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The depletion of ozone has been of particular concern to our two constituent countries, since the ‘hole’ in the ozone layer was discovered in 1985. Although referred to as a layer, ozone molecules are scattered sparsely throughout the stratosphere, from 10 to 50 km above the earth’s surface, where their presence absorbs most of the potentially harmful ultraviolet-B radiation from the sun. Chlorofluorocarbons and halogenated halocarbons released into the atmosphere may reach the stratosphere and release halide breakdown products which cause the catalytic destruction of ozone. The ozone-depleting potential of halogenated hydrocarbons is a function of molecular stability, their stratospheric lifetime, and the breakdown products (bromide being the most destructive, and fluoride, the least). 80% of volatile anaesthetic agents are exhaled unchanged, with 20% entering the stratosphere. Halothane has the highest potential for ozone depletion, however only 1% will have sufficient lifetime in the stratosphere to react, and neither sevoflurane nor desflurane have any significant ozone depleting effect. Thus, the contribution to ozone depletion by halogenated anaesthetics is small, estimated to be less than 0.001%.

Nitrous oxide also affects ozone, indirectly by the nitric oxide formed in the stratosphere by photodissociation or combination with atomic oxygen. The ozone depleting potential of nitrous oxide is 1% of that of CFC-11, the principle ozone depleting propellant now highly regulated as a result of the Montreal protocol. Nitrous oxide is also a ‘greenhouse’ gas, contributing to global warming by virtue of its ability to absorb thermal infrared radiation from the earth. The principle ‘greenhouse’ gas is CO2, with N2O contributing about 5% of the total ‘greenhouse’ gas effect. However, the majority of nitrous oxide released into the atmosphere comes from anaerobic denitrification in the soil (enhanced by the use of fertilizers) and burning of fossil fuels, with medical use comprising approximately 0.35% of the total.

Should Fellows of ANZCA be phasing out the use of volatile anaesthetics and/or nitrous oxide, or is it enough for the College to promote the use of ‘low flow’ and closed circuit anaesthesia delivery systems?

There are other ways for Fellows of the College to assist the community to deal with climate change. In our everyday working environment, there are many practices that may contribute to the global problem.

The ever expanding use of disposable items in hospitals, especially petroleum sourced plastic products, is usually justified on the basis of lower cost – primarily labour cost. If we use bacterial/viral filters, do we need to change the anaesthetic circuit after each patient, and do we need to use a new syringe for each drug we administer to the one patient?

Hospitals are huge consumers of electricity and water, and yet they are rarely involved in conservation of either. How often do lights continue to burn in offices and non-clinical areas – even when those areas are unoccupied? How often do taps continue to pour in scrub sinks? How often do hospital staff consider water conservation when scrubbing, washing or undertaking everyday tasks? How many hospitals utilise their huge roof areas to collect and store rain water? Why not install solar panels for generation of electricity?

Fellows of the College should take a leading role, and encourage more rational use of our precious resources.

Anaesthetists and intensivists should examine their daily practices and be able to find ways to reduce plastic waste, and to conserve water and electricity. Simple audits of water or power wastage may be helpful. Get involved in hospital design or whenever renovations are being undertaken, and demand that low energy principles be applied. Even consider how you get to and from your place of work – do you need to use that four-wheel drive?

St John’s Hospital, Murdoch, in WA has set an example with a 12% reduction in energy use over the last 4 years. The College too, is making an effort in this area, having recently installed a 9000 litre rainwater tank at Ultimara in Melbourne, so that the gardens can be maintained.

You too can do your bit for the planet.

References:
Initiating a mentor programme

One department’s experience

The role of the Supervisor of Training, the SOT as they are known, is arguably one of the most important in the College’s training program. In recent years, and in particular, after the establishment of the ANZCA Department of Education under Professor Russell Jones, there has been much greater effort to provide ongoing support for SOTs.

The following article by Natalie Smith is an indication of the enthusiasm that exists within the ranks of new Fellows of the College, and their preparedness to give back to the organisation, some of the benefit that they have gained during their training. Editor.

As an enthusiastic new SOT in a large outer metropolitan teaching hospital, I was aware that previous SOTs had encountered ‘difficult’ registrars who had failed to progress satisfactorily. With increasing information in the literature (both anaesthetic and general) about the value of mentorship, I decided that my department needed a mentorship programme for registrars. I concluded that any scheme with a potential to improve the welfare of my registrars and to involve the consultants in an extended role would be worthwhile. I researched the concept as much as I could, using models mainly from the business community, then decided to go ahead.

After distributing information to the consultants at the end of 2005, seven indicated a desire to be part of the scheme. They ranged from new consultants to senior members of the department. All registrars who were going to be in the department for 6 months or longer were given an information pack in January 2006, and asked if they wanted to participate. Six replied – all new, junior registrars. As the SOT, I acted as the co-ordinator of the scheme, but did not become personally involved in any mentor partnerships.

In February 2006, after approximately 4 weeks in the department, interested registrars and consultants were asked to nominate a first and second choice partner, and were then matched together by the co-ordinator, trying to take account of various issues such as personalities, existing friendships, and likely requirements and abilities of each party during the programme. Six partnerships were established.

Both mentees and mentors were supplied again with more specific literature explaining the various concepts involved in the mentor relationship, and possible ways that it could be developed. An example ‘contract’ was supplied, to be filled in if they wished. The partners were then left with no external interference from the co-ordinator until the process was reviewed in November 2006, approximately nine months later.

SURVEY QUESTIONS:
1. How many times have you met as part of the programme?
2. In what locations?
3. What has been the main focus of the relationship?
4. Have you focussed on any other areas?
5. Have you found the relationship helpful?
6. In what ways?
7. How do you think your partner has found the relationship?
8. How would you like the relationship to develop in the future?
9. Would you like to continue the relationship next year?
10. Other comments?

Overall, the programme was considered to be a useful one. The mentees generally found the programme more useful to them than did the mentors. There was a large emphasis on examination and career advice, reflecting the general stage of training of most mentees. A diversity of types of relationships became apparent, which I believe is largely a reflection of the personalities involved. In only one relationship was a sense of frustration and unhappiness expressed by one of the parties.

SEVERAL MAIN THEMES EMERGE:
1) The mentees found it helpful and wished to continue. It was more than an informal chat on a casual basis with a passing sympathetic consultant for them. They valued having a specific person available to them for whatever their needs were.

2) Two mentees mentioned help with problems and stress at work. I consider this to be a justification for the programme in itself. These two registrars had experienced various problems at work, largely related to their personalities and the standard of their clinical work, and had been followed closely by the SOT throughout the year. Both had admitted to being very stressed at different times throughout the year, and one is not pursuing a career in anaesthesia. Any extra support that these registrars received is an extremely valuable resource. The mentors for these registrars were chosen very carefully, with this issue in mind – one mentor being a wise, strong, yet sympathetic senior consultant, and the other being a friend outside work. The former approach seems to have been more successful than the latter.

3) I had anticipated that a major benefit from the programme would be the establishment of the mentor as role model. Only one mentee explicitly stated this, and only one other mentioned a similar sort of concept. Interestingly, these were the two registrars in point 2 above.
Meetings may be informal or formal, but the mentees seem to interpret many interactions between the two as part of the programme, whereas the consultants tended to consider the more formal meetings as part of the programme. This suggests perhaps that registrars place a higher value on interactions that the consultants considered everyday and mundane, and reinforces the concept of the consultant as a role model, even when they are not aware of being so. Only a few partnerships had met outside work. The partnerships with the fewest formal meetings were considered to be the least useful by the participants.

The number of times the partners met was not necessarily an indication of the strength of the relationship.

The gains by the registrars depended largely on their individual needs. However, all of the registrars valued the support from the mentors, and even those perceived as being ‘strong’ registrars felt that they gained from the relationship.

**POINTS TO DEVELOP IN THE FUTURE:**

1) More input is needed from the co-ordinator during the year, to help identify and encourage relationships that might be having difficulties or stagnating.

2) To generate more enthusiasm for the programme, I believe that the mentors need to perceive more gain for themselves in the programme.

3) Although informal interactions at work are useful, the co-ordinator needs to encourage the partners to set up and identify their mentoring sessions more formally. The more effort and thought that goes into the relationship, the more that both parties will gain.

4) Pairing existing friends together did not seem to produce a strong mentor relationship. Relationships with slightly contrasting personalities were just as successful, if not more so, than the others.

All participants have now been given feedback from the audit, and encouraged to meet again to consider the general points above, their own specific relationship, and how they plan to continue next year.

The process will be repeated in 2007, with all consultants and registrars asked if they wish to participate.

**NATALIE SMITH**

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President’s Message

2007: What does the year hold in store?

Welcome to 2007 and I trust that you are rejuvenated after the festive and holiday seasons.

Before commenting on what 2007 holds in store let me first say that 2006 concluded with the Council adopting the Strategic Plan that was mentioned in my December Message and the commencement of a major upgrade to the computer facilities at the College headquarters. Both of these initiatives are designed to position ANZCA to face the challenges ahead, to enhance the communication and educational capabilities of the College and to improve the internal processes.

NATIONAL REGISTRATION AND ACCREDITATION
The Council of Australian Governments (COAG) and the Department of Health and Ageing (DOHA) are working towards the promulgation of their next round of proposals on these matters. I am led to believe that they will shortly be published and that they represent a substantial departure from the documents produced last November. These new documents will then be the subject of a further round of consultative processes. The Colleges, the CPMC and the AMA continue to advocate for the retention of the Australian Medical Council, for Profession Specific Registration ‘panels’, for portability of medical registration and for the appropriate recognition and support of the additional functions that are currently performed by Medical Boards. This is an important area for the medical profession and it is essential that the profession remains united on these issues and remains committed to professionalism and excellence in medical practice.

ANAESTHESIA FOR ENDOSCOPY AND OTHER PROCEDURES
This has become a major area of anaesthesia practice with the growing demand for anaesthesia for endoscopic procedures, radiological procedures, cardiac procedures and a host of other interventions that occur outside the operating theatre suite. In the past the requests have generally been for a form of ‘sedation’ but increasingly the proceduralists and the patients are demanding what is in fact anaesthesia. These requests for anaesthesia have been readily met in the private sphere but the public hospitals have in many instances failed to secure the funding to provide the extra services. As a result there is now an increasing demand for these services in the public arena and the hospitals and some proceduralists have started to look at the ‘modes’ of sedation and who might provide such ‘sedation’. ANZCA has been quite clear in pointing out that they should not focus on the drugs but they need to realize that what they are requesting is anaesthesia and that requires the presence of an appropriately trained medical practitioner. ANZCA Council has formed a working group to consider the promulgation of a statement indicating the College’s position on sedation, the provision of training in sedation/anaesthesia for endoscopy by ANZCA and to review all four of the Professional Documents relating to sedation.

‘EXPANDED SETTINGS FOR MEDICAL SPECIALIST TRAINING’
The Australian Health Ministers’ Advisory Council (AHMAC) has accepted the recommendations of a report from the Medical Specialist Advisory Committee on ‘Expanding the Settings for Medical Specialist Training’, in order to better prepare specialists for actual practice, to match service delivery with community requirements and to cater for the increased number of trainees as we move to the year 2011 without increasing the pressure on public hospitals. Funding is being made available to pilot mechanisms that will allow for the gradual movement of some training into these expanded settings, providing that there is an ‘educational imperative’ for such a movement and there is no detriment to health care delivery by the public health system. Several healthcare organizations in the private health sphere have indicated that they are interested in accommodating trainees. A number of issues remain to be fully resolved and these include funding, accreditation, supervision, indemnity and the transfer of trainee entitlements but this is an issue that the governments are determined to settle in the next 12-18 months.

The College has in recent years accredited a small number of private hospitals or institutions for anaesthesia training. These hospitals have been required to meet the same criteria for accreditation as public hospitals and must be part of a rotational training program. ANZCA will consider proposals for training in ‘expanded settings’ on their merits and will investigate ways in the training program can be improved through cooperative ventures between the different jurisdictions of
EXAMINATION
In May, we will have the largest Final examination ever with 187 candidates. There are 167 trainees and 20 Overseas Trained Specialists. The oral examinations will not be conducted at the College headquarters and those plus the clinical examinations will be a major logistic exercise. The College is very grateful to all the examiners who have made themselves available for this examination.

CONTINUING PROFESSIONAL DEVELOPMENT
The documents related to the new CPD program are out for consultation and are available on the College website. Fellows are encouraged to comment on the proposed CPD program prior to it being reconsidered by Council. There will also be a survey of 5% of the Fellowship to determine the responses to aspects of the proposed CPD program. It is currently envisaged that the new CPD program will commence in January 2008.

CODE OF CONDUCT
This was a recommendation from the Taskforce on Professionalism. The document has been refined in the last few months and was reconsidered by Council in February. Following lengthy discussion it was decided that the document should undergo further revision and that Council will seek input from an ethicist prior to reconsideration of the redrafted code. After that comments will be sought from the Fellowship.

ANZCA FOUNDATION
It is pleasing to note that a number of Fellows have included donations to the Foundation with their annual subscriptions. The ongoing support for the Foundation is welcome and will go some of the way to bridging the huge funding gap that exists in relation to funding for anaesthesia research in Australia and New Zealand. The objectives of the foundation are:
- To increase the ANZCA funding for research
- To provide funding to promising investigators so that they can become competitive for government funding
- To provide research Fellowships for PhD and MSc students in order to foster the ‘researchers of tomorrow’
- To increase the seed funding that is available to the Clinical Trials Group in order to further

healthcare delivery.
The ANZCA 2007 Strategy was approved by Council on 9 December 2006. (The main areas covered by the strategy were outlined in the December Bulletin, pp.8-9.) College staff have begun to identify the numerous tasks that need to be completed in order to achieve the strategic objectives in the proposed timeframe.

Within the next three months several initiatives will be commenced by staff with the active participation of relevant committee and Council members and Directors of Professional Affairs (DPAs). By way of example, the following list of activities will be completed in the next three months. These follow the Implementation Plan that is being used to manage the many activities that will need to be undertaken in the course of the year:

> The iMIS database is systematically being updated to ensure that the information in our Trainee files is fully captured on the database.
> Educational grants have been awarded to successful applicants for the conduct of Clinical Skills Assessment Trials. These trials have commenced and the results will be submitted to the College by April 2008.
> Tenders for distance education materials for any one of the Clinical Modules are currently being sought. The closing date for submissions is 16 March 2007 and a decision on the successful tender will be made soon after this date. The successful tender will be required to supply the distance education materials prior to the end of this year, ready for implementation at the commencement of the 2008 training year.
> The Supervisor of Training role is being reviewed to assess the adequacy of current training materials and to ensure that Supervisors have appropriate support from the College. An important part of this is simplifying the administrative requirements of the role, and making greater use of electronic records.
> A comprehensive Communications Strategy for the College is also being developed to ensure that Fellows and Trainees are kept abreast of the changes being undertaken by the College, and that these changes are also communicated to other stakeholders and relevant external parties.
> We have also initiated a search for a policy specialist, who will be a member of staff, assisting Council and the CEO in the development of policies of strategic importance to the College. A main feature of this position will be the further development of a network of contacts among policy-makers at the state and federal levels, and at other specialist medical colleges.

The budget also provides for significant capital investment to improve the College's technical infrastructure, particularly in the areas of information technology equipment and website functionality.

BUDGET 2007
The College’s budget for 2007 was also approved by Council at its December meeting. Budgeted operating income and expenditure has increased to around $15 million for 2007. On the income side, this reflects the increase in ANZCA subscriptions, and continuing strong returns on the College’s investments. Expenditure increases are also budgeted to rise, principally as a result of new spending on technical and staff capabilities to implement the objectives of ANZCA’s 2007 Strategy. The budget also provides for significant capital investment to improve the College’s technical infrastructure, particularly in the areas of information technology equipment and website functionality. Fellows and Trainees should begin to see the benefits of this investment in their dealings with the College later in the year.

This budget was the first to be developed using a new chart of accounts that closely aligns revenue and costs with the College’s administrative structure. Monthly reporting of spending against budget will give managers feedback on the areas for which they are accountable and permit appropriate oversight by the CEO and Council. In future years budget development will be an integral part of the strategic planning process. We are also currently engaged in analysis of College spending to ensure that activities are undertaken cost-efficiently without reducing service quality.
Continuing Medical Education (CME) is an essential part of professional life for all medical specialists. Yet the effectiveness of CME can be dramatically reduced if it fails to meet the needs of the medical specialists for whom it is intended. Therefore the challenge for providers of CME is to ensure appropriate educational activities are provided in ways that will meet the needs of anaesthetists.

The first study to undertake a comprehensive survey of the CME needs of anaesthetists within Australia, New Zealand, Hong Kong, Malaysia and Singapore has recently been published in an article within Anaesthesia and Intensive Care entitled ‘Continuing medical education: A needs analysis of anaesthetists’. This research was conducted by Adam Tucker, Anne Miller, David Sweeney and Russell Jones to specifically determine the CME needs of ANZCA Fellows. Fellows from the Joint Faculty of Intensive Care Medicine and the Faculty of Pain Medicine may be interested to learn that Tucker, Miller, Sweeney and Jones also produced similar CME reports for the JFCIM and the FPM. A synopsis of some of the key results from Tucker et al pertaining to anaesthesia is presented below.

1,800 anaesthetists responded to a survey distributed to 3,156 anaesthetists throughout Australia, New Zealand, Hong Kong, Malaysia and Singapore. This represents a response rate of 57 percent. Although the majority of anaesthetists (92%) believed that their involvement in CME improved patient care, almost half of respondents either reported that they have difficulty participating in current CME activities (31%) or implementing new knowledge into their workplace (14%). Specific inhibitors to CME are summarised in Table 1.

Despite these difficulties our Fellowship is clearly motivated to engage in CME in order to learn to make better decisions and to ensure that their practice compares favourably with current best standards of care. Specific motivators are summarised in Table 2.

The distribution of skills and attributes of anaesthetists relating to learning styles indicated that flexible distance education was a feasible approach to CME for many Fellows, though face-to-face interaction was highly valued. Anaesthetists described themselves as having personal and professional organisational skills that equip them well for a variety of CME approaches. In particular, 67% felt able to follow instructions with little direct help, 95% did not require immediate feedback regarding their educational progress, 86% were prepared to try new technologies associated with CME, 72% had schedules that were at least generally predictable, and 91% were able to prioritise tasks for completion by deadlines. Anaesthetists were equally divided in their preferences to learn by ‘doing’ (tactile 42%) and those who preferred to learn by reading or viewing material (visual 42%). Interestingly, only half of respondents (52%) reported a moderate-high need for distance education which may suggest that respondents may not be entirely familiar.
The distribution of skills and attributes of anaesthetists relating to learning styles indicated that flexible distance education was a feasible approach to CME for many Fellows...

Percent of Respondents I prefer to learn by (CHOOSE AS MANY AS APPLY TO YOU):

83 Reading
75 Skills workshop e.g. hands on
72 Informal ad hoc discussions
65 e.g. tea room discussion with colleagues
56 Facilitated discussions e.g. departmental meeting
56 Tutorials with small group discussion e.g. journal club
45 Didactic presentations
39 Time working with colleagues
35 e.g. shared list or hospital attachment
31 Conducting information searches
29 Self-assessment exercises
25 Role playing sessions e.g. simulation sessions
22 Audit of practice
11 Attending clinical rounds

TABLE 3. PREFERRED LEARNING ACTIVITIES OF ANAESTHETISTS

An approach to CME that attempts to meet the preferences of anaesthetists—by providing flexible distance education—may be more effective in achieving learning outcomes. In this study, we found that the majority of anaesthetists preferred to learn through multiple modes of interaction, including reading, discussion, and hands-on activities. These methods are consistent with professional learning research, which suggests that learning is more effective when it occurs through social interaction and practical application.

References
This all started, unbeknownst to me, by one of our Melbourne daughters nominating my name for the South Australian of the Year 2006! Of course I did not get it! The first I knew was a letter some weeks later telling me that as I had been short listed in the State nominations, I was invited to be available for a photograph to be featured in the forthcoming ‘Still Inspiring’ Calendar, promoting older Australians who were still ‘contributing.

The names of the 12 were released to the media in advance and I received a phone call from ‘The Adelaide Advertiser’, was interviewed by phone and they obtained one of the photographer’s images of me.

I was subsequently interviewed at some length by a Federal Department representative and they chose the particular Calendar photograph.

All this is a result, I gather, of my continuing to work on patient safety issues part-time with Professor Bill Runciman and others in the Australian Patient Safety Foundation (APSF). I had been involved with several Australian anaesthesia colleagues in incident reporting since about 1982 but had retired from full time clinical practice in 1999. My present APSF work is in connection with applied clinical research in Healthcare incident reporting. My main focus in the APSF has been with Australian and New Zealand anaesthesia safety issues and we in APSF are just bringing to a conclusion an Australian and New Zealand College of Anaesthetists 2006 Research Project Grant Study involving incident reporting data.

(I shall retire ‘fully’ from medicine in July 2007, as I am now way past my ‘used-by’ date!).
Each year, the Australian and New Zealand College of Anaesthetists allocates $AUD 25,000 to the ANZCA Trials Group to administer a fast track pilot grant program. In 2007 five grants may be awarded up to a maximum of $AUD 5,000 each with the addition of infrastructure support from the Trials Group Research Coordinator. Such infrastructure support could include mail outs, data collection, database development, randomization or data analysis.

This grant is open to all Fellows of ANZCA, JFICM and FPM, who wish to conduct pilot research in anaesthesia, perioperative medicine, or pain medicine. The purpose of these awards is to:

- provide essential information that is necessary prior to the launch of a full study
- gather sufficient preliminary data to enable investigators to prepare for future research funding

A Pilot Study project could include pilot-phase testing of trials, collection of baseline data using surveys or establishing a network of investigators. To date the Trials Group has awarded four pilot grants. Below is a synopsis of these trials and the support provided by the Trials Group.

The Australasian Obstetric General Anaesthesia for Caesarean Section Survey. Awarded to Prof Michael Paech, King Edward Memorial Hospital for Women, Perth WA.

The project is a prospective survey designed to collect contemporary perioperative data regarding women undergoing general anaesthesia for caesarean section in Australia and New Zealand. This survey aims to provide new information about certain risks and complications and identify potential areas for research. The study will quantify the number of patients identified as difficult to intubate and approximate the incidence of failed intubation. It will also estimate the incidence of awareness in this patient group and establish baseline demographics of women undergoing general anaesthesia for caesarean section. To date the Trials Group has provided the data collection and management for the study and is assisting in the data analysis.

A pilot study into the adjuvant use of intravenous lignocaine for pain relief in those with burn injury. Awarded to Dr Alex Konstantatos, Alfred Hospital, Melbourne VIC.

The aim of this study is to document the safety and effectiveness of the adjuvant use of intravenous lignocaine for pain relief during burn wound dressing changes in patients admitted to The Alfred Hospital. It is anticipated that the administration of adjuvant lignocaine, used in combination with the current regimen (opiates with occasional combination of ketamine) will lower opioid and ketamine requirements and related complication compared to the standard regimen (alone). The pilot trial seeks to confirm in a small group of burns patients whether a regimen of lignocaine bolus and infusion (previously validated in a migraine population) can produce therapeutic levels of lignocaine in the blood. The results of this study will inform the development of a larger trial. The Trials Group has provided advice on database development, and data collection. It has also developed the randomisation for the trial and will assist in the data analysis.

RECENTLY AWARDED PILOT GRANTS

Development of an Australian Spinal Cord Injury Pain (ASCIIP) research database. Awarded to Dr Paul Wrigley and A/Prof Phil Siddall, Royal North Shore Hospital, Sydney, NSW.

The database will be designed to record spinal cord injury and pain-related information, track volunteers through research projects and identifying subjects suitable for future trials. The development of an ASCIIP database would facilitate collaborative, multicentre trials through the development of a database that can be shared across centres and enable researchers to collect a common pool of data using the same assessment tools.

Anatomical and volunteer study to investigate the accuracy of ultrasound detection of the lateral femoral cutaneous nerve (LFCN). Awarded to Dr Irene Ng, Vancouver General Hospital, BC Canada.

This study will compare the success rate of blocking the LFCN on patients using ultrasound guidance and gold standard, anatomical landmark technique. The results of this pilot study will provide information about the accuracy of identifying the LFCN with ultrasound imaging. Australian anaesthetists with an interest in performing regional anaesthesia with ultrasound guidance can utilize this technique to block the LFCN. This may allow a more accurate placement of local anaesthetic around the target nerve. A higher rate of block success and a lower complication rate may result. The intention of this project is to provide essential information for future clinical studies. It is the first description of an ultrasound-guided approach to the lateral femoral cutaneous nerve (LFCN). The data collected from this study on cadavers and volunteers will allow investigators to generate sample size estimates for future clinical trials.

For those interested in applying for a pilot grant please refer to current advertisement or please contact the ANZCA Trials Group Research coordinator Ornella Clavisi for further information.
Ross Holland was born on the 1st of December 1928 at the Royal Hospital for Women, Paddington, NSW. He was the first born to Cyril and Ailsa Holland. His early schooling was at Earlwood Primary from 1934-1936 and Erskineville Opportunity School 1937-1939. Thereafter he attended Sydney Grammar School from 1939-1944 representing the school in cricket.

After completing his medical training at the University of Sydney, graduating in 1951 in fourth place in his final year, his first appointment was to the resident medical staff of St Vincent’s Hospital Sydney for two years, 1952 and 1953. During this period he was rostered for nine of these 24 months in anaesthesia, the first three as an intern but the other six months as Senior resident whose responsibility included allocation of lists between interns and doing the more difficult cases such as ENT, neurosurgery and head and neck surgery.

At the end of this period it was Ross’ ambition to become a physician but failing to obtain the only third year post at St Vincent’s Hospital he moved to Lidcombe Hospital where he was a medical officer for four years 1954-1957. He remembers that the main attraction of Lidcombe was that the post included a house which at that time, in Sydney, was a massive incentive. In fact the Holland family with sequential additions continued to live in Lidcombe Hospital accommodation for 23 years. This harkens back to an earlier time when such accommodation was ‘far beyond what I could have afforded to purchase’. Here he almost exclusively provided anaesthetic services for several years before deciding to ‘Get serious’ about anaesthesia, realising that he had no future as a physician, and went on to prepare for the Primary. Deciding that he needed broader experience, Ross moved on to the Royal North Shore Hospital, Sydney in 1958. In fact at a time when the Fellowship training was two years, Ross and Dr Fenwick from Perth, both successfully sat the Primary in March and the second part in May of the same year. The RNSH appointment was as an anaesthetic registrar, on secondment from Lidcombe Hospital, Sydney in 1958. In fact at a time when the Fellowship training was two years, Ross and Dr Fenwick from Perth, both successfully sat the Primary in March and the second part in May of the same year. The RNSH appointment was as an anaesthetic registrar, on secondment from Lidcombe Hospital, Sydney in 1958. After gaining the Fellowship of the FARACS he took up a post as specialist anaesthetist at Lidcombe Hospital where he stayed until 1968. Ross lists his mentors as K.McLeod St Vincent’s Hospital, Jim McCulloch RNSH a future Dean of Faculty and E.H.Morgan RNSH.

Ross Holland’s Clinical Appointments
1968–1978 Senior Specialist in Charge, Anaesthesia Services, Schedule V Hospitals
1978–1987 Director, Department of Anaesthetics and Resuscitation, Westmead Hospital
1987–1988 Professor, Anesthesiology Unit, Department of Surgery, University of Hong Kong
1988–1990 Professor and Head, Department of Anaesthesia, University of Hong Kong
1990–1993 Professor and Chairman, Department of Anaesthesia and Intensive Care, University of Newcastle
1990–1993 Chairman, Department of Anaesthesia and Intensive Care, John Hunter Hospital, Newcastle and Director of Anaesthesia and Intensive Care Hunter Area Health Service.

During my Deanship the Faculty was under considerable pressure to separate from the RACS. In my judgement and that of the Board, it would have been premature at that time.

Ross Holland was the 16th Dean of the Faculty of Anaesthetists Royal Australasian College of Surgeons. He held this position from 1984-1986 following Bill Crosby and succeeded by Robin Smallwood.

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THE AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

**Appointments within Faculty of Anaesthetists**

1962–1987 NSW Regional Committee of the FARACS being Chairman 1970–1971
1976–1988 Member, Board of FARACS
1979–1984 Chairman of the Executive FARACS
1982–1984 Vice Dean FARACS
1984–1986 Dean FARACS.

Issues of particular relevance or importance that occurred in his period of leadership of the Faculty as listed by him are:

> Considerable development of Policy Documents
> Rejection of Campaign to restrict training positions
> Ability to remain separate from the NSW doctors dispute over the Medicare crisis of 1985. He believes this was a situation that could have resulted in the College losing autonomy and its position as an advisory standard setting organisation in the eyes of the Government. Ross readily admits that it was a controversial decision and difficult to remain apart from the struggles of colleagues in his home state.

> (Unsuccessful at the time) campaign for establishment of Chair of Anaesthesia in Melbourne
> Growing Influence of Faculty members at the level of the College Council of the RACS
> Excellent relations with Presidents of the RACS Mervyn Smith and Scotty McLeish

During my Deanship the Faculty was under considerable pressure to separate from the RACS. In my judgement and that of the Board, it would have been premature at that time (1985–86). Subsequent events enabled the “divorce” to occur in a much more favourable atmosphere, and at a time when majority support was unmistakeable.’

Ross married Eileen Hocking on the 14–3–53 in Sydney. They had three children: Elizabeth (Beth) 22–10–55
Susan 27–1–57
Paul 14–6–64

Qualifications

FFARACS 1959
FHKCA 1990
FANZCA 1992
1992 Orton Medal for distinguished services to Anaesthesia
1995 Vietnam Logistic and Support Medal as a member of a Civilian Surgical team headed by Mr Des Hurley from Melbourne
1945-1975 Active Service Medal

Another aspect of endeavour has been Ross’ involvement in introduction of systematic analysis, investigation and recommendations after deaths under anaesthesia. This role has consumed his thoughts and time for several decades and he is acknowledged as one of the world leaders in this field that we all now take for granted.

The Special Committee Investigating Deaths Under Anaesthesia.

This Committee was first convened in 1960 by the Minister for Health of the NSW Government. The Committee operated continuously to mid-1980, but was interrupted for three years by a medico-legal problem which threatened its confidentiality. Fortunately this was restored by legislation, and the Committee resumed its activities in mid 1983. On the retirement of Dr David Storey in 1975 until August 1987, I became the Committee’s Chairman. By then it had classified over 2,500 cases of death occurring prior to complete recovery from anaesthesia, of which 650 cases have been assessed as partly or wholly attributable to anaesthesia.

This is the largest series of such material gathered anywhere in the world, and has served as a model for similar Committees in other states of Australia and New Zealand. It is acknowledged as the most experienced body in the field, with the most accurate data, based on a reliable notification mechanism and a 92% response rate. It continues in operation under the Chairmanship of Dr Chris Borton, and I was invited to rejoin the Committee as a Member in January 1993.

I will leave the last word on Ross Holland to Ross himself who in an email to me suggested that ‘mine (career) has been one in which mediocre talent has been rewarded beyond its desserts’ I am confident that many, many would seek to disagree.

DR TERRY LOUGHNAN
The College has received a Report to the Australian Health Ministers’ Advisory Council by the Medical Specialist Advisory Committee entitled ‘Expanding Settings for Medical Specialist Training’. It is not called the ‘Training in Private’ report, but for anaesthetists that is what it is about. The full report is at www.coag.gov.au.

Background to this report includes the Phelan report of 2002, entitled ‘Medical Specialist education and training: responding to the impact of changes in Australia’s health care system’; and the Medical Specialist Training Taskforce report of 2003, which confirmed the need to provide training in settings that match the current and longer term service delivery requirements of the community – including public hospitals, private hospitals, private practices, community-based practice, rural settings and non-clinical settings.

Reasons for expanding specialist training settings provided in the newly released report include increasing training opportunities and experiences so that specialists are better prepared for actual practice; expanding training to match service delivery and community requirements; allowing for increased numbers of trainees without increasing pressure on public hospitals; and improving health care.

Key points made by the Chair (Professor John Horvath) include:

> Patient length of stay in public metropolitan teaching hospitals is decreasing, while patient acuity is increasing.
> Day surgery has altered the casemix profile within hospitals.
> Decreased pre- and post-procedural care from many acute settings, and increased ambulatory care in other settings.
> The number of places in Australian medical schools has increased dramatically, with increasing outputs from 2011.
> Council of Australian Governments has agreed that the Commonwealth and States/Territories will establish, by January 2008, a system for specialist trainees to undertake rotations through an expanded range of settings beyond traditional public teaching hospitals. This could include a range of public settings (regional, rural and ambulatory), the private sector, community settings and non-clinical (e.g., simulated learning) environments.

Recommendations include statements that ‘the expanded training arrangements should meet appropriate accreditation standards and facilitate high quality training’ and that ‘the development of expanded training settings be contingent on the States and Territories not facing a reduction in capacity for health care delivery by the public health system’.

A structured system for the administration and funding of expanded training arrangements is to be developed and implemented; an appropriate governance structure is to be established to oversee implementation of specialist training in expanded settings; and membership of the governance structure should include Governments, specialist medical colleges, trainees, and consumers.

Three Reference Groups, assisted by consultants, sought and provided information for the report. They looked at existing and potential changes to College training programs; the impact on public hospital service delivery and training capacity; and the financial implications, including workforce considerations.

Issues currently being explored further include the implications of the proposed changes for patient acceptance, patient consent, patient education, private health insurance, and medical indemnity.

During 2006, representatives of the Committee, and groups of consultants met with ANZCA staff, and with several focus groups which included Fellows, ASA Members, and ANZCA trainees. Their draft reports were provided to the College for comment, but final figures and other details quoted in their reports to the main Committee.
Recommendations include statements that “the expanded training arrangements should meet appropriate accreditation standards and facilitate high quality training” and that “the development of expanded training settings be contingent on the States and Territories not facing a reduction in capacity for health care delivery by the public health system.”

For Anaesthesia, PriceWaterhouse Coopers used two scenarios to calculate the number of extra training positions that would be required to expand training into alternative settings and still maintain the public teaching hospital workforce ‘to meet the educational imperative for training in other settings.’ The estimated increase for trainees in anaesthesia is between 127 and 140 from the quoted current number of 795. The projected increase in annual training costs to expand is given as between $20,000 and $30,000 (this does not include trainees’ fees). For all specialities, some $130 million per annum would be required.

Reference Group 1 reported on the views of stakeholders. ANZCA sources are quoted as saying that we ‘did not identify any significant educational gap for trainees within the current full training program. However it is important to note that there are significant trainee access issues for a few of the compulsory training modules – paediatric surgery, cardiac surgery and neurosurgery – which could be improved through the use of additional training settings.’

Reference Group 2 reported on projected trends in medical school intake and graduates, and in first year vocational trainee supply. Overall figures for first year specialist vocational trainee supply were an increase from some 1700 in 2006 to 2300 by 2011, an increase of 605, of which up to 8% would be first year trainees in anaesthesia.

Reference Group 3 used the CanMEDS system to define which educational goals would be achieved in what settings. ANZCA is not mentioned in the table, because the College took the view that in any given training setting – e.g., an orthopaedic operating list whether in public or private, most of the CanMEDS principles could be learnt at the same time (knowledge, skills, communication, teamwork etc.). We were not alone in this approach.

Issues to be resolved before implementation of expanded training settings were common across the colleges, and included funding, accreditation, supervision, indemnity, and transfer of trainee entitlements. Colleges in general believed that 10-20% of training could be spent outside traditional public hospital settings to satisfy curricular requirements optimally.

PROF GARRY PHILLIPS
Director of Professional Affairs

The State Coroner Victoria has written to the College advising of his finding following an investigation involving the death of a patient who had had a partial gastrectomy following diagnosis of a bleeding gastric ulcer.

Some two weeks postoperatively, during insertion of a nasojejunal feeding tube under sedation in the operating theatre, cardiac arrest occurred and resuscitation was unsuccessful.

Expert opinions to the Coroner were firstly, that this patient ‘was at an increased risk of aspiration of gastric content’, and that ‘intubation of the trachea would have reduced that risk’; secondly that ‘the decision to perform the procedure under sedation, rather than intubate the patient, is reasonable but is essentially a decision made by the anaesthetist rather than the gastroenterologist’; and thirdly that (this) ‘decision would ultimately rest with the anaesthetist....who would be expected in making the decision, to make appropriate enquiry of the circumstances, from the patient’s notes and from examination of the patient, prior to the procedure, so that the preferred technique was undertaken in each individual case’.

The Coroner’s conclusion was that ‘whether the intubation of...trachea under general anaesthetic would have altered the eventual outcome is a matter of speculation. However, what can be said is that...chances of a successful outcome would have significantly increased had the procedure been different.’

PROF GARRY PHILLIPS

PROF GARRY PHILLIPS
The recipient of the 2004 ANZCA/ASA Gilbert Troup Prize was Sarah Young. Sarah achieved the best overall performance in the anaesthesia module of the Medical School of the University of Western Australia.

Dr. Hug to receive the 2006 Distinguished Service Award of the American Society of Anesthesiologists.

The DSA is the highest recognition the ASA bestows upon an outstanding member each year. The 2006 ASA House of Delegates voted to present the 61st annual DSA to Carl C. Hug, Jr., MD, PhD, Professor of Anesthesiology, Emeritus, of Emory University School of Medicine in Atlanta, Georgia, USA.

In 1994, Dr. Hug became a Fellow by election of the Australian and New Zealand College of Anaesthetists.

The DSA is given in recognition of meritorious service in clinical practice, research and teaching in anaesthesiology. The characteristics in common for recipients are a history of service and the advancement of this specialty of medicine. The awardees exemplify the values and qualities esteemed by their peers in the ASA. It will be presented at the annual ASA meeting in San Francisco on October 15, 2007.

Successful candidates

The following 25 candidates were successful in the Overseas Trained Specialist Performance Assessment:

Sureendra Bhutra
Rajesh Brijball
Lynda D’Souza
Jeffrey Gadsden
Harald Gammelin
Volker Gerling
Mathonsi Luthe Jila
Gerhardus Labuschagne
Peter Marko
Kurichi Marudhachalam
Oscar Naar Cifuentes
Neil Alan Paterson
Vasanth Rao

William Campion Read
Simon Reginiano
Natalie Rogoff
Amar Saluja
Sanjv Sawhney
Helmut Schoengen
Jeffrey Singer
Manfred Thumm
Lucie Voldanova
Jane Walton
Iftkhar Younis
Drasko Zembic
On Saturday 25th November 2006 a Festschrift was held in Wellington, New Zealand, for Dr Steuart Henderson who retired as Director of the Department of Anaesthesia at Wellington Hospital. Following the scientific programme, which reviewed aspects of his outstanding career his contributions to anaesthesia, a most successful Retirement Dinner was held at the Icon Restaurant of Te Papa Museum on the Wellington Waterfront.

Dr Henderson was presented with a number of special gifts at the Dinner – a Pashmina (Kashmiri shawl) and a Solomon Islands tafulai given by the first ANZCA Fellow from the Solomon Islands (Dr Narko Tútuo) who had trained with Dr Henderson in the Wellington Department. He was also presented with a stunningly beautiful Greenstone bowl by Bill Matheson, one of New Zealand’s leading greenstone carvers, which was set on an equally beautiful carved base of maire wood all set in an enclosing rimu wooden box. Many colleagues and friends from Australia and New Zealand were in attendance and ANZCA President Dr Wally Thompson reflected on Steuart’s many years of involvement with the College as councillor.
The practice of EBM has four key steps:
(i) ask a clinically important question,
(ii) search the literature, (iii) evaluate the published evidence, and (iv) apply the results to your clinical practice. Most of us are confronted with clinical questions on a daily basis – should I use a total intravenous or volatile anaesthetic technique, should I intubate this patient, should I use a regional technique, should I insert a central line (and how should I do it), does this patient require antibiotic prophylaxis, are beta-blockers indicated (or contraindicated), should I give an antiemetic before emergence from anaesthesia?

Most anaesthetists rely upon their own training and experience to tackle such questions, or ask a respected colleague, but these approaches presume up-to-date knowledge of effective treatments and there is no sure way of knowing when or if this is accurate. Searching for the right answers has been made easier with ready access to the internet. Pubmed (US National Library of Medicine) is a user-friendly website that can be readily accessed, even in the operating theatre. Relevant abstracts of articles can be used to answer some clinical questions, and if more detail or greater critical evaluation is required then the full manuscript can be electronically accessed from most hospital libraries (or the ANZCA website). Some training is required to evaluate study methods and statistical techniques in order to identify unreliable studies – those with bias - but regular application of such training will develop these skills. Critical appraisal of the literature should be considered an essential skill for all medical specialists.

The introduction of EBM into clinical practice has encouraged the design and conduct of better quality studies, with greater attention to minimising sources of bias. For example, the importance of random allocation to treatment groups, sample size calculation to avoid type II error (false negative results), focusing on a primary endpoint that is clinically important, blinded assessments of outcome, and avoidance of sub-group or multiple comparisons have become standard criteria for high-level evidence of effectiveness. Failure to include or report these features are useful markers of unreliable studies.

There are, now, numerous good quality clinical trials to guide our daily clinical practice (see Inset). Many anaesthetic interventions are unproven, or have been demonstrated to be ineffective or cause net harm. If we can accept that patient safety is paramount then we should actively seek to include proven therapies in our practice, and to not include those that are harmful, unproven or where costs outweigh benefits.

Evidence-based medicine (EBM) is now established in medical teaching and continues to permeate clinical practice. EBM practices are preferentially supported by health policy developers and providers of funding. It’s explicit aim of identifying effective therapies based on objective reproducible criteria is inherently appealing. Nevertheless most patients are satisfied with their doctor’s opinion, but even this probably underpinned by an expectation that their care is the latest and best on offer. So, are anaesthetists providing evidence-based care in their routine practice?

The introduction of EBM into clinical practice has encouraged the design and conduct of better quality studies, with greater attention to minimising sources of bias.

PROF PAUL MYLES

It’s Time for Evidence-based Anaesthesia

Quality and Safety Committee Report

THE ANZCA BULLETIN MARCH ISSUE 2007

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Evidence-based Practice in Anaesthesia and Intensive Care

- Maintenance of normothermia prevents surgical site infection after abdominal surgery
- Avoidance of nitrous oxide decreases postoperative nausea and vomiting
- Patients at increased risk of postoperative nausea and vomiting should receive at least two prophylactic antiemetics
- Supplemental oxygen (FiO2 >0.8) reduces wound infection after colorectal surgery
- Low-dose aspirin reduces thromboembolism after hip surgery
- In patients with acute lung injury or acute respiratory distress syndrome, mechanical ventilation with a lower tidal volume decreases mortality
- Intensive insulin therapy for hyperglycaemia reduces mortality and major morbidity in critically ill surgical patients
- There is no evidence that combined GA and regional block reduces mortality or major morbidity in high-risk patients undergoing major abdominal surgery
- Perioperative beta-blockade may reduce postoperative myocardial infarction and death in patients with coronary artery disease, but further studies are needed
- Routine postoperative nasogastric drainage is not indicated in abdominal surgery
- Central venous cannulation should be done with chlorhexidine antisepsis, and ultrasound guidance; the preferred site is the subclavian vein.

Unravelling and Embolisation of Guide-wires with PICC lines

A recent case report is an example of the need for continued review of Therapeutic Goods Administration (TGA) warnings and demonstrates deficiencies with the process of system improvement after previous warnings. In November 2002, the TGA alerted the medical community of potentially serious adverse events when Peripherally Inserted Central (venous) Catheters (PICC) are trimmed at the time of insertion. Several reports from Australia and New Zealand included instances where the guide-wire had been cut and then unraveled. This can result in a portion of the wire embolising and remaining in the circulation, causing occlusion of major vessels and the need for surgical intervention for retrieval.

The most recent report was with a small 3 French PICC line which was trimmed at insertion, as per the manufacturer’s instructions, but still resulted in an intracardiac embolus of a portion of wire which was not picked up until several days later by X-ray. Two problems are worthy of note here. Firstly, there is no obligation by manufacturers to include on their products a warning label once the TGA has issued such a warning. This may result in further incidents many months later if the user is unaware of the potential risks. In fact, the TGA had to issue a second warning in 2005 as the complication was still occurring! In 2006 it appears we still have a problem.

Secondly, the manufacturers’ recommendations are often inadequate and on this occasion state to ‘trim with caution’ instead of ‘DO NOT TRIM THE GUIDE-WIRE’ which would be the more appropriate recommendation. If cutting the catheter is absolutely necessary the guide-wire must not be cut and should be pulled back first.

For more information on this potentially serious complication of PICC lines visit the TGA website at www.tga.gov.au/docs/html/tganews/news39

DR PHILIP RAGG

The Quality and Safety Committee would welcome feedback from Fellows as to the usefulness of this dedicated section in the College Bulletin. This section was instituted to promote communication on all issues concerning quality and safety and to encourage interaction between the College Council and all Fellows. To date most of the contributions to this section have come from Victoria. For it to be maintained it is essential that there should be contributions from anesthetists from other States and New Zealand. Contributions may be results of hospital or personal audits, unusual events, safety alerts, new initiatives in promoting safety and recommendations for relevant references or web sites.

Please respond by emailing me at patmack@bigpond.net.au as material is needed for the June issue of the Bulletin

DR PATRICIA MACKAY
Co-ordinator
The following services are offered to all Fellows and Trainees of the College, the Joint Faculty of Intensive Care Medicine and the Faculty of Pain Medicine.

- Loan of books, videos and DVDs
- Supply of journal articles
- Literature searches

ONLINE JOURNALS
To access online journals go to:
A website username and password is required to access the online journals.
To apply for a website username and password go to:

CONTACT THE LIBRARIAN
Library Tel. (03) 8517 5305
Library Fax. (03) 8517 5381
Email: libanzca@anzca.edu.au

NOTICE TO NEW ZEALAND FELLOWS AND TRAINEES
Contact details for the New Zealand office are as follows:

New Zealand National Committee (ANZCA)
PO Box 7451
Wellington South
New Zealand
Tel. (04) 385 8556
Fax. (04) 385 3950
Email: anzca@anzca.org.nz

New additions to the College library

NEW BOOKS

POPULAR BOOKS
Hugh James Clarkson was a very significant figure in New Zealand anaesthesia: consultant anaesthetist in Hamilton from 1966 to 2005 just a few months before his death; supervisor of training, Waikato Hospital; president, New Zealand Society of Anaesthetists; chairman, New Zealand Committee of FARACS (now ANZCA); chairman, Braemar Hospital Trust.

These bare facts almost conceal the extent of Hugh’s influence on those around him, the extent of his interests and expertise. Though anaesthesia occupied more time than anything else in his long professional life, it was but one of many consuming interests.

He can be seen as a late 20th century Renaissance man: someone who with remarkable energy pursued the explosive expansion of knowledge in medicine (and anaesthesia in particular), science, and technology and both the new and the old ideas in arts and music. He enjoyed the sense of discovery. His great excitement and enthusiasm for so much enabled him to accumulate a huge knowledge in so many fields – as diverse as Riley cars and Russian music; all this with great humility and a sense of fun. His last paper presented to Journal Club investigated the physics of why dropped toast nearly always landed butter side down!

Yet he had a deep respect for and knowledge of history. For Hugh, history was not just a study of the past but a means of keeping the present in perspective. This was particularly so in anaesthesia. He brought to his colleagues and trainees the infectious excitement of the great advances in anaesthesia he encountered in Melbourne in the 1960s, but he taught in the context of the history of the specialty.

One of his goals was to re-invigorate Braemar Private Hospital, and bring it up to the highest standard of practice and with first-class equipment. Braemar grew to be the largest private hospital in the central North Island providing an extensive range of medical and surgical services, including cardiac.

In doing this, he developed the collegial environment of ‘the Braemar Family’, of which he was clearly the ‘father’. The Braemar Family was not just a family of anaesthetists, but of all who worked there. Hugh found it easy to foster a supportive collegial environment which is essential for safe and effective specialist practice. His was an engaging and gentle personality, he abhorred conflict, he spoke only well of people. He assumed the best in people. That was what he found in them.

One of his most endearing characteristics was his deep absorption in people. Those to whom he spoke, or who needed his advice, had the feeling that his whole attention was focused on them, that this encounter was of the utmost importance. This was entirely sincere, not an act. Hugh was incapable of hollow insincerity. His human relationships were founded on humility and boundless respect. Perhaps, despite his busy anaesthetic practice, his lifelong small general practice was perpetuated by this consuming interest in people. He claimed that this helped to keep his feet firmly on the ground.

Hugh brought an essentially civilised dimension to anaesthesia at a time when the speciality was rapidly expanding. He maintained a sense of proportion. His focus was on the patient first, next the collegial environment, then science, and lastly technology. He brought these aspects together to provide a comfortable and safe atmosphere. In his relationship with his patients, he engendered confidence through both his humane sympathy – his empathy, his quick understanding of individual needs and apprehensions, and his underlying professionalism.

He regretted the growing emphasis on technology, super-speciality and clinical progress which could be inflicted on patients whatever the cost, at the expense of the human side of the patient–doctor relationship. He felt that to some extent, the profession had lost its way and that we should reflect on the balance between progress and our holistic responsibilities as doctors.

Yet technology never frightened Hugh – it fascinated him enormously. He always maintained a sense of proportion in the application of technology and of interventional anaesthesia.

His life was founded on his strong but questing Christian faith, his great love for Mary, and his joy in his family. The relentless time demands of his professional life failed to shake this foundation.
Jeanne Collison, AO Medical Pioneer
8-4-1929 – 13-5-2006

Anaesthetist led way with heart-lung machine

Jeanne Collison, described by her Australian and New Zealand peers as the ‘grand dame of cardiac anaesthesia’ after she developed the first heart-lung machine in this part of the world at The Alfred Hospital in Melbourne in 1957, died of thyroid cancer at her home in Salamander Bay, north of Sydney. She was 77.

Collison built a workable unit in 10 days from a rough sketch of an American design sent to her by a colleague, and then experimented on animals before leading a team of seven male doctors in the first successful open-heart surgery in the southern hemisphere. She was 27, and the operation was performed on a small girl with a ‘hole in the heart’.

‘Please don’t play up my part,’ Collison, who is pictured with the machine, told a journalist at the time. ‘Rather, say as much as you can about this machine, which offers such new hope to all those suffering from heart complaints.’

Dr Robert Orton, the director of anaesthesia and resuscitation at the Alfred, said: ‘The success of the operations was not due so much to the machine as to Dr Collison’s detailed knowledge of physiology and the way she would drive to get things done.’

Intrigued by the world’s first successful open-heart surgery by Norm Shumway and Walton Lilliehi in Minneapolis in May 1955, Collison joined the cardiac research team at the Baker Institute, Melbourne, in 1956. This led to her building the first heart-lung machine at The Alfred the following year. Earlier, in 1954, Collison and Helen Windon were the first female trainee anaesthetists appointed at Royal Prince Alfred Hospital in Sydney.

Her doctor husband, Neville York, an RAAF Dakota pilot in World War II whom she married in 1955, recalled how she built the heart-lung machine: ‘She rummaged around the back rooms of Melbourne food and beverage factories for components to construct a similar machine (to the US drawing). PVC tubing of various diameters had to be obtained.’

Her success became legendary in Australian medical circles. The History of the Cardiac Society of Australia and New Zealand refers to Collison as the ‘grand dame of cardiac anaesthesia,’ and she was still receiving thanks at the time of her death. A letter in the week of her funeral said: ‘Thank you for looking after our seven-year-old son with the heart defect. He is now 48 and has never looked back.’

Years before, after a cardiac procedure, Sir Frank Packer had sent a huge floral arrangement, with a card that read: ‘Dear Doctor, I enjoyed sleeping with you.’

Collison was born in Mosman in Sydney to Albert and Beatrice; her father was a master builder and neither parent had benefited from secondary school education. At high school the headmistress advised her not to bother with medicine because she would never make the grade.

She obtained a diploma in music while still at school and played the pipe organ at North Sydney Baptist Church at 16. She studied medicine at Sydney University, and was resident medical officer at Royal Prince Alfred Hospital, Sydney, while her husband-to-be was resident medical officer at Royal Melbourne.

Collison graduated with honours in 1952. Colleagues remember her knitting during lectures instead of taking notes. ‘Why bother?’ she would say. ‘It’s all in the textbooks.’

Her husband added: ‘I never understood how she could study Gray’s Anatomy while basking on Bondi Beach.’

Collison returned to Sydney from Melbourne in 1957 and set up a cardiopulmonary bypass department at RPA, working there for 20 years. She organised another, at Westmead, also in Sydney, in 1978.

In 1965, she and her husband spent a year overseas, visiting heart surgery pioneers John Kirklin at the Mayo Clinic, Michael De Bakey and Denton Cooley in Houston, Texas, and others in Europe.

Collison taught and inspired generations of young doctors in anaesthesia, winning the respect and affection of peers, patients and theatre staff alike.

Dr Alan Skyring pointed out at her funeral that hospital and health administrators had little enthusiasm for the work Collison was doing in the 1950s, regarding it as terribly expensive. What’s more, few women did medicine and very few entered specialist areas. ‘The wider Australian community owes her a further debt of gratitude,’ he said. ‘She didn’t give speeches, write books or burn her bra, but she and a small group of women like her, helped to make it possible for subsequent generations of women to take their rightful place in the professions, commerce and industry.’

Professor Ross Holland said: ‘Of all the hands-on clinical specialties, anaesthesia has a higher proportion of women in its ranks, many of outstanding quality. None has been more distinguished than Jeanne Collison.’

The success of RPA’s open-heart program, he said, was due largely to her.

Collison and York’s marriage began a 50-year personal and professional partnership of immense happiness, marred only by the accidental death of their only child, Simon, at 18.

Collison maintained her musical skills until arthritis intervened. She loved fishing, sailing and waterskiing, was skilled with needlework and knitting, and in retirement took up bridge with her typical pursuit of excellence. She obtained her private pilot’s licence in midlife.

Collison was invested as an officer in the Order of Australia eight days before she died.

Tony Stephens is a senior Sydney Morning Herald writer
DEATH OF FELLOWS
Council noted with regret the death of the following Fellows:
> Dr Philip David Sturrock (Vic) – FFARACS 1978, FANZCA 1992
> Dr Hugh James Clarkson (NZ) – FFARACS 1965, FANZCA 1992
> Dr Elisabeth Jane Avraamides (WA) – FANZCA 1996
> Dr Ian Matheson Steven, AO (SA) – FFARACS 1967, FANZCA 1992

HONOURS, APPOINTMENTS AND HIGHER DEGREES
Council noted the following:
> Prof Michael Paech (WA) – conferral of Honorary Fellowship, Royal Australian and New Zealand College of Obstetricians and Gynaecologists
> Prof Michael Cousins (NSW) – receipt of the Pugh Award, Australian Society of Anaesthetists
> Dr James Bradley (Qld) – award of Honorary Life Membership Australian Society of Anaesthetists
> Dr Stuart Henderson (NZ) – award of Honorary Life Membership New Zealand Society of Anaesthetists
> Dr Anthony Newson (NZ) – award of Honorary Life Membership New Zealand Society of Anaesthetists
> Dr Annette Turley (NZ) – award of Honorary Life Membership New Zealand Society of Anaesthetists

EDUCATION AND TRAINING
Enforcing College policy on submission of trainee documentation
In an effort to ensure that accurate trainee data are retained by the College, Council resolved that if a trainee fails, without reasonable excuse, to lodge the relevant training form within three calendar months of completion of each training year (BTY1 etc), the trainee is ineligible to have further training time recognised until the form is received. Loss of eligibility will be from the date that the form was due until the date that the form is received by the College.
This regulation will be effective from May 1st 2007.

Recognition of Auckland University Postgraduate Diploma and Medical Sciences/Diving and Hyperbaric Medicine Program
Council supported an application from the University of Auckland, to have its Post Graduate Diploma in Medical Science – Diving and Hyperbaric Medicine recognised as a pathway towards the ANZCA Certificate in Diving and Hyperbaric Medicine.

Educational Resources
Council supported the development of ANZCA training modules into flexible delivery modes. The College will call for tenders for the development of educational materials to support learning towards the completion of one of the clinical modules of the FANZCA program. One tender will be selected initially, as a pilot for further such development in the future.

Education Assessment Tools Grant Applications
The following applications were supported by Council:
1. Feasibility, reliability, validity and acceptability of the mini-CEX assessment process during the anaesthesia training process. Faculty of Medical and Health Sciences, University of Auckland. A$31,370
2. An investigation of the efficacy of DOPS for anaesthetic trainees. Departments of Anaesthesia, Royal Melbourne Hospital and Royal North Shore Hospital, Australia, and Department of Psychological Medicine, Monash University. A$37,994.64
3. ‘All in a day’s work’ Training ANZCA Fellows to use ANTS effectively in an 8-hour program. Department of Anaesthesia, Sir Charles Gairdner Hospital. A$14,110

Introduction to Anaesthesia Course Sydney, February 2007
Council supported this course on non-clinical issues related to a career in anaesthesia as a worthwhile initiative as part of the introduction to anaesthesia. It was noted that the course would include involvement from the Black Dog Institute.

EXAMINATIONS
The following changes have been made to the Final Examination from 2008:
> Timing of the vivas is to be split to enable the medical clinical examination to be convened on a weekend, at sites where the written examination is undertaken.
Restructuring of the Primary Examination is under consideration through the General Examinations Committee.

CONTINUING EDUCATION AND QUALITY ASSURANCE

Annual Scientific Meetings
Tenders are being called for the Professional Conference Organiser for the 2009 ASM in Cairns, with a closing date of the end of January 2007.
The 2010 ASM will be held in Christchurch, and Hong Kong will be the venue for the 2011 Meeting.

Continuing Professional Development Program
Council approved the revised process, to replace the original MOPS Program. It was considered that the revision provides greater flexibility through its more generic nature, and acts as a template for specialists to build on their own continuing learning.

INTERNAL AFFAIRS

Regulations
The following Regulations have undergone review:
> Regulation 2.16 – Research Committee
The membership was revised to include a community representative, and the Chair of the ANZCA Trials Group Executive.
> Regulations 14 and 15 – Examinations and Training
> Regulation 20 – Lennard Travers Professorship
> Regulation 21 – Douglas Joseph Professorship
The deadline for receipt of submissions for both Professorships was amended to 1st March.

ANZCA Foundation
The corporate launch of the ANZCA Foundation has been confirmed for Thursday 12th April, and will be undertaken by the Governor of Victoria, His Excellency Dr David de Kretser.

Regional/NZ Committee Accommodation
The sale of the College’s equity in the Queensland property has been completed. Temporary leased accommodation is in place and the search for long-term accommodation continues. Discussion has taken place with the RACS’ CEO on ANZCA selling its 32.5% equity in ‘Elliott House’ in Wellington.

PROFESSIONAL

Professional Documents
The following documents have undergone the normal review process and were approved by Council:
> TE6 – Guidelines on the Duties of an Anaesthetist
> PS2 – Statement on Credentialling in Anaesthesia
> PS19 – Recommendations on Monitored Care by an Anaesthetist
> PS20 – Recommendations on Responsibilities of the Anaesthetist in the Post-Anaesthesia Period
> PS44 – Guidelines to Fellows Acting on Appointments Committees for Senior Staff in Anaesthesia
TE14 – Policy for the In-Training Assessment of Trainees in Anaesthesia, was also accepted, but its promulgation was deferred until a Regulation referred to within the document is finalised at the February Council meeting.

Withdrawal of Document
The following document was withdrawn:
> PS14 – Guidelines for the Conduct of Major Regional Analgesia in Obstetrics
It was considered that the content of this document is covered in PS3 – Guidelines for the Management of Major Regional Analgesia, which contains a section titled: Specific Principles for Epidural Analgesia in Obstetrics, and the Joint Document on Obstetric Anaesthesia. Its withdrawal was supported by Council.

RACS Correct Site and Correct Side Guidelines
Council emphasised the importance of the anaesthetist being part of this as a team activity, and confirmed that all checks should be undertaken before the patient is anaesthetised.

RANZCOG/ANZCA/RACGP/ACRRM Position Statement on the Provision of Obstetric Anaesthesia and Analgesia Services
Council approved the latest draft of this document. It was hoped that the Statement would be formally promulgated in the near future.

Sedation for Endoscopy
Council agreed that should the GE Society wish an earlier review of the joint ANZCA/GESA/RACS documents, the College would participate. The issue of training in the area of anaesthesia for endoscopy will be considered by Council in February.

RESEARCH

Three $20,000 grants have been established for the Novice Investigator Scheme.
Documentation for the adjudication process has been revised to ensure more feedback is received from researchers about their work and how the grants have been expended.
A Community Representative has been appointed to the Research Committee.

DR WALTER R THOMPSON
President

DR LEONA WILSON
Vice President
DEATH OF FELLOWS

HONOURS, APPOINTMENTS AND HIGHER DEGREES
Dr Carl C Hug Jr (USA) is the recipient of the 2006 Distinguished Service Award of the American Society of Anesthesiologists. This will be awarded at the American Society Meeting in San Francisco October 2007.

ELECTION OF PRESIDENT
Dr Walter Thompson was re-elected as President for the period May 2007 to May 2008.

EDUCATION AND TRAINING
Training Agreements
Formal approval of the documentation will be undertaken at the April Council Meeting.

CONTINUING EDUCATION AND QUALITY ASSURANCE
2009 ASM Cairns
ICMS Australasia Pty Ltd has been appointed as the PCO for the 2009 ASM in Cairns.

College Visitors
Council resolved the following with regard to regional/NZ visits:
> That the 2008 Foundation Visitor, Prof Steven Shafer visit Tasmania.
> That the 2008 Australasian Visitor, Prof Mike Paech visit SA/NT.
> That the 2009 Foundation Visitor visit New Zealand.
> That the 2010 Foundation Visitor visit NSW/ACT.
> That the 2011 Foundation Visitor visit SA/NT.

ANZCA Continuing Professional Development (CPD) Program
A randomised survey of Fellows is to be undertaken to seek feedback on the proposed CPD Program.

Mandatory Clinical Indicators
Council’s view was sought on the concept of the ACHS introducing a set of mandatory Clinical Indicators. Council generally did not support implementing mandatory Clinical Indicators, noting that they had originally been introduced for self-review purposes.

2007 New Fellows’ Conference: Bettering Interaction with Trainees
The anaesthesia representatives to the NFC are as follows:
Mark Adams, Vic
Christopher Bain, Vic
Catherine Cakhwell, NZ
Julia Coldrey, SA/NT
David Duke, ACT
Nicole Fairweather, Qld
Lia Freestone, Tas
Harald Gammelin, Qld
Mohua Jain, NZ
Elaine Lee, ACT
Lee Eng Kiang, Sing
Forbes McGain, Vic
Allan Millard, WA
Linda Partridge, SA/NT
Prani Shrivastava, WA
Natalie Smith, NSW
Paul Wrigley, NSW
Andrea Lin Yau Yu, HK
Sui Cheung Yu, HK
Dr Frank Moloney was appointed Councillor in Residence to the conference.

INTERNAL AFFAIRS
Review of ANZCA Constitution
Following input from the College’s Honorary Solicitor, the revised Constitution will be put to a postal vote of Fellows.

New Regulation 33 – Trainee Performance Review
Council approved the promulgation of this new Regulation, but agreed to defer its publication until the April Council Meeting to enable development of procedures, and reporting and assessment processes.

Joint Consultative Committee on Anaesthesia (JCCA)
The following JCCA Policy Documents were endorsed by Council:
> Guidelines for GP Supervisors/Mentors of Advanced Rural Skills Training Posts in Anaesthesia
> Terms of Reference – Joint Consultative Committee on Anaesthesia.
> Guidelines on the Treatment – of Morbidly Obese Patients by GP Anaesthetists
> Recommendations on Hospital Attachments for Assessment, Upskilling, and Practice Re-entry for GP Anaesthetists
rotational training schemes may be accredited for an initial period of two years, and must then become part of a rotation within twelve months. HAC and the relevant Regional/National Committee will assist in this matter.

If hospitals have not succeeded in joining a rotation within twelve months, then accreditation will be withdrawn at the end of two years.

As a result of the recommendation being withdrawn, the current policy is confirmed, which is: ‘That all hospitals should be part of a rotational training scheme’.

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DR WALTER R THOMPSON
President
DR LEONA WILSON
Vice President

PROFESSIONAL

Professional Documents
After the normal process of review, Council approved the following documents:
> PS12 – Statement on Smoking as Related to the Perioperative Period.

Draft Position Statement on Sedation
A working group comprising Profs Phillips, Baker and Merry, A/Prof Leslie, and Drs Orr and Moloney agreed to pursue this matter and provide an update to the April Council meeting.

Queensland Health – The Alert Doctors Strategy Project
Queensland Health is working with the University of South Australia’s Centre for Sleep research to implement an evidence-based fatigue risk management framework for doctors. Council expressed support for this initiative.

ANAESTHESIA CONTINUING EDUCATION CO-ORDINATING COMMITTEE (ACECC)
Special Interest Groups – Trauma and Airway Management
Council approved the formation of Special Interest Groups in Trauma and Airway Management, with ANZCA as the parent secretariat provider.

COLLEGE AWARDS AND ELECTION
Admission to Fellowship by Election
Following the result of a secret ballot, Dr Michael Barrowcliffe (Vic) was elected to Fellowship under Regulation 6.3.1(b).

HOSPITAL ACCREDITATION COMMITTEE
Approval of Hospitals outside Rotational Training Schemes
Council withdrew the following recommendation passed by HAC in April of last year: ‘That hospitals outside of
As well as providing anaesthetic services, anaesthetists lead the pre-admission process, organise the flow of cases in the operating suite, co-ordinate care for major trauma victims, and participate in patient care post-operatively.

Photos: The Royal Melbourne Hospital
The Kind Cuts for Kids Foundation was established to facilitate the efforts of paediatric surgeons, anaesthetists and nurses improve surgical services to children in developing countries.

The Kind Cuts for Kids Foundation was established to facilitate the efforts of paediatric surgeons, anaesthetists and nurses improve surgical services to children in developing countries.

The Foundation mission is to ‘advance medical and nursing techniques in Paediatric Surgery and Anaesthesia by education and demonstration, in collaboration with Paediatric Health Professionals throughout the developing world. The aim is to evolve sustainable programs of improved care for children with surgical disease. The concept of Kind Cuts for Kids was first developed as a subcommittee of the Australasian Association of Paediatric Surgeons, to mirror the success of Interplast and Orthopaedic outreach, and followed on the inclusion of Paediatric Surgery in work by the International Federation of Surgical Colleges and the Royal Australasian College of Surgeons. The Foundation was established to assist with the funding and organisational aspects of the work.

Surgeons and anaesthetists from all over Australia and New Zealand have participated in visits to a wide range of countries, including Mongolia, Bangladesh, Vietnam, China, Cuba, Gaza, Mauritius, Sri Lanka, Thailand, Indonesia, Solomon Islands and Papua New Guinea. The anaesthetists have provided manpower support for the trips and have assisted with the teaching of local trainees, particularly in skills required for the management of the neonate, regional anaesthesia and pain management.
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Funding support has been obtained from various services clubs, donations of medical supplies from hospitals and companies, plus funds from the International Federation of Surgical Colleges, ROMAC, Care International, Children First Foundation, and the Variety Club, Rotary of Mannigham and Coburg, the governments of Cuba and Mauritius, and the Society for Children Inoperable in Mauritius. The Foundation has recently launched its revamped website and is to hold a major fund raising event, hosted by the Raddison Hotel in Melbourne on 28th April.

The last trip for 2005-06 was to Mauritius, when Professor Paddy Dewan, Dr Ken Brownhill (Anaesthetist) and Nurse Caron Oakley all made a return visit to the Jeetoo Hospital in Port Louis. In total 110 patients were reviewed, having been extensively screened prior to the visit by Dr Hosany Nazeer and Dr Fakim. Fifty-nine operations were performed on 43 patients during the visit, once again involving close contact with the Ministry of Health and Well-being, and the staff of a number of hospitals. The plan to extend the mission to Madagascar was started during this visit.

Overall 159 operations were performed on 107 patients in the 12 months, with a total of 249 children having been seen by the teams. It should be remembered that most of those treated had complex anomalies and prolonged surgery.

The end of 2006 included a trip to both Mauritius and Gaza, when a further 176 children were seen and 99 children underwent 147 surgical procedures.

In 2007 plans are being developed for visits to Cuba, Mauritius, Madagascar, and Sri Lanka, and it is anticipated that further funding will be available to assist other projects with fund raising efforts such as a Gala Dinner Dance in Melbourne on 28th April.

Further information can be found on the website: www.kindcutsforkids.net or via the Secretary Maggie Hammerton: mhamm73@bigpond.net.au

Those wishing to be assist as anaesthetists on training visits can contact Dr Ken Brownhill, Department of Anaesthesia, Western Hospital, Footscray (03 8345 1333)
A number of interesting Museum activities are planned for this year’s ANZCA Annual Scientific Meeting. The ASM will be taking place in Melbourne, which has provided a great opportunity to showcase the Museum and its plans for the future.

The activities include: A joint Museum and Library display, located at the ASM venue, the Melbourne Exhibition and Convention Centre; a Museum Tour on the afternoon of Friday 25 May, as part of the ANZCA Open Afternoon and the launch of the new Museum Display on Monday 28 May, following the History of Anaesthesia and Resuscitation SIG Workshop which will be held at the College.

A variety of items including a Hellige Hemometer in its original box.
Donated by Mr S Ziccone, Victoria

Hemometers were used to analyze haemoglobin levels.

Donated by Dr K Lewis, Queensland.

Left, centre and right: A Hellige Hemometer in its original box.
Donated by Mr S Ziccone, Victoria

RECENT DONATIONS

A selection of plastic Airways in their original packaging.
Donated by Dr R. Haridas, Victoria.

Penhalor in its original box with mask and User’s Manual.
Donated by Dr K. Lewis, Queensland.

Visits to the Museum are welcome and can be made by arranging an appointment with the Museum Manager. All bookings and enquiries regarding the Museum should be directed to, Ms Elizabeth Triarico, on: (61 3) 9510 6299 or museum@anzca.edu.au
Dean’s Message

Dr Richard Lee

ICU development: Lamarck, Darwin or self-determination?

While recently discussing innovations with a prominent member of the Royal Australasian College of Surgeons (RACS), he spoke of moves within that College to ensure risk reduction and quality improvement. He highlighted the movement to cohesive and collegial group practice that RACS is promoting and the components of this practice that are seen to be beneficial. They include:

- Identification with the group
- Trust within the group
- Strong leadership
- Effective and comprehensive handover
- Fair and equitable remuneration

These may be new and challenging concepts for surgeons but it is apparent that these elements occur within good ICU practice and healthy ICU training environments around Australia, New Zealand and Hong Kong. It is also apparent that we should not dilute what has helped to make us strong when others are recognising its importance.

Intensivists bringing diverse talents to their units and working collegially in groups have strengthened Intensive Care Medicine. These groups produce a balanced mix of research, rigorous training, academic achievement, data accumulation and financial rewards. The importance of that balance is not underestimated. Therefore, in the macro-environment, ANZICS and JFICM are finalising a Cooperation Agreement, based on mutual recognition and respect, to maximise the quality of the input to each of these fields of endeavour and avoid duplication of efforts.

In the micro-environment of the ICU, JFICM is worried that it is easy to disturb the balance and varied external forces may perturb a once cohesive and effective training environment, splintering the intensivists into itinerant gypsies without commitment to a particular unit or program. For example, it is possible for ‘non-clinical’ activities to be devalued by the seductions of private practice or a hospital management’s desire for service provision within ICU and extramurally. The Hospital Accreditation Committee (HAC) will therefore continue to demand high standards of supervision and teaching in the training environment. The Royal Adelaide Hospital has lost its accreditation from the 2008 academic year, yet it is encouraging to observe the efforts that management and staff are putting into restoring standards of training to ensure re-accreditation for 2008.

Typical of early, effective intensive care group members was Dr Ron Trubuhovich, who was one of the pioneers of ICM in New Zealand and who brought intensivists together via his work as President of ANZICS and Vice-Dean of the Faculty of Intensive Care. We are honouring Ron at this year’s ASM as one of the giants on whose shoulders JFICM stands. It is hoped that he will also deliver the oration on that occasion when David Ernest leaves the Board after extensive contributions to the specialty as Education Officer, Project Assessor, JSAC member and Coordinator of Advanced Training.

So we come to the title: ‘Lamarck, Darwin...?’. Lamarck was convinced that transmutation or change in the nature of a species occurred over time under the influence of the external environment. Darwin proposed natural selection. I suggest self-determination. We as a specialty must decide whether development of ICM practice and training will be left to external forces, survival of the fittest or whether the specialty determines its own future.

Members of the Board and Council conferred recently with the President, Vice-President and CEO of ANZCA to address several concerns. The discussions were amicable and clarified that JFICM will not move from Ulimaroa in the short term, and that JFICM funds will remain identified and available to a future separate College of Intensive Care Medicine. A review of cost sharing is planned and will be agreed by Board and Council later in the year.

The specialty is strong through the contribution over many years of the training program, ANZICS, the CTC, the APDMC, PRICE and the academic achievements of individuals. We need to work to our strengths and not rest on our laurels.

Without maintaining our group commitment, geographical, emotional and philosophical to our hospitals, our units, our patients and our trainees the specialty will lose its heart and soul. The lessons of the past will be lost in the clouds of change. We must not be distracted from the concept that, if we keep our house in order, aim for excellence, update methods of assessment and curriculum, maintain best practice in all areas, we will remain strong.
HONOURS AND APPOINTMENTS
The Board noted the following:

> A/Professor G.A. Skowronski has been awarded the John Sands Medal for his outstanding contribution to RACP affairs. The Citation is reproduced separately in this edition.
> Professor B. Venkatesh appointed Professor, University of Queensland
> Associate Professor R. Nagappan, appointed Clinical Associate Professor, Monash University
> Professor A.J. Bell, appointed Clinical Professor, University of Tasmania, Faculty of Health Science, School of Medicine

EDUCATION AND TRAINING

Intensive Care Primary Examination – structure
The Board approved a set of Notes for Candidates sitting the new JFICM Primary Examination, along with a Mock Exam document. (See separate article in this edition.)

Fellowship Examinations April/May 2007
A record number of candidates for this Examination was noted. The format of the Examination may change in 2008 to accommodate the growing number of candidates. Venues for the 2007 Examinations are Sydney (April/May) and Perth (August/October).

Conjoint JFICM and ACEM Training
The Board noted approval of Regulations by ACEM Council which outline the joint training requirements for trainees undertaking dual intensive care and emergency medicine training. These are available at http://www.acem.org.au/media/regulations/04a_-_Joint_Training_Programs.pdf

Review of In-Training Assessment Forms
The Board approved revised in-training assessment forms for each component of training. Separate forms now exist for the medicine term, the anaesthesia term, the elective term and Core Intensive Care Training Year 1 and 2. Further information is recorded elsewhere in this edition.

Survey on Supervisors of Training
These results will be published in Critical Care and Resuscitation in due course.

Objectives of anaesthesia and medicine training
Two documents summarising the aims of the anaesthesia term and the medicine term were also approved and will be provided to trainees and Supervisors.

Critical Care Registrar Website Proposal
The Board supported a proposal by Fellows to establish a Website Resource which will comprise information regarding the Examinations, a Journal Club, presentation library, course calendar, sample investigations and protocols and other information.

PROFESSIONAL

Cooperation Agreement – ANZICS
The Cooperation Agreement with ANZICS was finalised. This document clarifies the roles of each organisation and identifies joint initiatives/shared activities.

ANZICS/JFICM Conjoint Rural Committee
Membership of this Committee includes Michael Cokeron (Chair), Todd Fraser (Vice-Chair), Dianne Stephens (Secretary), Paul Goldrick (NT), Ross Freebairn (Board representative), Gerard McHugh (NZ), Marcus Skinner (Tas) and Stan Yastrebov (Tas). It was agreed to co-opt a Trainee representative to this Committee.

RACP Governance Review
The JFICM reviewed the report of the RACP Governance Review. There are no significant changes to intensive care training. The review is aimed at ensuring proper governance processes. Further information is available from the Executive Officer.

Procedure for intensive care appointments
The Board reviewed and approved its procedure for advice to Hospitals regarding applicants for intensive care specialist positions. Such requests are handled by Regional/National Committees.

Productivity Commission initiatives
An update was provided on DoHA projects affecting the Joint Faculty: specifically a) accreditation of medical colleges which will include generic standards and b) assessment of Overseas Trained Specialists. The Medical Training Review Panel is also reviewing workforce data collection.

DPA
The Board noted a report from the Director of Professional Affairs on current activities. These include a submission for application of the JFICM MOPS Program as a protected Quality Assurance Activity, a report on the meeting of the International Association of Medical Regulatory Authorities held in Wellington in November 2006 and the ‘Better Skills, Best Care’ project by Dept of Health in Victoria. This initiative is piloting a workforce review affecting intensive care, anaesthesia and emergency services.

MOPS
The revision of the MOPS Program was assisted by a presentation from the ANZCA DPA Prof Teik Oh. The presentation outlined the history of recertification, current developments and detailed coverage of the proposed ANZCA Program. The Board is closely examining possible adoption of this Program.

RESEARCH

CTG Arise Study
The Board reviewed the proposal for the Australian Resuscitation in Sepsis Evaluation (ARISE) Study and recognises it as an important study.

CONTINUING EDUCATION

ASM
The scientific program of the JFICM ASM 2007 was reviewed. Further details are included elsewhere in this edition. The proposed theme for the 2008 meeting of ‘Blood’ was supported. JFICM will also offer a number of intensive care sessions arranged for the ANZCA ASM in May 2007, in Melbourne.

INTERNAL

Amendment to Regulations
The Board approved amendments to Regulations pertaining to the introduction of the Primary Examination, which are outlined elsewhere in this section of the Bulletin.

Election
Two positions on the Board are up for re-election. The Board noted with regret that Dr David Ernest will not be re-standing in June.
Training abroad

In July of 2006, the Board of the Joint Faculty visited Dublin to review both the St James’s Hospital and the Mater Misericordiae University Hospital, accommodated by a prearranged visit to the UK. As a result these Units are now accredited by the Joint Faculty for up to 12 months of the core component of Intensive Care training, as C12. Both Units are also accredited for the elective component of intensive care training.

Trainees considering undertaking part of their intensive care training in an overseas unit should note the following:

a. The training must be accredited prospectively by the Censor
b. The 12 months must be continuous and be in a single unit
c. The trainee must occupy a role with clinical training consistent with training required in a C24 unit
d. The remaining 12 months of core intensive care training must be continuous and in a C24 Unit in Australia, New Zealand or Hong Kong
e. A minimum of two years of the whole six year program must be undertaken in Australia, New Zealand or Hong Kong

For further information on training requirements please contact Ms Narelle Hardware at the Joint Faculty office.

Supervisors of Training

The Board ratified the following appointments:

Drs A P Wurm and G O’Callaghan
Flinders Medical Centre
Co-Supervisors of Training

Dr J Hunt-Smith
Royal Melbourne Hospital

Policy document review

The following documents are due for periodic review this year:

Policy Document IC-6
‘The Role of Supervisors of Training in Intensive Care Medicine’

Policy Document IC-13
‘Recommendations on Standards for High Dependency Units Seeking Accreditation of Training in Intensive Care’. Comments are invited and should be directed to the Executive Officer.

New Fellows representatives

The following Fellows were confirmed as JFICM representatives to the New Fellows Conference in May 2007, to be held in Daylesford, Victoria.

J.P. Lewis Western Australia
S. Sturland New Zealand
S. Lane New South Wales
H. Gangopadhyay Victoria
C. Foote Queensland
N. Widdicombe Queensland

Amendment to JFICM regulations

Structure of the Primary Examination

Regulation 7.7.5 regarding the structure of the JFICM Primary Examination was amended to highlight that both written and oral sections of the Examination must be taken at the same sitting.

7.7.5 The subject areas for the JFICM Primary Examination are set out in the Syllabus for the Basic Sciences in Intensive Care.

The Primary Examination is not split by subject thus the complete Written and Oral Sections must be taken at the same sitting unless prior exemption has been awarded.

Clarification of the Appeals Procedure

JFICM utilises the ANZCA Appeals process. The Regulation has been updated to clarify the requirement for review and reconsideration. The Board amended Regulation 16 as follows:

16. Review and reconsideration / appeals procedure

It is expected that persons will lodge a formal appeal only as a last resort. Before convening the Appeals Committee, the Executive Officer will generally advise an applicant to seek a reconsideration and/or review of the original decision. The Appeals Committee shall only be convened if the Executive Officer is satisfied that the applicant has exhausted all other avenues of reconsideration and review of the relevant decision.

Requests for reconsideration and Appeals against decisions of the Joint Faculty of Intensive Care Medicine will be subject to the Review and Reconsideration/Appeals Process of the Australian and New Zealand College of Anaesthetists.
Citation for the award of the John Sands Medal

George Andrew Skowronski

The John Sands Medal is awarded to Fellows of the RACP who have demonstrated outstanding service and a significant contribution to the RACP. Council recognised A/Professor Skowronski at their meeting in October 2006.

George Skowronski graduated in Medicine from the University of Melbourne with honours in 1974. After completing his internship at Prince Henry’s Hospital, he completed the MRCP in the United Kingdom, training at University College and Guy’s Hospital in London. He returned to Australia in 1978 and completed his FRACP in 1981, specialising in thoracic and intensive care medicine.

He began his consultant career in Intensive Care Medicine at Westmead Hospital, Sydney in 1982 and moved to Adelaide where he joined the Department of Intensive Care Medicine at Flinders Medical Centre until 1994. After spending a year at the Royal Adelaide Hospital in 1995, he moved to the St George Hospital, Sydney as a senior consultant. During these years he held conjoint academic positions with Flinders and Adelaide Universities and currently holds an Associate Professorship at the University of New South Wales.

George Skowronski has made a significant contribution to Intensive Care Medicine over the last 25 years, particularly during the period of growth of this new specialty. He was chairman of the Specialist Advisory Committee in Intensive Care Medicine for the Royal Australasian College of Physicians from 1987-1992 and member of the specialties Board of the RACP from 1995-1997. Contemporaneously, he was an examiner for the Faculty of Intensive Care of the Australian and New Zealand College of Anaesthetists from 1987-2002, thereby providing a unique contribution to the education and examination processes of the two parent colleges of the current Joint Faculty of Intensive Care Medicine. His commitment to teaching and training of trainees in Intensive Care Medicine continues to this day and many leading intensive care physicians today have benefited from George Skowronski’s teaching and mentorship.

George Skowronski has also made a substantial contribution to the administrative and political advancement of the specialty. Foremost of these was his contribution to the Australian and New Zealand Intensive Care Society, where he served on the Board and Executive from 1989-1998, acting as President from 1993-1995. During his tenure as President, he was instrumental in establishing the Clinical Trials Group which is now a world class intensive care research consortium and the fee structure for Intensive Care Medicine. He continues to be involved in the Society to date and is current Chairman of the Intensive Care Foundation. His other contributions include advisory positions to Australian Drug Evaluation Committee, the Commonwealth Department of Health Therapeutic Device Evaluation Committee, the United States Pharmacopeial Convention, the Intensive Care Working Party of the Australian Council for Healthcare Standards, the Early Management of Severe Trauma (EMST) course of the Royal Australasian College of Surgeons in addition to hospital and university committees. He also played an integral role in the establishment of private Intensive Care Units in South Australia and New South Wales.

During his impressive career which encompasses all domains of practice – education, research, administration, professional development and private practice – George Skowronski has left an indelible impression on all who have benefited from his association. He conducts himself in the highest professional manner, is a dedicated physician and continues to make substantial contributions to the specialty. He is a most worthy recipient of the John Sands Medal.

Summary of SOT survey

In August 2006 a brief survey was circulated to all Directors of Intensive Care on the role of the SOT to explore the appointment and ongoing training of JFICM SOTs. The survey covered topics such as the nomination of Fellows of less than 3 years post Fellowship or who only have a fractional appointment to the Intensive Care Unit, and poor attendance by Supervisors at dedicated SOT Workshops.

The Board recognised a number of issues which contributed to the concerns detailed above, and as such sought to garner feedback to assist with addressing those issues.

The survey was conducted and results showed that the majority of Intensive Care Unit Directors who responded supported:

> The SOT being greater than 3 years post-Fellowship
> attendance at a SOT workshop within 1 year of appointment and every 2-4 years thereafter
> that sufficient non-clinical time should be allocated to perform the role
> the minimum ICU appointment of a SOT should be 1.0 FTE (12%), 0.8 FTE (30%), 0.7 FTE (10%), 0.6 FTE (13%) and 0.5 FTE (35%)

There was no clear view among Directors that the role was onerous and SOTs may burn out, that the role was highly regarded, or that the age difference would influence the role between the SOT and the Trainee.

The survey has since also been distributed to all SOTs to gain further information on the role.
Trainee committee

The Trainee Committee of the Joint Faculty was established in December 2003 to represent trainee interests in the affairs of the Joint Faculty of Intensive Care Medicine, with particular regard to matters concerning education and training.

The Committee is constituted by a Trainee Representative from each region of Australia and one from New Zealand, and the New Fellow Representative elected to the Board who acts as Chair. Currently this is Dr Nikki Blackwell.

The Committee generally meets 3 times per year via teleconference, though it is envisaged that the first meeting of 2007 will be face to face at the Annual Scientific Meeting in June 2007.

Membership
In order to be eligible for nomination to the Trainee Committee, trainees are required to have been a registered JFICM trainee for at least 2 years or be a current advanced trainee of the JFICM. Once elected, members of the Trainee Committee are eligible to stay in that role for up to 3 years, contingent upon them remaining a registered JFICM trainee for that period.

To establish the Committee, representatives were co-opted by each region. An election will now be held for all positions during the months of April and May. Nominations have been requested from Trainees from each region by the relevant Regional/National Committee.

It is anticipated that the election will be finalised by 18th May 2007 in time for the first meeting in June.
The Joint Faculty of Intensive Care Medicine, in association with the Australian and New Zealand Intensive Care Society are proud to host the third Annual Scientific Meeting at the Sofitel Wentworth, Sydney from 1-3 June 2007. The theme of this year’s meeting is ‘The Heart of the Matter’ and will include a series of debates and lectures which will provide an insight into the spectrum of cardiac problems in intensive care.

International speakers Prof Sheldon Magder (Canada), Prof Alexandre Mebazaa, (France) and Mr Samer Nashef (UK) will join local and national speakers to present in this exciting and dynamic program.

The ASM Dinner will be held at The Great Hall, University of Sydney in the evening of Saturday 2 June. The Great Hall is a spectacular Gothic style venue with old-world charm surrounded by the sweeping lawns of University Place, creating the perfect setting for this event. The Dinner includes the presentation of New Fellows, awards and an oration.

Full details of the ASM, including an up-to-date version of the scientific program can be obtained from the meeting website www.jficm.anzca.edu.au/asm/. For further information or to register for the meeting, please contact the ASM Secretariat:

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PROF SHELDON MAGDER
McGill University
Montreal, Canada

MR SAMER NASHEF
Papworth Hospital
Cambridge, UK

PROF ALEXANDRE MEBAZAA
Hospital Lariboisiere
Paris, France
Over the last couple of years there has been increasing interest from government and some health care providers in chronic disease and its self management. This interest has targeted conditions such as diabetes, chronic airways disease and heart disease. Persistent pain is an obvious addition to this list.

In the United Kingdom significant government funding has been made available to develop and implement some management strategies for these conditions. In Australia, the Australian Federal, State and Territory governments have indicated that they will begin implementing a five year, five hundred million dollar national package called The Australian Better Health Initiative to Reduce the Impact of Chronic Disease.

As pain medicine practitioners, we have for a long time, been aware of, and supported professionally led cognitive behavioural pain management programmes for patients with persistent pain. The evidence base for measuring change in patients going through these types of programmes is strong (3). How therefore can we engage in the debate for self-management of chronic pain? Recently, Buszewicz et al published a randomized controlled trial on self-management of arthritis in primary care. This was a large trial but unfortunately was unable to demonstrate any significant effect on pain, physical functioning or decrease in contact with primary care providers. (2)

Kate Lorig from Stanford University has championed community led, structured self management programmes which have been developed further in the United Kingdom into ‘expert patient programmes’. However, it is yet to be seen if these have lived up to expectations.

At Flinders University a programme for a collaborative approach between an individual and a health professional has been developed and shows promise (1).

In our day-to-day practice we know that provider behaviour has a strong impact on patient behaviour. We also see patients who are in no way ready for behaviour change. Can we take up the challenge set by Kerns et al to use the ‘stages of change’ model to help identify which patients are ready? (4, 5)

For those patients who are ready to change, is it possible to triage them into different intensities of self-management? (6)

There is some evidence that not all patients need every component of the standard 100 hour cognitive behavioural pain management programme (6).

Could some patients be managed in the community with a programme designed to deliver education, activity, goal setting and pacing? Will joint care planning and case conferencing between the Pain Centre/Pain Physician, the General Practitioner and the patient allow education and behaviour change for all of us? These opportunities are now being funded through new initiatives put in place by Medicare Australia.

Currently, there seems a strong desire and commitment from the federal government to explore self-management for patients with chronic disease. Our Faculty has endorsed the concept that persistent pain is a chronic disease and we should take up the challenge to provide our patients and their referring practitioners with the tools to provide ongoing care in the community.

REFERENCES


ROGER GOUCKE

FACULTY OF PAIN MEDICINE
DEAN ELECT
Dr C Roger Goucke, FANZCA was re-elected as Dean for a second year.

HONOURS AND APPOINTMENTS
The following awards were noted:
Prof Michael Paech (WA) – conferral of Honorary Fellowship, Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Prof Michael Cousins (NSW) – receipt of the Pugh Award, Australian Society of Anaesthetists
Conferral of DSc, University of Sydney for his dissertation related to pain, analgesia and anaesthesia in the management of acute, chronic and cancer pain
Dr James Bradley (Qld) – award of Honorary Life Membership Australian Society of Anaesthetists and New Zealand Society of Anaesthetists
Dr Walter Thompson (WA) Conferral of Fellowship, Academy of Medicine of Malaysia

FELLOWSHIP
Four Fellows were admitted to Fellowship by training and examination and
Dr Murray Taverner, FANZCA, (Vic), Dr Owen Williamson, FRACS (Vic) and Dr S K Vallipuram, FANZCA (Vic) were admitted to Fellowship by election.

CENSOR ISSUES
It was reaffirmed that part-time training must comprise a minimum of 50% of the commitment of a full time trainee.

FINANCE
The accounts for the 12 months ended 31 December 2006 were accepted. The 2007 Budget had been accepted by ANZCA Council. In a recent meeting with the ANZCA President, Honorary Treasurer and CEO to discuss governance and financial issues, it had been acknowledged that the Faculty will likely operate at a deficit for some years.

A delegations document will be re-submitted to Council with minor changes following discussion at this meeting.

The Board resolved that, from January 2008, an annual administration fee of 1/4 of the Annual Training Fee will be applicable to trainees with outstanding requirements. Those who choose not to remain registered, but later decide to complete their training and/or assessment will be required to re-enrol as a trainee.

ANZCA DIRECTOR STRATEGY AND ORGANISATION DEVELOPMENT
Mr Ian Collens, ANZCA’s newly appointed Director, Strategy and Organisation Development, addressed the Board and outlined the six main strategic priorities identified by Council for the 2007 and 2008 years. These were arrived at through a strategic planning process attended by the Dean. The six strategic initiatives are to:
> Position the College and Faculties as the primary conduit of specialist training
> Ensure Fellows continue to possess relevant skills and knowledge
> Develop and communicate the College’s position on the roles of Fellows and others providing anaesthesia-related care
> Improve the College’s standing with governments, media and other key stakeholders
> Ensure that the Council and Committee structures are responsive to the strategic priorities of the College
> Improve the support for, and communications to, Fellows and Trainees; and improve the ease of doing business with the College.

EDUCATION AND TRAINING
Seeds – Interactive online tutorial program
The Education and Training Committee are developing, along with Allori[1], an online interactive tutorial program that will address Visceral Hyperalgiesia. Fellows will be notified of how to access the program when it is posted. Fellows are also requested to let the Executive Officer or Prof Ted Shipton, Chair of Education and Training, know of any ideas and/or topics for future interactive programs.

The Answer Page
Fellows may be interested in ‘The Answer Page’, a service provided out of Harvard covering all major subjects in Pain Management over the course of a year. A question is posted every weekday and one on weekends. There are links to peer-reviewed, referenced answers that become more complex over time. Website details: http://www.theanswerpage.com/pain/home/home.html

Supervisors of Training
A successful SoT Workshop was held in November 2006 with 80% of Faculty SoTs present. In response to issues raised at the Workshop, the Board agreed to formalise a process to support SoTs in managing unsatisfactory ITAs and supported the concept of portability of ITAs from previous rotations and primary specialty training. A half day Supervisor of Training Workshop will be held during the Melbourne ASM on Monday 28 May. A schedule of ANZCA Clinical Teaching Course Workshops for 2007 is available from the College Website. Faculty SoTs are invited to attend courses in their region.

Highlights from the Board Meeting
Held on 26 February 2007
Continuing Professional Development
The MOPS Program has undergone a major revision and is to be relaunched as the Continuing Professional Development (CPD) Program in January 2008. The draft documents are on the ANZCA website and Fellows are urged to review them at this stage and provide any feedback to the Executive Officer or the CPD Officer, A/Prof Milton Cohen.

Undergraduate Education in Pain Medicine
A ten-point awareness plan of the most important issues that a graduate medical student should know is in development for circulation to Chairs of Curriculum Committees of Medical Schools throughout Australasia along with the guidelines ‘Managing Acute Pain – a Guide for Patients.’

EXAMINATION
There was a 70% pass rate at the 2006 FPM Examination at the Sir Charles Gairdner Hospital, Perth. An examination report will be published shortly.

The 2007 examination will be held at the Westmead Hospital, NSW on 28-30 November. The Pre-Examination Short Course will be held on 27-28 September at the Royal Adelaide Hospital.

TRAINING UNIT ACCREDITATION
Royal Prince Alfred Hospital was accredited for Pain Medicine training for a period of three years. Sir Charles Gairdner Hospital and Royal North Shore Hospital were re-accredited for a further 5 years. Westmead Hospital, Geelong Hospital and Flinders Hospital were re-accredited for a period of three years.

VICTORIAN PAIN MEDICINE TRAINING ROTATION
Up to four, six month rotations are now available across Melbourne. The accredited training units include the Royal Children’s Hospital, the Geelong Hospital, the Royal Melbourne Hospital and the Barbara Walker Centre for Pain Management at St Vincent’s Hospital. An advertisement has been published in the Bulletin, through participating Colleges e-newsletters and on the Faculty Website. Expressions of interest should be addressed to the Executive Officer.

RESEARCH
Pain Medicine Prize
Adjudication of eligible papers for the inaugural Dean’s Prize, for original work judged to be a significant contribution to Pain Medicine and/or Pain Research, will take place at the Dean’s Prize/ FPM Free Papers Session of the FPM ASM in Melbourne at 8.30 – 10.00am on Sunday May 27. A Certificate and voucher for $1,000 will be presented to the winning submission at the FPM AGM.

Pain Outcome Measures
A workshop has been organised (Determining Key Outcome Indicators for Chronic Pain: Is it Possible?) as part of the FPM ASM Program (1400-1700, Sunday 27 May at RACS) with a view to working towards consensus for a minimum data set.

PROFESSIONAL
Professional Documents
A new Faculty Professional Document, PM6 Guidelines for Long Term Intrathecal Infusions was accepted for promulgation. A sub-committee has been formed to progress a Faculty Educational Document: Recommendations for the Conduct of Diagnostic Medial Branch Blocks.

Recognition of Pain Medicine as a Specialty – New Zealand
It was agreed that a formal application will now be progressed with the Medical Council of New Zealand. The ANZCA New Zealand National Committee has accepted the role of Branch Advisory Body. It is anticipated that the application process will take around 18 months.

CONTINUING EDUCATION
2007 ASM, Melbourne
The scientific program has been finalised and can be viewed at: http://www.anzca2007asm.com

2007 Refresher Course Day
Registration brochures have been circulated and can be downloaded from the website: http://www.fpm.anzca.edu.au/meetings/index.htm (ARC 2007).

2007 New Fellows’ Conference Representatives
Dr Mark Schutze (2006 Barbara Walker Prize recipient), WA and Dr Lorna Fox, NZ have been nominated as the Faculty’s representatives.

2008 ASM, Sydney – 3 – 7 May
The Faculty’s Foundation Visitor for 2008 was confirmed as Professor Quinn H Hogan, USA. It was confirmed that a second Pain Visitor will be invited.

Inaugural FPM Spring Meeting – 12-14 October 2007
A revised date was confirmed for the Faculty of Pain Medicine’s Inaugural Spring Meeting in combination with the Medico-Legal Society of Queensland. The venue has now been confirmed as the Sheraton Mirage Resort and Spa, Gold Coast. The meeting will analyse aspects of concern for Pain Physicians and Lawyers. Dr Dan Carr, Boston, USA will be the International Visitor.

STAFF
The Faculty welcomed Ms Jenni Allison, who commenced her appointment as Administrative Officer, Education and Research on 29 January 2007.
Upper left: Dr Mark Schutze, Barbara Walker Prize Winner, with Dr Penny Briscoe and Dr Roger Goucke

Upper: FPM Court of Examiners 2006

Lower: Successful candidates
<table>
<thead>
<tr>
<th>Code</th>
<th>Year</th>
<th>Title</th>
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<tbody>
<tr>
<td>PM1</td>
<td>2006</td>
<td>Policy for Trainees Seeking Faculty Approval of Programs for Training in Multidisciplinary Pain Medicine</td>
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<tr>
<td>PM2</td>
<td>2005</td>
<td>Guidelines for Units Offering Training in Multidisciplinary Pain Medicine</td>
</tr>
<tr>
<td>PM3</td>
<td>2002</td>
<td>Lumbar Epidural Administration of Corticosteroids</td>
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<tr>
<td>PM4</td>
<td>2005</td>
<td>Guidelines for Patient Assessment and Implantation of Intrathecal Catheters, Ports and Pumps for Intrathecal Therapy</td>
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<td>PM5</td>
<td>2006</td>
<td>Policy for Supervisors of Training in Pain Medicine</td>
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<td>PS3</td>
<td>2003</td>
<td>Guidelines for the Management of Major Regional Analgesia</td>
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<tr>
<td>PS38</td>
<td>2004</td>
<td>Statement Relating to the Relief of Pain and Suffering and End of Life Decisions</td>
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<tr>
<td>PS40</td>
<td>2005</td>
<td>Guidelines for the Relationship Between Fellows and the Healthcare Industry</td>
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<td>PS41</td>
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<td>Guidelines on Acute Pain Management</td>
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<td>PS45</td>
<td>2001</td>
<td>Statement on Patients’ Rights to Pain Management</td>
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<td>2003</td>
<td>Statement on Clinical Principles for Procedural Sedation</td>
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<td>PS49</td>
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<td>Guidelines on the Health of Specialists and Trainees</td>
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<td>ANZCA Professional Documents adopted by the Faculty:</td>
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<td>PS7</td>
<td>2003</td>
<td>Recommendations on the Pre-Aneesthesia Consultation (Adopted November 2003)</td>
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<tr>
<td>PS9</td>
<td>2005</td>
<td>Guidelines on Conscious Sedation for Diagnostic, Interventional Medical and Surgical Procedures (May 2002)</td>
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<tr>
<td>PS10</td>
<td>2004</td>
<td>The Handover of Responsibility During an Anaesthetic (Adopted February 2001)</td>
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<tr>
<td>PS15</td>
<td>2000</td>
<td>Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery with amendment to the title to read Recommendations for the Perioperative Care of Patients Selected for Day Care Procedures (Adopted February 2001)</td>
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<td>PS18</td>
<td>2006</td>
<td>Recommendations on Monitoring During Anaesthesia (Adopted February 2001)</td>
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<td>2001</td>
<td>Recommendations for Responsibilities of the Anaesthetist in the Post-Operative Period (Adopted February 2001)</td>
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<tr>
<td>TE1</td>
<td>2005</td>
<td>Recommendations for Hospitals Seeking College Approval for Vocational Training in Anaesthesia</td>
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<td>Policy on Vocational Training Modules and Module Supervision (interim review)</td>
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<td>2006</td>
<td>Policy on Supervision of Clinical Experience for Vocational Trainees in Anaesthesia</td>
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<td>TE4</td>
<td>2003</td>
<td>Policy on Duties of Regional Education Officers in Anaesthesia</td>
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<td>TE5</td>
<td>2003</td>
<td>Policy for Supervisors of Training in Anaesthesia</td>
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<td>TE6</td>
<td>2006</td>
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<td>2005</td>
<td>Guidelines for Secretarial and Support Services to Departments of Anaesthesia</td>
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<tr>
<td>TE8</td>
<td>2003</td>
<td>Guidelines for the Learning Portfolio for Trainees in Anaesthesia</td>
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<tr>
<td>TE9</td>
<td>2005</td>
<td>Guidelines on Quality Assurance in Anaesthesia</td>
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<td>TE10</td>
<td>2003</td>
<td>Recommendations for Vocational Training Programs</td>
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<td>TE11</td>
<td>2003</td>
<td>Formal Project Guidelines</td>
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<td>TE13</td>
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<td>Guidelines for the Provisional Fellowship Program</td>
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<td>Policy for the In-Training Assessment of Trainees in Anaesthesia</td>
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<td>Policy on Advisors of Candidates for Anaesthesia Training</td>
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<td>2005</td>
<td>Guidelines for Assisting Trainees with Difficulties</td>
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<td>2006</td>
<td>Policy on Examination Candidates Suffering from Illness, Accident or Disability</td>
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<td>T1</td>
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<td>Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations</td>
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<td>T3</td>
<td>2006</td>
<td>Minimum Safety Requirements for Anaesthetic Machines for Clinical Practice</td>
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<td>2002</td>
<td>Recommendations on Essential Training for Rural General Practitioners in Australia proposing to administer Anaesthesia</td>
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<td>2006</td>
<td>Statement on Credentialling in Anaesthesia</td>
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<td>Guidelines for the Management of Major Regional Analgesia</td>
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<td>PS6</td>
<td>2006</td>
<td>The Anaesthesia Record. Recommendations on the Recording of an Episode of Anaesthesia Care</td>
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<td>PS8</td>
<td>2003</td>
<td>Guidelines on the Assistant for the Anaesthetist</td>
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<td>2005</td>
<td>Guidelines on Conscious Sedation for Diagnostic, Interventional Medical and Surgical Procedures</td>
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<td>Statement on Smoking as Related to the Perioperative Period</td>
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<td>PS16</td>
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<td>PS21</td>
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<td>Guidelines on Conscious Sedation for Dental Procedures</td>
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<td>Guidelines on Sedation for Gastrointestinal Endoscopic Procedures</td>
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<td>PS26</td>
<td>2005</td>
<td>Guidelines on Consent for Anaesthesia or Sedation</td>
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<td>PS27</td>
<td>2004</td>
<td>Guidelines for Fellows who Practice Major Extracorporeal Perfusion</td>
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<td>PS28</td>
<td>2005</td>
<td>Guidelines on Infection Control in Anaesthesia</td>
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<td>PS29</td>
<td>2002</td>
<td>Statement on Anaesthesia Care of Children in Healthcare Facilities without Dedicated Paediatric Facilities</td>
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<td>PS31</td>
<td>2003</td>
<td>Recommendations on Checking Anaesthesia Delivery Systems</td>
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<td>PS37</td>
<td>2004</td>
<td>Regional Anaesthesia and Allied Health Practitioners</td>
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<td>PS39</td>
<td>2003</td>
<td>Minimum Standards for Intrahospital Transport of Critically Ill Patients</td>
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<td>Guidelines for the Relationship Between Fellows and the Healthcare Industry</td>
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<td>PS42</td>
<td>2006</td>
<td>Recommendations for Staffing of Departments of Anaesthesia</td>
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<td>PS43</td>
<td>2001</td>
<td>Statement on Fatigue and the Anaesthetist</td>
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<td>PS44</td>
<td>2006</td>
<td>Guidelines on Fellows Acting on Appointments for Senior Staff in Anaesthesia</td>
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<td>2001</td>
<td>Statement on Patients’ Rights to Pain Management</td>
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<td>PS46</td>
<td>2004</td>
<td>Recommendations for Training and Practice of Diagnostic Perioperative Transoesophageal Echocardiography in Adults</td>
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<tr>
<td>PS47</td>
<td>2002</td>
<td>Guidelines for Hospitals Seeking College Approval of Posts for Vocational Training in Diving and Hyperbaric Medicine</td>
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<td>PS50</td>
<td>2004</td>
<td>Recommendations on Practice Re-entry for a Specialist Anaesthetian</td>
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GUIDELINES ON THE DUTIES OF AN ANAESTHETIST

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

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

3. OTHER PROFESSIONAL DUTIES
3.1 Managerial duties relating to the functioning of the department and the hospital including perioperative units, pre-anaesthesia clinics, operating suites and recovery rooms.
3.2 Organisation of and participation in appropriate educational activities for:
   3.2.1 anaesthesia trainees
   3.2.2 intern and resident medical staff
   3.2.3 medical students
   3.2.4 trainee and postgraduate nurses
   3.2.5 anaesthesia nurses and/or technicians
   3.2.6 recovery room nurses
   3.2.7 operating room nurses
   3.2.8 other health professionals
   3.2.9 community groups in subjects such as “basic life support”.
3.3 Participation in peer review and quality improvement activities to ensure and review the quality of patient care.
3.4 Participation in continuing medical education to maintain personal knowledge and skills as established in the College’s Continuing Professional Development Program.
3.5 Contribution to activities of professional associations, hospital committees, and other relevant state and national organisations.
3.6 Participation in research and reviews on matters relevant to anaesthesia, perioperative medicine, pain medicine, resuscitation and intensive care. These activities may include assistance to trainees with their Formal Project.
3.7 Participation in programs to safeguard personal wellbeing as well as the wellbeing of colleagues, trainees and related professionals.
3.8 Participation in activities to promote a positive image of the specialty to professional colleagues and to the public.
3.9 Duties related to the management and direction of operating rooms.
(continued)

(2006)

RELATED DOCUMENTS
TE3 Policy on Supervision of Clinical Experience for Trainees in Anaesthesia
TE9 Quality Assurance
TE11 Formal Project Guidelines
PS4 Recommendations for the Post-Anaesthesia Recovery Room
PS7 The Pre-Anaesthesia Consultation
PS9 Guidelines on Conscious Sedation for Diagnostic, Interventional Medical and Surgical Procedures
PS10 The Handover of Responsibility During an Anaesthetic
PS15 Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery
PS16 Statement on the Standards of Practice of a Specialist Anaesthetist
PS20 Recommendations for Responsibilities of the Anaesthetist in the Postoperative Period
PS26 Guidelines on Providing Information About the Services of an Anaesthetist

COLLEGE PROFESSIONAL DOCUMENTS
College Professional Documents are progressively being coded as follows:
TE Training and Educational
EX Examinations
PS Professional Standards
T Technical

POLICY – defined as ‘a course of action adopted and pursued by the College’. These are matters coming within the authority and control of the College.

RECOMMENDATIONS – defined as ‘advisable courses of action’.

GUIDELINES – defined as ‘a document offering advice’. These may be clinical (in which case they will eventually be evidence-based), or non-clinical.

STATEMENTS – defined as ‘a communication setting out information’.

This document is intended to apply wherever anaesthesia is administered.
This 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 document in each case.
Professional 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. Professional documents have been prepared having regard to the information available at the time of their preparation, and the practitioner should therefore have regard to any information, research or material which may have been published or become available subsequently.
Whilst the College endeavours to ensure that professional documents are as current as possible at the time of their preparation, it takes no responsibility for matters arising from changed circumstances or information or material which may have become available subsequently.

Promulgated: 1990
Reviewed: 1995, 2000
Date of current document: Dec 2006
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College Website: http://www.anzca.edu.au/
1. PREAMBLE
Credentialling is verification of the qualifications, experience and professional standing of anaesthetists in order to decide whether they are professionally capable and suitable to provide safe, high quality anaesthesia and perioperative medicine services within specific organisational environments. Defining the Scope of Clinical Practice is delineating the extent of an individual anaesthetist’s clinical practice within a particular organisation, based on his or her credentials, competence, performance and professional suitability, and the needs and capability of the organisation to support his or her clinical practice. Processes of credentialling and defining the scope of clinical practice depend for their effectiveness on strong links between health care organisations and professional bodies. Such processes must be fair, transparent, and legally robust. Credentialling in anaesthesia allows a medical practitioner to provide clinical services at a healthcare institution. The process of credentialling should be performed by a committee appointed by the institution. Credentialling is an integral part of processes for the maintenance of the professional standards necessary for all Fellows of the College and for other anaesthetists working in any institution. The scope of practice would be determined by negotiation between the anaesthetist and the head of clinical service of the institution. Medical regulatory authorities are moving towards a requirement that all medical practitioners be credentialled regularly by the healthcare institution(s) in which they work. Credentialling is one of several measures aimed at ensuring ongoing competence to practise in a designated area of medicine. Credentialling indicates that an individual has maintained his/her consulting, communication and clinical skills at an appropriate standard. The College does not credential its Fellows directly. It does offer its Continuing Professional Development program (CPD) to all anaesthetists as an integral part of continuing medical education and quality assurance. The following statement on credentialling and defining the scope of clinical practice has been established by the College to assist healthcare institutions with the development of processes appropriate for anaesthetists.

2. QUALIFICATIONS IN ANAESTHESIA
Anaesthesia should be practised by a specialist anaesthetist and/or a trainee or other medical staff supervised as described in College Professional Document TE3 Policy on Supervision of Clinical Experience for Trainees in Anaesthesia. It is recognised that in some healthcare institutions, specialist anaesthetists may not be available or present in sufficient numbers to provide a complete service. Under such circumstances appropriately trained general practitioner anaesthetists or career medical officers (see College Professional Document PS1 Essential Training for Rural General Practitioners in Australia proposing to Administer Anaesthesia may be service providers. In all situations, staff should be aware of the provisions of College Professional Documents TE6 Guidelines on the Duties of an Anaesthetist and PS16 Statement on the Standards of Practice of a Specialist Anaesthetist.

3. CREDENTIALLING COMMITTEE
When the credentialling of anaesthesia staff is undertaken, two specialist anaesthetists (normally holding FANZCA), including one who does not hold an appointment at the healthcare institution, should be members of the Committee. The Committee should have representative member(s) from other clinical divisions of the healthcare institution. The Committee must comply with all relevant legal requirements, and must conduct itself according to the rules of natural justice, without conflicts of interest or bias. Members of Committees responsible for credentialling and defining the scope of clinical practice, and members of relevant appeals committees must be protected against potential adverse legal consequences of their participation in committee activities.

4. PROCESSES FOR CREDENTIALLING
The following processes are suggested for the operation of Credentialling Committees:

4.1 Except where there is prior agreement between healthcare institutions, credentialling should be unique to the granting institution. Work at a new institution ordinarily requires the definition of the scope of clinical practices as part of the process of appointment.

4.2 The process and requirements for credentialling should be determined prospectively by each healthcare institution. If changes are made, all staff must be advised, together with a date for application of the new or altered requirement(s).

4.3 Credentialling and scope of clinical practice should be approved for a specified time.
4.4 Evidence of participation in a Continuing Professional Development program should be obtained.

4.5 There should be a written statement of credentialling with a clear indication as to the process followed. This document may be used by the anaesthetist for his/her professional needs, including licensing for practice as a medical practitioner and as an anaesthetist. The anaesthetist must have the opportunity for comment on matters related to credentialling before a final decision is taken by the Committee.

4.6 The credentialling process may include a review of performance with evaluation by peers and other staff as determined by the Committee. Submissions to the Committee should be in writing.

4.7 The organisation, with advice from the relevant clinical leader and/or the relevant committee, should:

- Establish criteria for the position
- Establish a policy on credential verification
- Establish a policy on indemnity insurance requirements
- Decide on information required from applicants. This may include details of professional history (including education and training, registration, employment, teaching and research); clinical experience; involvement in continuing medical education and quality insurance activities (including membership of relevant College CPD programs); declaration of matters relevant to deliberation of the Committee (including previous or existing limitations on practice, presence of any physical or mental condition or substance abuse problem that could affect his or her ability to practise safely and competently); satisfactory references.
- Determine processes for temporary and/or emergency credentialling
- Determine processes for re-credentialling
- Establish processes for suspension of the right to practise within the organisation
- Establish review and reconsideration, and appeals processes

RELATED DOCUMENTS

- **TE3** Policy on Supervision of Clinical Experience for Trainees in Anaesthesia
- **TE6** Guidelines on the Duties of an Anaesthetist
- **PS1** Recommendations on Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia
- **PS16** Statement on the Standards of Practice of a Specialist Anaesthetist
- **PS44** Guidelines to Fellows Acting on Appointments Committees for Senior Staff in Anaesthesia

COLLEGE PROFESSIONAL DOCUMENTS

College Professional Documents are progressively being coded as follows:

- **TE** Training and Educational
- **EX** Examinations
- **PS** Professional Standards
- **T** Technical

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Promulgated: 1982
Date of current document: Dec 2006
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1. INTRODUCTION
The Australian and New Zealand College of Anaesthetists endorses the concept of monitored care provided by an anaesthetist for a procedure performed under local anaesthesia or sedation. Monitored care may also be required in special situations such as the intravascular administration of contrast medium in a suspected susceptible patient. Monitored care may be requested by a surgeon, dentist, obstetrician, physician, endoscopist, radiologist, radio therapist, or other proceduralist, or by a patient or his/her carer. The provision of monitored care may be exacting and time consuming because of the general condition of the patient and, in some cases poor access, the location of the procedure and availability of support staff.

2. GENERAL PRINCIPLES
2.1 Monitored care shall include:
2.1.1 Performance of a pre-anaesthetic consultation in accordance with College Professional Document PS7 Recommendations on the Pre-Anaesthesia Consultation, including obtaining consent in accordance with College Professional Document PS26 Guidelines on Consent for Anaesthesia or Sedation.
2.1.2 Monitoring of the patient, as appropriate, in accordance with College Professional Document PS18 Recommendations on Monitoring During Anaesthesia.
2.1.3 Administration of intravenous sedation, if required, in accordance with College Professional Document PS9 Guidelines on Conscious Sedation for Diagnostic, Interventional Medical and Surgical Procedures.
2.1.4 Other therapeutic measures as required.
2.1.5 Transfer of the patient, if required, to an appropriate Recovery Area in accordance with College Professional Document PS4 Recommendations for the Post-Anaesthesia Recovery Room.
2.2 A record of clinical observations and of drugs administered shall be kept in accordance with College Professional Document PS6 The Anaesthesia Record. Recommendations on the Recording of an Episode of Anaesthesia Care.
2.3 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 Document T1 Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations.
1. INTRODUCTION
The purpose of this document is to state the general principles and outline important specific responsibilities of the anaesthetist following sedation or anaesthesia.

1.1 Following sedation or anaesthesia, the patient is particularly at risk of adverse events related to the airway, ventilation and the circulation.

1.2 The system for care of the patient in this important period is designed to prevent harm to the patient.

1.3 The anaesthetist has a major responsibility for the management of the patient recovering from surgery and anaesthesia, particularly while the patient is in the post-anaesthesia care unit.

2. PRINCIPLES

2.1 The anaesthetist has responsibility for ensuring that the patient recovers safely from surgery and anaesthesia in an area appropriate for that purpose as specified in College Professional Document PS4 Recommendations for the Post-Anaesthesia Recovery Room.

2.2 Care of and responsibility for the patient following sedation or anaesthesia is shared with nursing staff and with the practitioner performing the procedure. There must be effective communication between those sharing care of the patient.

2.3 The anaesthetist is responsible for recognition, management and documentation of any adverse effects that may be related to sedation or anaesthesia. This includes a responsibility to inform patients and/or caregivers of any future health care matters relevant to the conduct of sedation or anaesthesia.

2.4 When a patient is to be discharged from medical care on the same day that sedation or anaesthesia has been administered, the anaesthetist must ensure that the patient and caregivers understand the principles of post-anaesthesia care. See College Professional Document PS15 Recommendations for the Peri-operative Care of Patients Selected for Day Care Surgery.

2.5 The anaesthetist has a responsibility to audit outcomes of anaesthesia care and include these in quality assurance or peer review processes. See College Professional Document TE9 Guidelines on Quality Assurance.

3. SPECIFIC RESPONSIBILITIES

3.1 The anaesthetist is responsible for safe transport of the patient from the operating theatre or procedure room to the post-anaesthesia care unit, high dependency unit or intensive care unit.

3.1.1 Safe transport requires administration of supplemental oxygen in most cases.

3.1.2 The anaesthetist is responsible for selection and use of appropriate monitoring equipment for use during transport.

3.2 The anaesthetist will provide a formal handover of responsibility to suitably trained staff in the post-anaesthesia care unit or intensive care unit, with appropriate briefing on relevant aspects of the surgery, and anaesthesia or sedation.

3.2.1 Handover of care should only occur when the anaesthetist considers that the patient’s condition is stable, particularly with regard to cardio-respiratory status.

3.2.2 Handover should include instructions relating to specific relevant issues such as airways, throat packs, intravenous and intra-arterial devices, epidurals or drug infusions.

3.3 The anaesthetist will provide specific advice regarding

3.3.1 clinical observations and monitoring

3.3.2 pain relief

3.3.3 management of complications, particularly post-operative nausea and vomiting

3.3.4 fluid therapy

3.3.5 respiratory therapy

3.3.6 discharge from the post-anaesthesia care unit

3.3.7 on-going care related to anaesthesia matters

3.4 The anaesthetist must be readily available to deal with any unexpected problems or alternatively ensure that another nominated anaesthetist or other consultant is available and has access to necessary information about the patient.

3.5 Other responsibilities are:

3.5.1 To ensure that the patient remains in the recovery facility until safe for discharge to a ward or home.

3.5.2 To ensure there are plans for adequate post-operative care of the patient after discharge from the post-anaesthesia care unit.

3.5.3 to provide advice to the primary care team after discharge of the patient from the post-anaesthesia care unit.
This document is intended to apply wherever anaesthesia is administered.

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Promulgated: 1990
Reviewed: 1996
Date of current document: Dec 2006
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The College considers that it should provide advice to Appointments Committees in Australia or New Zealand when appointments in anaesthesia are being considered. This is best carried out by designating a specific Fellow to work with or be a member of the Committee. When trainee appointments are being considered, the procedures laid down in the College document Guidelines for the Selection of Trainees should be followed. For Committees dealing with senior staff appointments, the following matters are relevant:

1. The College representative should give advice on matters related to the qualifications and status of applicants. In the case of specialist appointments, consideration must be given as to whether applicants:
   1.1 Hold the Fellowship of this College or will hold that Fellowship by the date on which he/she takes up appointment.
   1.2 Hold another specialist qualification in anaesthesia. In this situation, the implications in respect of Overseas Trained Specialist Assessment by the College and registration as a specialist in Australia or New Zealand must be considered.
   1.3 Have appropriate experience for the position under consideration.
   1.4 Are participating in continuing medical education and quality assurance activities (including membership of the relevant College Continuing Professional Development Program).

2. The College representative may be a full member of the Appointments Committee, in which case his/her other duties will be determined by the employing authority. The employing authority must be asked to determine the status of the College representative prospectively. In matters other than those stated in Item 1, the Fellow will be acting on behalf of the employing authority and not as an ANZCA representative.

3. The nomination of Fellows to serve on Appointments Committees shall be made by Regional Committees or the New Zealand National Committee, and copied to the College for information.

4. The College nominee must have knowledge of College guidelines on matters related to the duties of senior staff. He/she should not be a member of the Medical Staff of the hospital seeking the appointment. He/she should be a participant in a relevant College Continuing Professional Development Program.

5. College nominees should serve in this capacity for a maximum of 12 years and should be in active practice. If the College nominee is unable to attend a meeting, he/she should seek permission to nominate a proxy after discussion as to an appropriate person with the Chair of the relevant Regional or National Committee.

6. Fellows acting on Appointments Committees should be aware of the following:
   6.1 Confidentiality and privacy must be maintained as part of the requirements of the employer.
   6.2 Written documentation of all relevant decisions and of significant issues should be maintained by the employer.
   6.3 Because of the significance of the matters considered, it is essential that the employer maintains fair procedures and follows due process.
   6.4 If a College representative has any doubts about a process or decision, the matter should be formally discussed with the employer in the first instance. If the issues cannot be resolved, advice from the College should be sought through the CEO.
   6.5 Appointments Committees must be free from bias. Its members must not have any relationship with an applicant which might prevent them from making a fair decision.
   6.6 Appointments must be made strictly according to prospectively established, relevant and objective criteria. Matters considered by the Committee must be strictly relevant to those criteria. Irrelevant personal issues may be potentially defamatory.

7. This document should be read in conjunction with the following College Documents:
   - TE6 Guidelines on The Duties of an Anaesthetist
   - PS1 Recommendations on Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia
   - PS2 Statement on Credentialling and Defining the Scope of Clinical Practice in Anaesthesia
   - PS16 Statement on the Standards of Practice of a Specialist Anaesthetist Overseas Trained Specialists - Assessment Process
   - Area of Need Process
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Promulgated: 2001
Reviewed: 2006
Date of current document: Dec 2006
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