bulletin July 2000, pg 86*
- TE7 (1999) Secretarial and Support Services to Departments of Anaesthesia *Bulletin Nov 99, pg 69*
- TE9 (1999) Quality Assurance *Bulletin June 99, pg 94*
- TE11 (1999) Formal Project Guidelines *Bulletin Mar 99, pg 70*
- E13 (1996) Guidelines for the Provisional Fellowship Year *Bulletin Nov 96, pg 66*
- E14 (1994) Guidelines for the In-Training Assessment of Trainees in Anaesthesia *Bulletin Aug 94, pg 62*
- TE17 (1999) Advisors of Candidates for Anaesthesia Training *Bulletin Nov 99, pg 66*
- TE18 (2000) Guidelines for Assisting Trainees with Difficulties *Bulletin Mar 2001 pg 76*
- EX1 (1996) Examination Candidates Suffering from Illness, Accident or Disability *Bulletin Nov 96, pg 70*
- T1 (2000) Recommendations on Minimum Facilities for Safe Anaesthetic Practice in Operating Suites *Bulletin Mar 2001 pg 68*
- T2 (2000) Recommendations on Minimum Facilities for Safe Anaesthetic Practice outside Operating Suites *Bulletin Mar 2001 pg 72*
- P1 (1997) Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia *Bulletin May 97, pg 81*
- P2 (1996) Privileges in Anaesthesia *Bulletin Nov 96, pg 72*
- PS3 (1998) Major Regional Anaesthesia and Analgesia *Bulletin Nov 98, pg 85*
- PS4 (2000) Recommendations for the Post-Anaesthesia Recovery Room *Bulletin Nov 2000, pg 72*
- P6 (1996) Minimum Requirements for the Anaesthesia Record *Bulletin Mar 96, pg 48*
- PS7 (1998) The Pre-Anaesthesia Consultation *Bulletin Mar 98, pg 73*
- PS8 (1998) The Assistant for the Anaesthetist *Bulletin Mar 98, pg 75*
- PS9 (2001) Guidelines on Conscious Sedation for Diagnostic, International Medical and Surgical Procedures *Bulletin June 2001, pg 88*
- PS10 (1999) Handover of Responsibility During an Anaesthetic *Bulletin Nov 99, pg 62*
- P11 (1991) Management of Cardiopulmonary Bypass *Bulletin May 91, pg 43*
- PS12 (1996) Statement on Smoking as Related to the Perioperative Period *Bulletin Nov 97, pg 78*
- PS14 (1998) Guidelines for the Conduct of Major Regional Analgesia in Obstetrics *Bulletin Nov 98, pg 81*
- PS15 (2000) Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery *Bulletin Nov 2000, pg 75*
- P16 (1994) The Standards of Practice of a Specialist Anaesthetist *Bulletin Nov 94, pg 45*
- PS17 (1997) Endoscopy of the Airways *Bulletin Nov 97, pg 80*
- PS18 (2000) Recommendations on Monitoring During Anaesthesia *Bulletin Nov 2000, pg 78*
- P19 (1995) Monitored Care by an Anaesthetist *Bulletin Nov 95, pg 60*
- P20 (1996) Responsibilities of the Anaesthetist in the Post-Operative Period *Bulletin Mar 96, pg 52*
- P21 (1996) Sedation for Dental Procedures *Bulletin Mar 97, pg 56*
- P22 (1996) Statement on Patients' Rights and Responsibilities *Bulletin Mar 96, pg 53*
- P24 (1997) Sedation for Endoscopy *Bulletin May 97, pg 78*
- PS26 (1999) Guidelines on Providing Information about the Services of an Anaesthetist *Bulletin Nov 99, pg 63*

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