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## Editorial

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Unless specifically stated otherwise, the opinions expressed and statements made in this publication reflect the author’s personal observations and do not imply endorsement by, nor official policy of, the Australian and New Zealand College of Anaesthetists.
A Good Day

Saturday 4 August 2001 was a good day. On that day, the Governor-General of Australia, Dr Peter Hollingworth accompanied by Mrs Hollingworth, opened ANZCA House, the new extension to Ulimaroa, the headquarters of the Australian and New Zealand College of Anaesthetists. His Excellency unveiled a plaque in front of over 300 VIPs, guests, and Fellows in the new auditorium. In his opening, he announced his acceptance of our invitation to be the Patron of the ANZCA Foundation, the College’s research foundation. A happy reception followed and the first President, Associate Professor Peter Livingstone, led a toast to the College, and Dr Kate Leslie, Chair of the Victorian Regional Committee, replied on behalf of Fellows and trainees.

Ulimaroa is a late Victorian Italianate villa and is of immense heritage importance. It is typical of the detached villas on St Kilda Road, of which only five remain out of 41 in existence in 1895. It was built in 1889 and is believed to be the work of architect John Augustus Bernhard Koch. From 1890 to 1946, the Trail family occupied the house. Mr John Trail gave the house the name ‘Ulimaroa’, believed to be a Polynesian name for Australia. He was Chairman of a shipping company which had a vessel, also named ‘Ulimaroa’, in regular service between Australia and New Zealand, an apt link to ANZCA. The property changed hands through the years until the College became the new owners on 1 September 1993. Following careful renovation and refurbishment, Ulimaroa was officially opened by Governor-General Bill Hayden on 19 February 1994.

While Ulimaroa serves as a proud headquarters to the College, it soon became obvious that it would be unable to cater to the College’s rapidly expanding activities. The founding of the Faculty of Intensive Care followed by the Faculty of Pain Medicine, increased examinations and overseas-trained specialists assessments, and the growth in Fellowship and trainee numbers were indicative of this. Subscriptions from Fellows had been nurtured for the purpose of expanding the College headquarters, and by 1996 it became feasible to do so. The next stage was not so easy. Council in 1996, under President Garry Phillips, took up the task of securing more space for the College headquarters, but with clear-cut conditions. The plan had to stay within budget, be acceptable to the Fellowship, and provide adequate space for the future. Council was faced with the huge responsibility for the expenditure of millions of dollars, i.e. our Fellows’ dollars. When considered, the options included leasing extra office floors elsewhere, selling Ulimaroa to purchase a bigger property, or building on to Ulimaroa itself. Surprisingly, despite months of searching, no office block or detached building could be identified that would suit our needs and budget. Also, the possibility of selling Ulimaroa did not sit well with Councillors, and it became apparent that the best option, and one that we could best determine our destiny, was to extend Ulimaroa.

Much work in earnest followed to examine plans, costs, and possibilities. Council debated at length whether to build to the five levels sufficient for our needs, or to seven levels at greater cost which would provide space in reserve for the next 10-20 years. Councillors bit the bullet and decided on the latter. The bulk of the construction took place in 1998/1999, during the term of Richard Walsh as President, and the building was finished within budget in April this year. The formidable challenge to the Councillors, CEO, architect, and builder was to build to a design that would blend the new with the old, and do justice to Ulimaroa’s magnificent exterior. What we have today is a modern seven floor extension, linked to Ulimaroa by two bridges. The seven storey natural-finish facade facing St Kilda Road shields the glass front of the building proper, and is visually complementary to Ulimaroa.

President’s Message

Teik E Oh, MD, PANZCA
House offers space; it is practical and with Ullimaroa, offers elegance. The challenge was well met. Indeed, one wonders why we had any doubts in the first place.

There are many people to thank for making ANZCA House a reality. They include past Treasurers, Deans, Presidents, and Councillors especially Dr lan Rechtman. Thanks are also due to the architect Norman Day and his team, the builders McCorkell Construction Company, the City of Port Phillip, and interior decorator Murray Sheldrick. Joan Sheales worked tirelessly as did Councillors in the past five years. I especially thank our Fellows for their financial and moral support, and invite them to visit ANZCA House. This is your building.

Our College now has a magnificent and workable headquarters for our disciplines. Ullimaroa / ANZCA House serves as a focus for educational and professional activities for Australasia in Anaesthesia, Intensive Care, and Pain Medicine. It raises the stakes in our professionalism and our commitment for excellence, now doubly enhanced by Dr Hollingworth’s patronage of the ANZCA Foundation. It raises the status of our Fellows and our disciplines. It is the wherewithal and core motivation for us to meet the challenges demanded by society and new advances in our profession. I quoted the words of Frank Lloyd Wright in my welcome address at the opening, and shall repeat them. The great architect said, ‘Noble life demands a noble architecture for noble uses of noble men (and women): We shall live up to those words.’

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**Admission to Fellowship**

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Address by His Excellency The Right Reverend Dr Peter Hollingworth, AC, OBE,

GOVERNOR-GENERAL OF THE COMMONWEALTH OF AUSTRALIA ON THE OCCASION OF THE OPENING OF THE AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS (ANZCA) HEADQUARTERS — ST KILDA, MELBOURNE
SATURDAY, 4 AUGUST 2001

Professor Oh, Members and Fellows of the College and Members of many other learned medical professions and colleges.

I am indeed pleased to be here this evening for the opening of this impressive new headquarters, what is clearly an outstanding blend of the old and the new. My wife Ann and I have just been treated to a tour of the building by Professor Oh and Mrs Sheales and your architects have created a truly excellent new space to complement the original building. I was interested to learn that “Ulimaroa” was built in 1899, a year before Australia became a nation. I suggest it provides a nice symmetry to have the new headquarters opened on the property during the centenary year of our Federation. And to observe the working partnership between the old and the new, between history and the contemporary needs of a large, specialist and increasingly diverse college.

This new headquarters, of course, is designed to serve the College well into the future, and I sense that its opening heralds a new era in public recognition for the work of anaesthetists all around Australia. Ever since you purchased Ulimaroa in 1993, it was always clear that the College would need to expand beyond the main building. Having worked alongside people associated with the College over the years, and I want particularly to make reference to the late Professor Robin Smallwood, former Dean of the College, I know that the range of services you provide to the community has broadened and that you continue to pioneer in significant areas of research, treatment and training. It is a somewhat extraordinary thing that most patients still don’t recognise anaesthetists as doctors, let alone acknowledging the role they play in affording patients a good outcome and in providing the necessary clinical environment upon which remarkable acts of surgery can take place.

But you can hardly blame the general public. Since when does the media identify the role of the anaesthetist in high profile surgical cases? How often do celebrity patients pay tribute to their anaesthetists? It’s been a “backroom” specialty from the start, under-supported and, as a consequence, somewhat on the back foot in terms of attracting research funding. This, I know, has been an ongoing issue for the College and for its Fellows, who have contributed funds from their own pockets so that the field of anaesthetics might advance and extend. The establishment of the ANZCA Foundation, another important body to operate out of this new building, is designed to address the shortfall by attracting support from the wider community. I believe this support will be easier to generate as people come to understand one of the newer specialties of anaesthetics, the specialty of pain medicine.

Highly complex in its application, pain medicine is clearly relevant to the health of the community as a whole, and to our nation’s prosperity. If there was ever any doubt about this, new findings from the chair of ANZCA’s Research Committee, Professor Michael Cousins, are impossible to ignore. One in five Australians now suffers from persistent pain. Apart from the profound human cost of that statistic, Australia must address the economic and social implications. An estimated loss of one million working weeks per annum. A staggering ten billion dollar annual price tag. Professor Cousins describes pain relief as a basic human right and is properly pushing for it to be included in the United Nation’s Charter of Human Rights. It reflects poorly on a society, he says, if 89 per cent of child cancer patients are suffering pain in their last month of their lives. When the pain specialist sees patients every week who are actively contemplating ending their lives. When the public debate on euthanasia is limited to the suffering of palliative care patients, brave though that may be and yet ignores the plight of hundreds of thousands of Australians who live with chronic, persistent pain.

The ANZCA Foundation has already identified its main research challenges, and the development of new strategies to deal with acute pain, cancer pain and persistent pain are a priority. But also of great interest and importance to the community is brain monitoring and addressing patients’ fear of awareness under anaesthesia. So too are the areas of critical care support, and identifying new drugs and techniques to use them. All of this important research will be generated out of the Australian and New Zealand College of Anaesthetists through the ANZCA Foundation. It deserves the support of government, corporate Australia and the community at large.

This evening, I am pleased to announce that I will be accepting an invitation from the College to become the Foundation’s Patron and I count it an honour. I hope that I can lend support...
to your work, and help promote anaesthetists' varied and significant contribution to the Australian community. Clearly the College and its Fellows and Members have come a very long way from those early days when you were regarded as, I think, the rag and bottle men.

But for tonight, I have a specific job to do. It is my great pleasure to unveil a plaque and, in so doing, officially to open the new headquarters of the Australian and New Zealand College of Anaesthetists.
Coronial Warning After Fatal Epidural Infusion

A Tasmanian coroner has recently given a warning about the potential dangers of multi-use infusion pumps following the death of a patient from a fatal epidural infusion. The coroner stated that hospitals should recognise that human error occurs and that appropriate steps should be taken to minimise the likelihood of such errors having regard to the potentially fatal consequences.

The coroner was investigating the death of a 75 year old woman four days after an otherwise successful operation. The patient had an epidural and a general anaesthetic, and was moved to the general ward from the high dependency unit after 48 hours. Bupivacaine and fentanyl were administered via the epidural catheter at the rate of 6 ml per hour. The pump used for the epidural infusion was a 3M/Graseby 3000 pump. She was also given intravenous fluid via a gravity-fed drip set.

Unfortunately, the patient suffered cardiac arrest, after the epidural infusion pump was mistakenly changed from 6 ml per hour to 125 ml per hour. The intravenous fluid rate should instead have been increased, in response to a diminished urine output.

The coroner found that the inadvertent administration of a fatal dose of drugs via an epidural infusion caused the death of the patient. The nurse responsible for the error was found to have contributed to the death of the patient but the coroner stated that there were specific aspects of the hospital’s work environment and practices which were unsatisfactory and which may have had an impact on the patient’s death.

These aspects included the hospital’s failure to ensure staff were required in all circumstances to operate the epidural infusion pump using a lock-out switch, and the difficulty faced by night duty nursing staff in taking breaks during their shifts if they wished to do so.

The coroner also found that there had been an incident six weeks prior to the death of the patient, in which an epidural line and an IV line had been inadvertently crossed, leading to an unacceptably high rate of epidural infusion. Potentially catastrophic consequences were avoided when the pump alarm sounded a minute later due to the pump running out of fluids to infuse.

As a result of this incident, certain recommendations were made including the clear and appropriate labelling of the pump, a revision of the epidural policy and procedure, and further education and training of nursing staff. The hospital does not seem to have acted upon these recommendations, until after the death of the patient.

The coroner recommended that the hospital implement the clear labelling of epidural infusion pumps, the line to it and the container sourcing the pump to avoid confusion. He further recommended that the 3M/Graseby 3000 pump not be used, in favour of another device with greater safety features. Where it was used, the pump should not be used for any purpose without the lock-out switch being utilised.
During the course of the inquest, the coroner had cause to comment upon the recording of information in patients' files. He found that there was a practice of not recording some matters in the progress notes until the end of the shifts, and thought it more desirable that notes be made as contemporaneously as possible to the observations of patients and any treatment of them.

The findings made by the coroner are of relevance to all practising anaesthetists, and hospitals. A review of practices and procedures should be conducted to ensure that the dangers identified by the death, and the coroner are averted. The coroner's findings now put us on notice of these dangers, and a failure to respond to them, may be evidence to suggest negligence in the context of any future adverse event. A copy of the findings can be obtained by contacting Janelle Talty at the College.

Errata

Dear Mrs Sheales,

Re: Mr Heath Thurlow Thompson, FRACS, FRCS Eng.

I read with appreciation John Gibbs' obituary for WJ Pryor, FANZCA and OBE, in the Bulletin for June 2001, page 57. Bill Pryor was an anaesthetist much loved, admired and respected. However, will you let me offer you a correction to one detail John has, please?

Mr Heath Thompson is referred to as 'the late Heath Thompson'. Heath has not passed on, he has just changed his address in Christchurch. I was talking to him a month ago and I can assure you he is in robust condition after being retired for 15 years now. He has a most valuable, ready recall of the history of early Intensive Care in Christchurch, for which he can be fairly described as the pioneer there. Anyone interested in that aspect of this remarkable man's contributions to this field, which was not his primary one by training, will find I have some details set out in the book 'Intensive Care in New Zealand: A History of the New Zealand Region of ANZICS' (by myself and James Judson). See therein the section 'Princess Margaret Hospital, Christchurch and Mr Heath T Thompson' on pp 108-109; also the brief reference under 'Christchurch Hospital, Christchurch' on p94.

I trust this will set the record straight.

Ron Trubuhovich, FFICANZCA

My personal apologies are extended to Mr Heath Thompson for this error published in the June issue of the College Bulletin.

Prof John M Gibbs
Sport and Pregnancy

The recent controversial ban on a pregnant woman participating in netball, instigated by Netball Australia, has been the subject of wide debate since the leading netballer made a claim to the Equal Opportunity Commission this year. Trudy Gardner, who was then five months pregnant, won an interim injunction against the ban in the Federal Magistrates' Court in July, on the basis that the ban discriminates against pregnant women, in contravention of the Sex Discrimination Act.

Under discrimination law, it would appear that doctors have an important role to play in this case in determining whether discrimination legislation will apply. Medical evidence will be an important part of the consideration of these issues.

However, it should be remembered that doctors have a wider role in this debate – the care of their patients – and the ordinary duties of obstetricians and gynaecologists continue to apply in relation to the care and treatment they give to their pregnant patients.

The legislation

Discrimination is covered by both Commonwealth and State based legislation. The federal Sex Discrimination Act 1984 is supplemented by equal opportunity legislation in all States and Territories. There is some overlap with the federal legislation and some variation between the State based legislation.

However, in general terms the legislation provides that it is unlawful to discriminate on the basis of pregnancy in a number of areas. These areas include sport, employment, provision of goods and services and clubs: all of which may be relevant to a ban against a woman playing sport whilst pregnant.

Accordingly, the blanket ban instituted by Netball Australia which prevents pregnant women participating in netball is, on its face, a contravention of the Federal Sex Discrimination Act, as well as relevant State and Territory equal opportunity legislation.

Some States provide an exception in their legislation to allow discrimination “if the discrimination is reasonably necessary to protect the health or safety of any person (including the person discriminated against)” (Victorian Equal Opportunities Act, section 80). Accordingly, where a sporting ban is instituted to protect the health or safety of the mother (and potentially the unborn child), the sporting body may seek to rely on this exemption. Accordingly, medical evidence will be crucial to determine whether the blanket ban is necessary for health or safety reasons.

However, the Sex Discrimination Act (Cwlth) contains no general exemption from the operation of the act on medical grounds. It does contain an exemption where the discriminatory conduct relates to competitive sport in which the strength, stamina and physique of competitors is relevant. However, this exemption would not appear to be highly relevant to the case of a blanket ban against pregnant participants.

Therefore, in some States, the central issue will be whether the ban on pregnant women can be justified on the basis of medical risk to the mother and/or the unborn child.
Medical risk
The general consensus in medical circles is that the positive effects of exercise upon the woman outweigh the theoretical negative possibilities. Maternal and foetal responses to exercise may vary with the pre-gestational maternal fitness level, coexisting medical conditions or pregnancy complications. The varied experience of pregnancy does not appear to justify an all-encompassing ban on medical grounds for women competing in sports whilst pregnant. The Guidelines issued by Sports Medicine Australia do not support a general ban on pregnant women because they do not suggest that sport poses any significant harm to the health of the unborn or the pregnant woman. The Guidelines are based on those provided by the American College of Obstetricians and Gynaecologists.

These Guidelines and the general medical opinion suggest that, provided professional medical opinion is sought on an individual basis, a woman is safely able to engage in some degree of sport throughout most of her pregnancy. The general Guidelines, which provide a starting point only, suggest the following:

• During the first trimester the foetus is susceptible to sustained increases of the mother’s core body temperature and consequently intensity of activities should be modified and fluid intake should be carefully monitored;
• Maximal intensity exercise should be restricted;
• Redistribution of body weight can lead to increased falls in the second stage of pregnancy. The foetus is also at greater risk of direct impact due to positional changes and contact sports are therefore less advisable; and
• Some medical conditions will preclude sporting participation in pregnancy.

In general, medical evidence suggests that non-contact sports are suitable throughout all stages of pregnancy provided the athlete has suitable medical supervision and the level of exertion is controlled. In sports where there is limited contact, the risk of falls and contact with a projectile are minimal. In a normal pregnancy, these sports are considered safe for at least the first trimester. However, unlimited contact and collision sports might be appropriate for the first trimester only. There are also a number of specifically excluded sports, such as scuba diving and horse riding which carry a high risk of falls and physical trauma and should be avoided altogether.

There is research available that suggests that exercise is an important element in a safe and natural pregnancy. There are documented benefits gained from medically supervised exercise. Such benefits concern maternal weight gain, maternal fitness, gestational diabetes, and the effects of gestational age, labour and birthweight. Additionally, exercise is known to help reduce backache, improve mood and energy, improve posture, aid sleep and promote muscle tone and strength.

In relation to the issue of ability to compete in terms of strength, stamina and physique it would seem that different women and women at different stages of pregnancy are affected to differing degrees, depending on the normality of the pregnancy and the fitness of the individual. Consequently it is inappropriate to put a general ban on pregnant women from competing in sports even if it was to be limited to a certain stage of pregnancy. The physiological changes being undergone by a woman will eventually mean that she is unable to compete to a sufficient standard but a decision that she ought to cease competing should in this respect be based solely on her individual inability to compete competitively.

Duty of care
It should be noted, however, that the duty of care owed by obstetricians, gynaecologists and other doctors is not altered by this debate. Doctors who are consulted by pregnant women in relation to participation in sport must nonetheless properly advise on risks that may be involved and the effect of competitive sport or general exercise. The increased media focus on these issues will no doubt lead to greater patient awareness.

Whilst having the duty to maintain proper standards of care, no doubt there will also be greater focus on the obligation of doctors to properly advise pregnant women who may be considering strenuous exercise or competitive sport both in relation to the health of the women and any potential risks for the unborn child. Of course, there can be great benefits to both the mother and child from appropriate exercise during pregnancy. Nonetheless, competitive sport, particularly sport involving physical contact, must necessarily entail some risks.

Some statements by Netball Australia indicated that their blanket ban on participation of pregnant women was motivated, not so much by health or medical risk, but the fear of litigation arising from potential damage to the mother or child. The fear of litigation from an impaired neonate with an injury shown to be related to the sport is real and the compensation sought in such cases can be significant (several millions of dollars).

The legal risk for sporting bodies is certainly not illusory. Australian case law indicates that a mother has a duty to her unborn child. It is therefore possible for others, such as sporting associations and other competitors, to owe a duty to an unborn child. Controversially, it may be that, whilst a competitor is not liable to a pregnant woman for injuries caused by actions performed within the rules of the sport, and which would reasonably be anticipated and consented to by other competitors on the field, the consent to such actions by the mother may not extend to the unborn child. In other words, notwithstanding that the mother may not be able to make a claim following an injury in sport, the unborn child/impaired neonate may later be able to claim. Whilst the issue is not
entirely clear as to the scope of any such claim, there is some case law to suggest that the duty of care owed to the unborn child should still be limited to participants acting within the rules of the game.

**Conclusion**

The blanket ban imposed by Netball Australia provides an interesting test case.

On the information available to date, there is a significant risk that the ban infringes anti-discrimination legislation in Australia. The evidence of medical experts will be an integral part of consideration of these issues.

On the other hand, the legal risk for sporting bodies arising from claims by pregnant participants and the unborn cannot be ignored.

One sound piece of advice for clubs and sporting bodies is therefore to ensure that appropriate insurance for such risks is maintained at all times.

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*Michael Gorton is a partner with Russell Kennedy Solicitors. He is a former Commissioner with the Victorian Equal Opportunity Commission. He holds honorary fellowships with RACS and ANZCA. I am grateful for the assistance of Lisa Griffin in the preparation of this article.*

1. Sports Medicine Australia Guidelines – Dr Marg Torode “Participation of the Pregnant Athlete in Contact Collision Sports”


4. RACOG Patient Information pamphlet on “Exercise During Pregnancy”


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**Errata**

Apologies are extended to Dr Gary Hopgood and Dr Shane Townsend whose names were spelled incorrectly in the June issue of the College Bulletin.

Dr Gary Hopgood was presented with the Renton Prize for August 2000 at the Combined Scientific Meeting in Hong Kong in May.

Dr Shane Townsend was presented with the Cecil Gray Prize for September 1999 at the Combined Scientific Meeting.
Regional Annual Report

Western Australia

Office Bearers
Chairman
Dr Grant Turner
Honorary Secretary
Dr Stuart Inglis
Honorary Treasurer
Dr Stuart Inglis
Continuing Education Officer
Dr Michael Paech
QA Officer
Dr Neville Gibbs
Regional Education Officer
Dr Lindy Roberts
Welfare Officer
Dr Simon Maclaurin
SARG/ Rural Education
Dr Leigh Coombs
Members
Dr Nedra vanden Driesen
Dr Craig Schwab
Councillors
Prof Teik Oh
Dr Wally Thompson

Attendance at Regional Committee Meetings

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<tr>
<th>Name</th>
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<td>Dr L Coombs</td>
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<td>Dr S Inglis</td>
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<td>Dr N Gibbs</td>
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<td>Prof Teik Oh</td>
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<td>Dr Lindy Roberts</td>
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<td>Dr Simon Maclaurin</td>
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<td>Dr Andrew Miller</td>
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<td>Dr Roger Goucke</td>
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<td>Dr N vanden Driesen</td>
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<td>Dr Wilson Lim</td>
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<td>Dr Stephen Watts</td>
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<td>Dr Richard Riley</td>
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<td>Dr Bernice Ng</td>
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<td>Dr Mark Josephson</td>
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Continuing Education Report
Dr Michael Paech

Regional Scientific Meetings
The 2000 Winter Scientific Meeting (WSM) was held on July 23 2000 at the McDonald Lecture Theatre. This was the final of three such meetings honouring the Dr Ian Miller Lecture and completed the continuing education activities of Dr Suellen Walker commenced during the preceding week. Dr Walker, of Royal North Shore Hospital, Sydney was a popular visitor, speaking at meetings and tutorials in Bunbury and at Royal Perth, Sir Charles Gairdner, Fremantle and Princess Margaret Hospitals. The WSM proved an ideal forum for presentations by local anaesthetists and the standard of free papers, principally by trainees, was excellent. WA Anaesthesia thanks Glaxo Wellcome and Boots Healthcare for their sponsorship.

The 2001 WSM welcomed Dr Kate Leslie of Royal Melbourne Hospital. Kate was busy in both Bunbury and the metropolitan teaching hospitals that week. WA Anaesthesia thanks her for her involvement as the inaugural Dr John Hankey Lecturer. We also wish to acknowledge the support of Boots Healthcare, our sole sponsors this year.

The 2001 Autumn Scientific Meeting was held on March 24 and 25 2001 at the Radison Hotel, Scarborough. This was a highly successful multidisciplinary meeting organised by Dr Hugh Welch as the ASA CE Officer. It involved contributions by Anaesthetists, Haematologists and Scientists and the Industry. It was also pleasing to see a strong attendance by anaesthetic technicians and nursing staff.

The 59th National Scientific Congress of the ASA held at the Sheraton Hotel from September 30 to October 4 2000 was also a tribute to the Organising Committee, in particular Dr Chris Johnson the Convenor.

Other Activities
In addition to a number of Industry-sponsored presentations by overseas speakers, visiting lectures arranged for professional colleagues included those of Professors Stephan Schug on 16 August 2000 and Prof Ian Davies on May 1 2001. Stephan has now moved to Perth and is currently the Associate Professor of Pain Medicine based at Royal Perth Hospital. Professor Davies from Calgary, Canada has a special interest in crisis management and prevention of critical incidents. Her visit was sponsored by the Health Department and included lectures at several hospitals. An evening meeting for anaesthetists organised by Anaesthesia WA was held at CTEC and kindly sponsored by Datex Ohmeda.
Western Australia (continued)

Anaesthesia WA continues to support rural General Practitioners with CE meetings and hospital visits, now held in Perth at CTEC and Royal Perth Hospital. Thanks to Dr Leigh Coombs for his organisation of these courses.

Future Continuing Education
In October 2001 King Edward Postgraduate Education is bringing Professor Jim Eisenach to Perth from North Carolina, as the KEMH RL Hutchinson Visitor. Professor Eisenach has spoken in Perth previously and during this two week visit he will be lecturing at public and evening meetings for the anaesthetic community on topics related to chronic pain and intraspinal analgesia. Full details of his program will be available in September.

Perth is host to the 2004 Annual Scientific Meeting of the College and organisation is already in place. The convenor is Dr Mark Josephson and the social convenor Dr Andrew Gardner.

Continuing Education for Rural GP Anaesthetists
The College and Society in collaboration with CTEC continues its innovative three-day combined classroom and simulation program over the past year specifically for rural GP Anaesthetists. This continues to be a high value educational activity.

New Fellows Report
Dr Eric Visser and Dr Sai Fong were the WA representatives to the New Fellows Conference in Hong Kong in May 2000.

Gilbert Troup Prize for Undergraduates in Anaesthesia
ANZCA has added support to the long standing Gilbert Troup Prize for Medical Students administered by the ASA WA.

Financial Report ANZCA WA Administration Account
Dr Stuart Inglis
The budgets were presented in accordance with College guidelines. Audit was performed and found to be satisfactory. A financial report will be presented to the ANZCA WA AGM.

Financial Report ANZCA ASA Continuing Education Fund
Dr Paul Rodoreda
Budgets and Reports were prepared according to the respective Guidelines and forwarded to ANZCA and ASA according to their respective schedules. Financial Reports will be presented at the respective AGMs.

Regional Education Officers Report
Dr Lindy Roberts

Changes to the WA Anaesthesia Program
Formal projects
Local guidelines have been developed and circulated to trainees. Two Fellows undertake assessment of non-published projects.

FICANZCA trainees
From 2002, one training position will be available to FICANZCA trainees.

Trainee numbers
Currently there are 38 trainees (years 1–4). ANZCA approval has been sought for three additional training positions in the WA Anaesthesia rotation for 2002, bearing in mind the limitations imposed by requirements for subspecialty experience. The results of recent Department inspections are awaited.
Trainee appointments
January 2001: David Butler, Erin Corcoran, Elizabeth Ferguson, Lisa Khoo, Irina Kurowski, Angeline Lee, David McGuire, Sharon Robless, Jay White, Denise Yim
July 2001: Julie McArthur, Suzanne McKenzie, Glenn Murray, Sarah Wyatt

Formal projects approved
T Hadlow: Vaporizer inaccuracy at low flows in the paediatric setting (with D Campbell, presented WSM 2000).
P Kalinowski: Mutant barley, Siberian camels and giant reeds: intravenous lignocaine for acute postoperative pain (presented WSM 2000).
B Stolk: BIS – an Australasian perspective (with J Bruce, presented Autumn Scientific meeting 2001).
G Sue: Accuracy of Graseby 3500 syringe pump during magnetic resonance imaging (presented ASA NSC Perth 2000).
M Veltman: The development of a performance indicator to objectively monitor the quality of care provided by an acute pain team (with E Hammond, G Turner, T Oh; AIC 2000;28:293-299).

New Fellows
We congratulate the following New Fellows:
Clare Cole Sai Fong Andrew Gardner
Clare Hanavan Andrew Imison Soo Im Lim
Tim Mann Richard Scolaro Craig Smith
Graham Sue Michael Veltman

Acknowledgements to the following without whose support the quality of WA anaesthesia training would be greatly diminished:
Dr Grant Turner, former REO

Supervisors of training
Dr Wilson Lim (Bunbury Regional Hospital)
Dr Jay Bruce (Fremantle Hospital)
Dr Liz Avraamides (Joondalup Health Campus)
Dr Polly Harmon (King Edward Memorial Hospital)
Dr Soo Im Lim (Princess Margaret Hospital)
Dr Ramin Gharbi (Royal Perth Hospital)
Dr Steve Myles (Sir Charles Gairdner Hospital)
Dr John Martyr (Advisor for non-aligned trainees)

Retired Supervisors of training
Dr Chris Cokis (Royal Perth Hospital)
Dr Charlotte Jorgenson (Princess Margaret Hospital)
Dr Craig Schwab (non-aligned trainees)
Course convenors
Part 1 – Dr Jay Bruce, Dr Nedra Vanden Driesen
Part 2 – Dr Chris Cokis, Dr Simon Maclaurin, Dr Bill Weightman

Clinical teachers, lecturers, trial examiners, mentors, and project supervisors
Too many to mention by name, thanks for your input.

ANZCA WA Welfare Officer
Simon Maclaurin

An orientation evening was held in January for all new ANZCA trainees at St John of God Hospital. Kindly sponsored by Astra-Zeneca and attended by nine out of 13 invited trainees.

The evening consisted of relatively informal presentations by representatives from the College, the ASA, the Part One teaching program, the Part One Exam committee and two trainee registrars sharing their thoughts and experiences.

Subsequent feedback from the new trainees was very positive. I would like to thank all involved and hope to run a similar program next year.

Australasian Anaesthesia – WA Sub editor
Dr Neville Gibbs renominated for this position and continues his excellent work.

Australian Resuscitation Council – WA Branch
Dr Aileen Donaghy represents WA Anaesthetists in this regional committee.

Faculty of Pain Medicine
Dr Roger Goucke (Vice Dean) represents the Faculty on the ANZCA WA Committee and has kept the committee abreast of the many developments in the new Faculty.

Faculty of Intensive Care
Dr Bernice Ng has represented the Faculty on the regional committee.

ANZCA and ASA in Western Australia
The past 12 months has seen a continuation of the close working relationship between the ANZCA and ASA. The two committees have held their respective bi-monthly meetings after a joint combined meeting. In doing so we have been able to avoid duplication of effort while constantly providing a unified voice on issues effecting all anaesthetists in Western Australia.

The combined secretariat was relocated from CASMS to share the services of Prof Oh’s secretary Mrs Peta Gjedsted based at Royal Perth Hospital. This is a temporary move and a new secretariat will be set up in the next six months.

The Regional Committee nominated Dr Robert Wong for the College Citation. Council approved this and Dr Wong was presented with the citation at the Regional AGM.

Western Australian Anaesthesia Mortality Committee
Dr Neville Gibbs has taken over the role of chairman of the WA Anaesthetic Mortality Committee and has embarked on a process of increasing the anaesthetic community’s awareness of the function and workings of the committee.

Anaesthesia WA Website
Dr Richard Riley
Webmaster www.anaesthesia-wa.iinet.net.au

Anaesthesia in Western Australia has its own website. It offers information on institutions, services, education, news, links to other WA hospitals, national and international sites. The site is a joint project of ANZCA and ASA in WA and is sponsored by AstraZeneca.
Health Department of Western Australia Committees

ANZCA WA contributes to state committees on Endoscopy Services, Day Surgeries and Rural General Practice Anaesthesia.

Chair of Anaesthesia in WA

Professor Teik Oh (President of ANZCA) is the inaugural Chair of Anaesthesia in Western Australia. He is based at Royal Perth Hospital. This year Associate Professor Stephan Schug from Auckland has joined him taking up the position of Associate Professor of Anaesthesia at the University of WA and the Director of Pain Medicine at Royal Perth Hospital. This appointment continues the process of enhancing the academic profile of Anaesthesia in Western Australia.

On behalf of the College I thank all the WA Committee members and Councillors who give so much of their time and talents to the ANZCA WA committee and the specialty in Western Australia.

Dr Grant Turner
Chairman
President Oh, President Lee, distinguished guests, ladies and gentlemen:

I am most honoured to be invited to speak at your Combined Scientific Meeting this evening. I guess I have been invited because over the years as a surgeon, I have cultivated the company and friendship of many anaesthetists. However I must admit that I am also surprised to be invited because I would have thought that the last thing any anaesthetist wants is to put up with more rantings from a surgeon!

I have chosen for the title of my talk “Hong Kong at the Crossroads” because I think our overseas friends would be interested in the development of Hong Kong. Otherwise the Australian and New Zealand College of Anaesthetists would not have picked Hong Kong for their meeting. For our local anaesthetists I hope to put a different perspective on Hong Kong for your consideration.

To understand Hong Kong one must go back in history. Hong Kong was an insignificant piece of barren rock with a few fishing villages in the middle of the 19th Century under a very weak Ching Empire. Hong Kong was hardly featured on any map at that time. The opium trade in China was flourishing under Western entrepreneurship. The Chinese authorities realised the immense harm the drug trade was having on the country ¾ very similar to today’s situation around the world. Not only was the health of the nation compromised but it was a drain on the silver reserve of the country. In desperation the local authorities took fairly drastic action. They seized and burned the opium stocks of the East Indies Co. Britain retaliated with invasion and occupied Peking the capital.

In the subsequent peace treaty, known as the Nanking Treaty of 1842, besides huge reparation, Hong Kong island and a small piece of Kowloon peninsula was ceded to Britain in perpetuity. What attracted Britain to Hong Kong was its natural harbour which was deep and safe from the elements and where the British ships could moor. This treaty might have seemed reasonable to the British Government but has always been the “infamous treaty” for the Chinese. To put this in perspective in a modern day equivalent, it would be like Colombian drug lords invading Australia because you have seized their cocaine shipments.

With the continual decline of the Ching Dynasty, it was not long before a second equally unequal treaty was forced upon China in 1898. In this second treaty the rest of Kowloon and a huge area called New Territories were leased to Britain at no cost for a period of 99 years.

Britain then governed Hong Kong as a colony where the local Chinese had no rights of representation. Certain areas were segregated where Chinese were not allowed to live and at night Chinese would have to carry a lantern with them whenever they ventured out. The colonial government then consisted of 4 men ¾ the Governor, the Chief of the Army, the Colonial Secretary and the Chief Justice. At the beginning of the 20th Century, the Hong Kong Chinese were active in fermenting the revolution which eventually overthrew the Ching Dynasty. They gave money and shelter to the revolutionaries and the Ching authorities were powerless to prevent these activities as they took place on British soil. Understandably in present day China, there is still sensitivities that Hong Kong may be used as a centre for subversion.

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After the establishment of the Republic of China in 1911, there was civil war. As Hong Kong was under British protection, it became a haven for refugees and those who yearned for peace and stability. Although the colonial government was strict it was clean with little corruption. In turn, the Chinese though deprived of any political rights, were able to devote their attention to commerce and trade as well as the professions. Some Chinese who excelled were obviously appreciated by and rewarded with honours by the British. It was a stable symbiotic existence.

Then World War II came. Despite hasty preparations, Japan over-ran Hong Kong in a matter of days. The invincibility of the British was shattered. From Christmas of 1940 to the liberation in August 1945, Hong Kong was under a new ruler, the Japanese Emperor. Under this new Imperial rule, the population suffered atrocities, hardship, starvation and disease. All the expatriates were put into concentration camps and suffered terrible deprivation.

After the War, Britain resumed its colonial administration. Hong Kong was governed by the Governor who was the representative of the Crown and had absolute powers. He had an Executive Council which was his cabinet but only advisory in nature. There was a Legislative Council which passed the laws of governance. All members of these 2 councils were directly appointed by the Governor. There was no elections. In the 1950s, 1960s and 1970s, half of the seats of each Council were reserved for Chinese and the other half for expatriates even though the Chinese made up of 98% of the population. There was also an Urban Council which was essentially responsible for the running of the city like garbage collection, granting of liquor or restaurant licences. Half the members of the Urban Council were elected while the other half were appointed by the Governor. The Urban Council served two important political purposes. First it allowed some form of representative government and the other was used as a testing ground for government appointees before they moved up to the Legislative and Executive Councils.

Hong Kong continued to flourish under such a stable government. With the large influx of refugees following the establishment of the People's Republic of China, manufacturing know-how especially in textiles was brought to Hong Kong. There was a pool of cheap labour and the colonial government undertook major infra-structural development in housing, education and welfare. Despite the cultural revolution in China, there was little lasting impact other than some riots in Hong Kong. Obviously China realised the commercial and financial values of Hong Kong and did not wish to kill the goose that laid the golden eggs.

It was in 1979 when the then Governor Maclehose went to China and was told privately by Deng Xiaopeng that China would resume sovereignty over Hong Kong in 1997. It was not until 1982 that matters came to a head because the financial sectors needed to know what would happen in 15 years time in relation to their lending and mortgages.

Margaret Thatcher, “the Iron Lady”, arrived in 1982 to open the negotiations. Unfortunately flushed with the success of the Falklands campaign, she maintained the 2 unequal treaties fostered upon a decaying Chinese Empire were valid. Little sensitivity was displayed because the Chinese regarded both treaties as national humiliations. The Chinese hardened their positions.

Over the next 2 years, the British negotiation team led by Sir Percy Craddock tried to keep British administration after 1997 with acknowledged Chinese sovereignty over the whole of Hong Kong and not just Kowloon and the New Territories. However it was to no avail. The Chinese maintained that sovereignty and administration must go together. In 1984 at the Great Hall of the People in Beijing, Britain and China signed the Sino British Joint Declaration whereby the whole of Hong Kong would return to Chinese sovereignty. However Hong Kong would maintain a high degree of autonomy with the slogans of “One Country Two Systems” and “Hong Kong people governing Hong Kong”.

To implement this joint declaration, a new constitution for Hong Kong would need to be written. A Basic Law Drafting Committee with representatives from China and Hong Kong was formed. A Consultative Committee of Hong Kong representatives was also formed to monitor the progress of the Basic Law. It was the first time I became involved with the politics of Hong Kong and China. Under the Basic Law, all our freedoms and way of life in Hong Kong after 1997 were guaranteed. At that point in time, the people of Hong Kong were quite schizophrenic. If you had asked if Hong Kong should become a part of China, an overwhelming majority would say yes. However if you then asked if Hong Kong should come under communist control, the same overwhelming majority would say no.

However it was obvious that Britain could not defend Hong Kong against communism or to be fair, Britain was powerless to do much. Margaret Thatcher confirmed that much to our Legislative Council. The Basic Law was the best deal that the people of Hong Kong could get. At least it was not as unequal as those of 1842 and 1898! Accordingly there was wide acceptance of the Basic Law when it was promulgated in 1990.

The drafting of the Basic Law was a great learning experience for me. Every Saturday we sat and discussed the various provisions. My particular interests were to guarantee autonomy for the professions, education and religion. A simple matter when put into legal jargon became very complicated. If I ask you to dinner, you know exactly what I mean. However to lawyers you have to define the exact time, the exact place, the exact menu and who is liable to pay.
We felt we had done a good job in drafting the Basic Law which provides full autonomy for Hong Kong to formulate policies to improve and develop medical and health services (Article 137), to protect intellectual property rights (Article 138) and to maintain the previous systems concerning the professions and work out its own methods of assessing professional qualifications. Moreover all prior qualifications and established professional organisations would be recognised and could assess and accredit these professional qualifications (Article 141). In essence the Basic Law would safeguard our professional autonomy.

Moving at the same time, the medical profession pressured the Government to ensure our autonomy would continue in postgraduate medical education and I was involved in the Working Party which eventually recommended the recognition of our Surgical Colleges and the Hong Kong College of Anaesthesiologists and the formation of the Academy of Medicine.

During this period the government of Hong Kong was changing. Localisation of some senior civil service posts and new composition of the Legislative Council and Urban Council were adopted and there was the introduction of 18 district boards to run district affairs. The most significant change was in the Legislative Council when for the first time in 1987 there were 18 elected members from the general public and the introduction of 22 functional constituencies. A functional constituency comprised of a special interest group ¾ like doctors and dentists, bankers or teachers. Each of these groups could elect among themselves a representative to the Legislature. For example each registered bank irrespective of its size would have one vote within their own constituency as each doctor or each dentist could elect their own representative. This is to ensure that all sections of our community are represented.

In 1989 the Tian An Men Affair was a major set-back in the confidence of the people of Hong Kong. We saw tanks rolled into the square in the early hours of June 4th. What we saw was of course only one facet. We had no idea what was the background or the political undercurrent within China. Nonetheless we were disappointed because on the one hand we were working hard to bring the Basic Law into fruition while on the other hand, we were witnessing the apparent chaos in the capital. When we confronted the leadership over the Tian An Men Incident, the reply was most interesting. “You are our friends and friends should not judge each other; let us leave it to history to make the judgement.” Although many people in Hong Kong were shaken by the event we had no choice but to try to do what was best for Hong Kong under the circumstances. No one would come to our aid, no one would stand up for us or defend us. We had to work with China for a solution.

The election of 1991 went off smoothly and members were to serve for four years till 1995. It was envisaged that by 1995, half the members that is 30 would be from the functional constituencies, another 20 and eventually up to half would be from direct elections. It was postulated that the Legislative Councillors would straddle 1997, ie from 1995-1999.

Unfortunately in 1992 Mr Christopher Patten lost his seat in Bath at the British General Election and was rewarded by being made the Last Governor of Hong Kong. He immediately embarked upon confrontation with China. Without prior consultation, he decided to open up the electorate of the functional constituencies. For instance, before, each bank would have one vote, Patten’s proposal was to allow everyone who worked in a bank to have one vote. This of course would drastically widen the franchise but defeated the whole spirit of the functional constituency.

China accused Britain of reneging on the Joint Declaration and the people of Hong Kong were horrified because this would allow China grounds for withdrawal from its concessions on autonomy for Hong Kong. The Stock Market reacted negatively the moment Chris Patten announced his proposals and continued to drop its value every time Mr Patten made a speech. Fortunately for Hong Kong, China kept its side of the bargain. Perhaps to be fair to Chris Patten, he believed that the guarantee of autonomy for Hong Kong was to democratise the running of Hong Kong. However the democratisation was much too late, note that it was not even mentioned during the previous British colonial rule of over 150 years. This created a climate of suspicion that Patten was undermining the future of Hong Kong and was cynically using Hong Kong to promote his international stature as a defender of democracy.

Meanwhile there were large scale infrastructural projects like the new Chek Lap Kok Airport on Lantau Island, with extensive reclamations not only on Lantau, but also in Kowloon. Massive rail linkages and building of bridges joining the new airport with the rest of Hong Kong were undertaken. Some people believed that these projects were to siphon Hong Kong money back to British firms.

I believed Mr Patten visited China twice and each time stayed no more than 3 days. Yet he wrote the book “East and West” as the authority on China. If he stayed a month, he could probably have written an encyclopaedia! China took the line to isolate Chris Patten and simply ignored him. China then appointed a number of Hong Kong advisors to help with the transition and I was priviledged to be among them.

When July 1997 came, amid fireworks, pomp and ceremony, China resumed full sovereignty over all of Hong Kong. Mr Patten and the British crown finally departed from the scene. The Chief Executive Mr Tung Chee Hwa, the senior civil servants and the Judiciary were sworn in right here in this
Many eyes have been on Hong Kong since that historic moment in 1997, and we have been through some rather rough weather.

Internally, the challenge has been to make the ‘One Country, Two Systems’ concept a working reality, while preserving the quintessential qualities that have made Hong Kong unique and successful. This is an altogether unprecedented experiment and one can imagine all the debates, arguments, quarrels, protests, and demonstrations that revolve around how that experiment should be conducted, what ought and ought not to have been done, and who should be held responsible for which misdeed.

The external challenge, of course, was the Asian financial crisis, which first led to the bursting of the economic bubble and then the worst recession in Hong Kong. It is a most unfortunate coincidence that the crisis should come at the time it did, when we just started a new page in our history and were beset with many internal difficulties.

But for the last three years, how have we done so far?

- According to the Heritage Foundation 2001 Index of Economic Freedom, Hong Kong is the world’s freest market for the sixth consecutive year.
- We are the most popular tourist destination in Asia (excluding the mainland).
- We are the 2nd largest stock market in Asia, after Tokyo in Japan, in terms of capitalization.
- Our foreign exchange reserves were the world’s 4th largest last year.
- Our new airport was the 5th busiest in terms of international passengers in 1999.
- According to the World Economic Forum 2000, ours is the 8th most competitive economy in the world.

Facts and figures speak for themselves. The worst of the Asian crisis is clearly behind us. In a short span of two years, we have achieved a most impressive recovery from the financial storm of 1997-98. Real GDP rebounded, and the economy grew by over 10% last year. Foreign direct investment in the first nine months of 2000 reached 33 billion US dollars, representing a 40% increase over the same period in 1999. Unemployment declined, prolonged deflation has eased considerably, and the continued fall in prices and business costs has helped improve Hong Kong’s competitiveness. There are now some 3,000 multinational corporations using Hong Kong as a regional base, and it is cheaper to call from Hong Kong to the US than it is to call between some US States.

No small feat indeed. The International Monetary Fund attributes this speedy turnaround to the flexibility of our markets and the authorities’ pragmatic handling of fiscal policy during the recession.

And none of this has been achieved at the expense of things dear to our heart and our system — things such as the rule of law, civic freedoms, social order, and commitment to fair play and equal opportunity. People may have dissenting views over individual issues but Hong Kong as a whole is proud and upright in 2001.

Yet critics continue to say Hong Kong people are unhappy, moody, downcast, lacking in confidence in a better future. I see it a little differently.

For one thing, while the ‘One Country, Two Systems’ prototype is working well, many details have yet to be finetuned, many unforeseen problems will crop up to vex us. We are treading a completely unknown path and simply can’t afford to be light-hearted. We may consider this the special demand of our times.

And then the painful adjustment following the Asian crisis has turned many of us sober. Yes we have survived the ordeal and rebounded, but it will be too simple and naive to believe that once the weather clears, everything will become rosy again. This is not the best of times for Hong Kong; neither is this the best of times for many other parts of the world. It will be foolish optimism to deny the stark realities of a globalized economy and ignore the possibility of another crisis or of recessions in the United States and Japan. We have not come this far without a struggle; we cannot go further without a struggle.

Such sobriety is not the same as pessimism or downheartedness. Not at all. It represents instead a responsible attitude towards problems of the present, and a realistic grasp of the dangers that lurk ahead. We dare not be complacent or frivolous; we realize that continued vigilance is needed to safeguard our long-term well-being.

Out of such vigilance, we have started to introduce measures to strengthen the risk-defense mechanisms in our financial and banking systems and the regulatory framework in our securities and futures markets. We have initiated reforms at various levels of our education system to upgrade human capital for our knowledge-based economy.

Out of such vigilance, we have devised plans to facilitate urban renewal and environmental protection, hoping to provide a quality home for all in Hong Kong. We have also launched the Mandatory Provident Fund System and reviewed the delivery of our medical and health services, all in anticipation of an ageing population.

Out of the same vigilance, we have stepped up efforts to boost our IT and tourism industries, to improve our telecommunications and transportation infrastructure, and to
increase the efficiency and transparency of government services.

In short, Hong Kong is 100% positive and constructive. No city that has lost heart will go to such lengths to prepare itself for the future.

And what kind of a future is there in store for us?

Ladies and gentlemen, we consider ourselves most fortunate to have returned to China at this great moment of her economic development. Both the upcoming accession to the WTO and the all-out development of the western provinces will have important implications for us. They will mean an increasing demand for advanced services and quality products from the mainland, and hence vast business opportunities for Hong Kong. The accessibility of China’s internal market will also attract numerous multinational corporations, many of which will still choose Hong Kong as their base of operation, as our facilities, knowhow, and contacts are assets that cannot be easily replaced. In 20 years, China’s economy will grow to be one of the world’s largest, her trade and investment systems will become more rule-based, more transparent, more aligned to international practices. I see no reason why Hong Kong should not derive enormous benefits from such an evolution, provided that we have made all the necessary preparation.

So far it has not been all work and no play.

Our film-makers not only have their products entertained the Hong Kong audience, they have also impressed many of our foreign friends. The fact that two local artists won for Hong Kong our first Oscar Awards a month ago is a big boost to our creative spirits. However we still need to produce a Mel Gibson!

Ladies and gentlemen, if you are, like me, a Hong Kong resident, I hope what I have said can give you an objective revaluation of our home city. If you are a guest from overseas, I shall leave it to you to explore and enjoy this City of Life. I am sure you will not be disappointed.

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Victorian Regional Committee
Annual Annual Combined CME Meeting

The 22nd Annual Combined CME meeting of the Victorian Regional Committee and the Victorian Section of the Australian Society of Anaesthetists was held on Saturday 21 July 2001. The meeting ‘Technology and the Anaesthetist’ attracted a record number of registrants and was well patronised by the Health Care and Technology Industries. Highlights were many, but the sessions on Palm and mobile computing, anaesthetic record keeping systems and education resources and the Internet were particularly well received. Most registrants said there was ‘something for everyone!’ Dr Kate Leslie awarded ANZCA Citations to Mr Bill Woodhouse and Dr David McCuaig for their contributions to Anaesthesia over many years. The CME Organising Committee is to be congratulated on a fine effort!

A limited supply of surplus copies of the Meeting abstract book remains and can be obtained by contacting the Victorian Regional Committee at the College.
The CVP Special Interest Group held its 6th Continuing Education Meeting, ‘Keeping Current with Problem Based Learning’ at Ayers Rock Resort, Northern Territory, 6–8 July 2001. This meeting was successful in its academic goals and the standard of presentation was extremely high. The main themes of the meeting included management of thoracic trauma, aspects of medical and surgical management of coronary artery disease, newer technologies in anaesthetic management of cardiac patients, including transoesophageal echocardiography and aspects of troubleshooting during vascular and cardiac surgery.

Much time was allowed for discussion and our overseas visiting speaker, Jonathan Mark, MD from Duke University Medical School was an outstanding success.

The CVP SIG Annual General Meeting was held on Sunday 8 July and the main item of business was to consider a motion regarding certification in transoesophageal echocardiography for anaesthetists. A motion was proposed by Gregory Deacon, seconded by Nigel Symons as follows:

‘That the Cardiovascular Thoracic and Perfusion Special Interest Group recommends to the Australian and New Zealand College of Anaesthetists that it not introduce certification for transoesophageal echocardiography.’

This motion and some general information regarding both certification and accreditation for transoesophageal echocardiography were distributed to the membership prior to this meeting.

The discussion at the AGM was conducted in the form of a debate with presentations supporting and opposing the motion. The motion was put and was passed with 72 supporting and 66 against. It is important to acknowledge two aspects of this vote. One aspect is that at the meeting 22 people voted in favour of the motion and 32 against with a significant number of abstentions. The motion was indeed carried by proxies, for which there were 50 in favour and 34 against. It should be noted that the proxies did not have the opportunity to hear and participate in the discussion.

The discussion and the audience response gave a clear mandate for the development of guidelines for training in diagnostic transoesophageal echocardiography. The Special Interest Group Executive will now proceed with the development of a statement on guidelines for a training programme in diagnostic transoesophageal echocardiography.

There was a brief discussion around the College professional documents on extra corporeal perfusion. Richard Walsh has undertaken to combine and update our existing policy documents to be considered by Council, which are clearly in need of revision.

Further information on the CE Meeting and the AGM can be found on the CVP SIG Website. With the kind permission of the authors, abstracts from the meeting have been published on this site.

PETER L KLINEBERG
CHAIRMAN

Australian and New Zealand College of Anaesthetists
The Medical Education Special Interest Group organised this three-day teaching conference at Couran Cove Resort on South Stradbroke Island in June. The initiative was prompted by the need to develop teaching skills in our anaesthetic educators along the lines of those accepted in adult learning environments in the medical teaching arena. Adult education has evolved at a rapid pace in the last 20 years and now embraces techniques such as problem based learning, workshops, snowballing and many others. All these techniques focus on the learner rather than the trainer. While the traditional model is one of didactic teaching, in this new paradigm, the trainer acts as a facilitator responding to the needs of the learner. Hence this course was seen as an inaugural meeting, the first of many.

Forty participants including facilitators attended the meeting. All states, New Zealand and Hong Kong were represented. The facilitators included the newly appointed Director of Education, Dr Russell Jones, and the Assistant Director Dr Mary Done as well as people with expertise in special areas. Two external facilitators included Professor Neil Paget the Director of Education with the College of Physicians and Dr Lynn Robinson from Med-E-Serv.

The course was launched by a lively debate conducted by Dr Michael Bujor entitled: ‘Has the traditional lecture had its day?’ Following this a session on adult learning with Neil Paget, Ed Loughman, Michele Joseph and Rod Tayler explored the essentials of what the good teacher does. Sessions were then run on selected areas of special interest to anaesthetists including: PBL (Geoff Cutfield), simulators (Leoni Watterson and Brenden Flanagan), small group tutorials (Kersi Taraporewalla), maximizing learning in the OT (Mary Done), principles of measurement (Neil Paget), designing the perfect ITA (Russell Jones), and facilitating learning using IT (Lynn Robinson).

The Couran Cove resort provided an ideal retreat for such a meeting with excellent facilities for a small group such as this. I wish to thank our College and AstraZeneca who jointly funded a package, which included meals and accommodation for the participants. In addition, Colin Albert from Astra Zeneca personally helped break the ice by providing welcoming drinks. Special thanks should also be given to Helen Morris for her secretarial services.

A major aim of the meeting was to provide the participants with the skills necessary to conduct similar educational training in their own regions with the help of the College educators. Already most states have begun preparations for follow up meetings.

BARRIE McCANN
CHAIR
As I wrote in the Education Report in the June 2001 edition of the Bulletin, I believe educational support for Supervisors of Training to be an extremely important issue. In recent weeks I have met with many Supervisors of Training and together we have explored many concerns. There are two pending initiatives which are designed to aid Supervisors of Training. The first is the provision of workshops with a focus upon specific areas of concern to Supervisors of Training. I would like to meet with as many Supervisors of Training as possible and to offer workshops on such topics as developing the skills of a good Supervisor, educational principles for effective supervision, dealing with Trainees who are experiencing difficulty, assessment and appraisal, and providing feedback. The next workshop is scheduled to be held in Perth during September. The focus of the workshop will be on the effective guidance of Trainees and arises out of a request by Western Australian Supervisors of Training via the co-ordination of their Regional Education Officer, Dr Lindy Roberts.

The second initiative is the provision of a Support Kit for Supervisors. This kit will include much of the information that a Supervisor of Training needs in order to effectively undertake their tasks. These kits will be distributed to all Supervisors of Training and will include:

- A description of Supervisor of Training duties.
- A manual for Supervisors.
- Procedures for dealing with Trainees experiencing difficulties.
- Copies of all relevant Regulations.
- Copies of College Professional Documents relevant to Supervisors.
- Guidance and suggestions for how Trainees can satisfactorily complete their formal project.
- Letter of welcome from the College President.
- Letter from the Director of Education.
- List of educational resources for Trainees.
- List of educational resources for Supervisors of Training for improving their own teaching skills.
- List of names and contact details of potentially useful people for Supervisors of Training (eg. other Supervisors, Regional Education Officers, Education Unit, etc).
- The name and contact details of experienced Supervisors of Training who would be willing to act as buddies for new Supervisors.
- Useful Educational modules.

The Education Unit seeks to provide support for educational activities within our College. Supervisors of Training form an essential link in College–Trainee communication and influence much of the education occurring in our College. Hence, I am keen to assist Supervisors in any matter. Supervisors who have particular topics for workshops that they would like me to develop and present or who wish to discuss any aspect of their supervisory roles should contact me at DirEduc@anzca.edu.au or (03) 9510 6299.
The 2001 Annual Registrars’ Scientific Meeting was held on 20 July in the Auditorium of the College’s ‘new building’. The standard of registrar presentations was commendable and once again the Meeting was well attended, attracting in excess of 110 Registrars, Fellows and Exhibitors. Dr Fergus Davidson, Department of Anaesthesia, Repatriation General Hospital, Concord NSW, was awarded the prize of $500 for his presentation ‘Protocols and Staffing Arrangements for Resuscitation of Neonates During Delivery by Caesarean Section’.

Thanks to our Administrative Officer, Ms Corinne Millane, College Staff and Dr Kate Leslie and Dr Winifred Burnett for their assistance and organisation of the Meeting.

A limited supply of surplus copies of the Meeting abstract book remains and can be obtained by contacting the Victorian Regional Committee at the College.
Your Excellencies Dr and Mrs Hollingworth, distinguished guests, ladies and gentlemen, welcome to the Opening of ANZCA House, the complement to ‘Ulimaroa’, the Headquarters for the Australian and New Zealand College of Anaesthetists.

In 1994, 7½ years ago, Governor-General the Honourable Bill Hayden opened ‘Ulimaroa’. I am particularly pleased to welcome the Governor-General and Mrs Hollingworth today, because their presence recognises the importance of Anaesthesia, Intensive Care, and Pain Medicine to patients. I also welcome Presidents and representatives of sister colleges and medical organisations, the Chief Medical Officer and other government health officials, Mr Ronald Walker and Mrs Barbara Walker, Councillor David Brand representing the City of Port Phillip, Nancy O’Donnell our first Administrative Officer, Past Deans of the Faculty of Anaesthetists, Past Presidents, past Councillors, Fellows of the College and Faculties, and friends.

The Mission Statement of this College is ‘To serve the community by fostering safe and quality patient care in anaesthesia, intensive care and pain medicine’. We strive to accomplish our mission for patients in Australia and New Zealand, through our core businesses in Education, Research, and Professional Standards.

This College provides the education and training of doctors in our disciplines in Australia and New Zealand. The education programs are planned, implemented, monitored, reviewed, and assessed for quality and outcomes. Our education foci continually evolve in our search for quality and safe care. For example, recently, the College established an Education Unit with educationists to further develop education programs, review policies such as trainee selection, examinations and In-Training Assessments, and develop support initiatives for our Supervisors of Training. We recently embarked on the use of anaesthesia simulators in training, and we are currently reviewing the whole anaesthesia Fellowship training program.

Our education endeavours also include providing continuing development programs for our Fellows and all specialists in our disciplines. We do this in the forms of convening CME meetings, developing self-development learning modules, and conducting the highly successful Maintenance of Professional Standards Program.

This College is a champion for research, because it is through implementation of new findings in research that we can further achieve our mission to provide safer and better quality care for our patients. This College is the largest research grants supporter for anaesthesia, intensive care, and pain medicine in Australia and New Zealand. Last year, the College awarded over AUS$360,000 in research grants, recognising the difficulties experienced by good researchers to obtain funding from national or state bodies. For this reason, the College established the ANZCA Foundation to better fund the search for new knowledge. ANZCA House will serve to build on the Foundation.

Professional standards and certification underpin practice in every profession. Every professional body must establish standards on which excellence is achieved and performance is based. The College's professional standards are cornerstones of practice standards in our disciplines in Australia, New Zealand and parts of Asia-Pacific.
The College undertakes all the above endeavours through our headquarters Ulmaroa. This new ANZCA House will enhance our standards and the reputation of Australasian anaesthesia, intensive care, and pain medicine practice as being among the best in the world.

Henrik Ibsen wrote in his play 'The Master builder', 'Castles in the air - they are so easy to take refuge in. And so easy to build, too'. Our castle-in-the air started 16 years ago when the former Faculty of Anaesthetists planned for future education and building ventures by using a cunning but effective strategy of charging Fellows an extra subscription in advance. This instant-noodle nest egg was nurtured by successive Honorary Treasurers and subsequent Presidents, Peter Livingstone, Michael Davies and Richard Walsh to later provide the funds for this castle in the air. The decision to proceed to building and the initial groundwork was undertaken by Council under President Garry Phillips in 1996. Our castle in the air, unlike Ibsen's, was not easy to build. However, importantly, it became a reality, with help from our architect Norman Day and our builders McCorkell Construction.

The great architect Frank Lloyd Wright said, 'The physician can bury his mistakes, but the architect can only advise his client to plant vines (because architects' work remain for all to see) so they should go as far as possible from home to build their first buildings'. Norman Day might have advised us to plant vines, but he need not move his home far away. ANZCA House will remain for many years for all to see, a proud and magnificent complement to Ulmaroa, our magnificent heritage Italianate villa. This is definitely not a physician's mistake. In this magnificent building today, it is appropriate to quote Frank Lloyd Wright again who said, 'Noble life demands a noble architecture for noble uses of noble men (and women)': We shall live up to those words.

It is with great pleasure that I now invite the Governor-General of Australia, His Excellency the Right Reverend Dr Peter Hollingworth to perform the official Opening.
Dear Mrs Sheales

In a thought-provoking message in the Bulletin’s June issue reference is made to the cessation of certain College activities in SE Asia. It would be of interest to Fellows if they were informed of the reasons behind those decisions, especially since their consequences are perhaps not as adverse as has been suggested.

When the Faculty of Anaesthetists (as it then was) ceased conducting examinations in South East Asia, the Board did so after prolonged and serious discussion. Several problems existed at the time, viz:

- approval of hospitals for training had been formalised and the process of inspections had exposed many deficiencies needing correction;
- in Australia and New Zealand, some institutions had their approval withdrawn pending significant improvements;
- approval of many SE Asian hospitals had been given after cursory visitations at a time when the Faculty’s inspection machinery was primitive or non-existent;
- subsequent visits by the Board members to the same Asian areas had given rise to serious misgivings as to quality of training in many hospitals of the Region.

A principal problem was the ratio of supervisors to trainees, and whereas in Australia and New Zealand these could be (and was) brought up to standard fairly quickly, but the deficiency of senior staff in SE Asia was severe and irreparable in the short term. Extreme examples existed where several trainees were notionally supervised by a single qualified anaesthetist, but by no-one at all in his or her absence on leave.

Even the better institutions could not match standards which the Faculty was now demanding in Australia and New Zealand, and clearly a ‘two tier’ system was unacceptable. Even if some areas were closer to the required benchmark, approving some countries but not others was out of the question. The only reasonable decision was a fundamental change to previous policy.

It is an over-simplification to describe this process as a ‘withdrawal’. The Board was insistent on offering whatever help it could give in supporting development of indigenous institutions to take the place of our Diploma of Fellowship, and despite their early disappointment, anaesthetists in Hong Kong, Singapore and Malaysia soon took up this challenge.

The results are now on the board. There is a College in Hong Kong; Singapore and Malaysia have gone down a different route and have thriving Masters’ programs – in the latter case, no less than three Universities now confer these degrees. Furthermore, Australian anaesthetists frequently function as external examiners, and/or conduct courses for candidates. Peter Kam, John Russell and Tony Newson are only a few of the many Australasian Fellows who have supported our SE Asian colleagues in this way.

What might have happened had we continued in our earlier mode?

Firstly, the development of indigenous institutions and postgraduate qualifications would have been delayed – possibly indefinitely.

Would there have been a Hong Kong College of Anaesthesiologists if the Australasian College was still operating in Hong Kong? I think not. There would certainly not be a MMed in Anaesthesia in either Singapore or Malaysia had our College maintained its program of examinations and continued to grant our Fellowships there.

Even more importantly, a ‘brain drain’ would have continued. Granting our Fellowship inevitably opened the door to emigration, and successful SE Asian candidates could hardly be blamed for seeking greener fields in Australia and New Zealand, as indeed many of them did – to our benefit, but the detriment of their countries of origin.

Anyone who has regularly visited this region over the last 25 years could not fail to be impressed with a radical change for the better which has occurred in the last decade. There are far more specialists on the ground; trainees are much better supervised and educated; the status of anaesthesia and anaesthetists has greatly improved, and the morale of local specialists substantially raised.

Whatever negative effect our ‘withdrawal’ may have produced is greatly outweighed by its positive results. It is possible that our actions at the time stimulated governments to allocate more resources to anaesthesia than they had been in the habit of doing. In the light of recent political developments, prolongation of our Diploma-granting activities in the region might now be perceived as ‘neo-colonialist’ behaviour.

As it is, our willingness to support local institutions, whether by visiting tutors, external examiners or simply friendship is not only appreciated, but is far more constructive than continued dependency on our Australian and New Zealand College could ever have been.

Yours etc.

Professor Ross Holland, FFARACS, FANZCA, FCAHK
Health Care Industry Supporting CSM 2001

THE AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS, FACULTY OF INTENSIVE CARE and FACULTY OF PAIN MEDICINE thank Health Care Industry for their support at the CSM 2001 in Hong Kong.
Meetings

There have been two CECANZ meetings in the year to July 2001. The Auckland Annual Scientific Meeting November 15-17, 2000 and the Single Theme Meeting in Palmerston North March 30-April 2, 2001.

The Auckland meeting had multiple themes including cardiovascular anaesthesia, perioperative medicine, and error/risk management. Keynote speakers were Profs James Cottrell, State University New York; Thomas Hornbine, University of Washington Seattle; Dennis Mangano, UCSF; James Reason, University of Manchester UK.

Australasian region invited speakers were Profs Tony Gin, Hong Kong; Bill Runciman, Adelaide; Stephan Schug, Auckland; A/Prof Alan Merry, Auckland.

The Single Theme Meeting on day stay anaesthesia had Prof Paul White, Texas, and Dr Glenda Rudkin as visitors.

Both meetings were well attended and rated highly successful. For this the Convenors Marian Hussey (Auckland) and Mike Hodges (Palmerston North) and their organising committees receive our grateful thanks. Attendance numbers (75) at the STM in Palmerston North were affected by concurrent meetings ANZICS NZ region and Trauma in Auckland.

CECANZ Visits to other centres

Visits were made to centres away from the meeting venues.

From the Auckland meeting

Wellington Jim Reason
Hamilton and Tauranga Dennis Mangano
Nelson and Christchurch James Cottrell

From the Palmerston North meeting

Christchurch and Rotorua Paul White
Invercargill and Dunedin Glenda Rudkin

HELP Modules

HELP modules produced for the July year were

42/33 Paediatrics August 2000
43/34 Trauma November 2000
44/35 Neural Blockade March 2001

Funding support for these modules continues from Boots Healthcare and the Australian and New Zealand College of Anaesthetists.

TREVOR DOBBINSON
MEDICAL DIRECTOR CECANZ

Hong Kong Golf Tournament CSM 2001

The Golf Tournament for the Combined Scientific Meeting took place at the Kau Sai Chau South Course in Hong Kong. This was a magnificent course in the New Territories set amongst some undulating country with magnificent views of the South China Sea. Dr Vincent Chan and his colleagues organised a great day. There were 32 players who played for various competitions in rather hot and humid weather. We were not only playing for the ANZCA Golf Trophy but also the Society of Anaesthetists' of Hong Kong Cup and a trophy for the Combined Scientific Meeting. Dr Anne Canty who had a handicap of 23 was the winner of the ANZCA Golf Trophy and the CSM 2001 Golf Tournament with a score of +2. The day was completed with some welcome showers, some refreshments and a pleasant trip back to our hotels by ferry and bus.

Once again thanks to Vincent Chan for his excellent organisation and also for looking after us so well. The ANZCA Golf will be organised by Assoc Prof Peter Moran in Brisbane in 2002.

ASSOCIATE PROFESSOR MICHAEL DAVIES
DIRECTOR OF ANAESTHESIA
ST VINCENT’S HOSPITAL, MELBOURNE
I am pleased to report that on July 31, 2001 at the Annual General Meeting of the Royal Australasian College of Physicians the following resolution was passed:

"that a Joint Faculty of Intensive Care Medicine of Australia and New Zealand be established by the College jointly with the Australian and New Zealand College of Anaesthetists, subject to Council giving final approval to the form of agreement between the two Colleges and subject to the Regulations of ANZCA for the Joint Faculty being approved by Council."

This resolution was the final step in the first phase of the formation of the Joint Faculty – approval by the parent Colleges that the Joint Faculty be formed. Now that its formation is assured, there is still much to be done.

Firstly the legal agreement between ANZCA and the RACP will be finalised. This will formalise the relationship between the two Colleges with respect to the Faculty.

Secondly, as noted in the RACP resolution, the Regulations of the Joint Faculty also need to be approved by both College Councils, and it is anticipated these two matters will be approved during September. As the Regulations define the new body, this step is clearly necessary. I anticipate that initially the Regulations will allow some breadth in interpretation and to be generally based on those of the present Faculty, to enable a smooth transition.

Following approval of the Regulations, the phase of promulgation of the criteria for Foundation Fellowship and invitation to apply will begin. Each Fellow of FICANZCA, intensivists known to the RACP, and members of ANZICS will be contacted by letter. In addition notices and criteria will be published in the next edition of the Bulletin and Fellowship News, the equivalent publication of the RACP. It is anticipated that the closing date for applications will be early in 2002. It will then be necessary to “process” the applications by matching them to the criteria. The successful applicants will form the Foundation Fellowship and will elect the inaugural Board. It is likely that this will take place around the middle of 2002.

One of the other issues that has engendered considerable debate has been the name of the new Joint Faculty. There are strong feelings that the word “Joint” must be included. On the other hand it is probably unnecessary to include “Australasian” or “Australian and New Zealand” since these are present in the names of the parent Colleges, although most would agree that “ANZCA” and “RACP” do not have to be included in the name. One of the hottest topics has been the question of whether “intensive care medicine” or “critical care medicine” should be used. It is the view of the Board of Faculty that ‘Joint Faculty of Intensive Care Medicine’ (JFICM) is the preferred option. This also will require ratification by both College Councils in the coming weeks.

However, throughout this time of negotiation and preparation for change, the trainees remain a primary focus for the Faculty. There must be a seamless transition from the present Board to the new Board so that the training program is not disrupted in any way. At the same time the imminent formation of the Joint Faculty is the ideal time to review the current program to ensure it offers the best possible training. A working party headed by the Education Officer, Jack Havill, is currently undertaking this task.

As I said at the outset – there is much to do. These are very exciting times.
It has been a very exciting and rewarding year for the Faculty, with continued negotiations towards a Joint Faculty nearly a reality. A single training scheme for certification of intensive care specialists in Australasia has long been the goal of the intensive care community and I would like to highlight the amount of work that not only current members of the Faculty have put into this aim, but countless Fellows and representatives of the College in the past.

It is now my pleasure to report on behalf of the Board on the affairs of the Faculty since the last Annual Meeting.

Awards, Honours and Appointments

The following Faculty Fellows were recognised for their contributions:

- Professor G A (Don) Harrison, NSW – Roll of Honour, Australian Resuscitation Council
- Professor T E Oh, WA – Elected to Fellowship, Academy of Medicine of Singapore

Education and Training

Under the supervision of the Education Officer, Professor Havill, the following matters were considered by the Board:

- Courses available to Faculty trainees. These include CCrISP, EMST, ADAPT and FCCS Courses.
- A module has been developed for Supervisors on giving feedback to Trainees.
- A policy entitled ‘Guidelines for the Selection of Trainees’ was promulgated. This policy was introduced following recommendations from the Medical Training Review Panel Report on Medical Workforce Training and Employment.
- A working party has been established to review the in-training assessment process, provide increased support for Supervisors of Training, and review the training program. The JSAC-IC revised the formal project requirements.
- JSAC-IC also reviewed the issue of logbooks and it was agreed that a template would be made available to Trainees as an optional educational exercise.

The Board welcomed the appointment of a Director of Education, Dr Russell Jones, and Assistant Director, Dr Mary Done.

Trainees

The following statistics are reported concerning Faculty trainees:

<table>
<thead>
<tr>
<th>Total Intensive Care Trainees</th>
<th>198</th>
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<tbody>
<tr>
<td>Of the active trainees:</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>164</td>
</tr>
<tr>
<td>Female</td>
<td>34</td>
</tr>
<tr>
<td>NSW</td>
<td>59</td>
</tr>
<tr>
<td>VIC</td>
<td>31</td>
</tr>
<tr>
<td>ACT</td>
<td>6</td>
</tr>
<tr>
<td>Qld</td>
<td>31</td>
</tr>
<tr>
<td>SA</td>
<td>16</td>
</tr>
<tr>
<td>WA</td>
<td>8</td>
</tr>
<tr>
<td>Unknown</td>
<td>8</td>
</tr>
</tbody>
</table>

Training via FIC only          | 73  |
Via FIC and ANZCA              | 91  |
Via FIC and RACP               | 18  |
Via FIC and ACEM               | 7   |
Via FIC, ANZCA & RACP          | 1   |
Via FIC, ANZCA & ACEM          | 1   |
Undertaking PIC                | 7   |

FELLOWSHIP AFFAIRS

From June 2000, the following were admitted to Fellowship by examination:

Elizabeth Ann Keegan Connolly SA
Paul David Cooper NSW
Michael John Davis NSW
John Edward Foy NZ
John Francis Fraser Qld
Gerard Thomas Joyce Vic
Peter Stanley Kruger QLD
Yat Tim Leong VIC
Craig Laurence McCalman NZ
Andrew Derrick McKee NZ
Emma Jane Merry SA
Priya Nair NSW
Sean Denis Newell QLD
Adam Purdon NSW
Peter Howard Scott Qld
Ian Mark Seppelt NSW
Ram Gopal Sistla SA
Penelope Clare Huston Stewart NSW
David Wayne Wrathall UK
Victor Yeo HK

Paediatric Intensive Care

Simon John Erickson WA
Fiona Kristine Isóla Miles NZ
It is worth noting that Dr Miles is the first female graduate endorsed in Paediatric Intensive Care.

**Admission to Fellowship by election:**

Daryl Richard Catt  
NT

The Faculty now has a total of 280 Fellows as at 30 June 2001. Of these 207 are by Intensive Care Examination and 234 are also endorsed in Anaesthesia. 46 have the intensive care endorsement only.

<table>
<thead>
<tr>
<th>Geographical Disposition</th>
<th>Male</th>
<th>Female</th>
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<tbody>
<tr>
<td>NSW</td>
<td>72</td>
<td>32</td>
</tr>
<tr>
<td>VIC</td>
<td>38</td>
<td>14</td>
</tr>
<tr>
<td>SA</td>
<td>27</td>
<td>16</td>
</tr>
<tr>
<td>NT</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>ACT</td>
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<td>QLD</td>
<td>38</td>
<td>7</td>
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<tr>
<td>WA</td>
<td>20</td>
<td>2</td>
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<tr>
<td>TAS</td>
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**Applications**

This area of the Faculty continues to grow and also commands a lot of time and resources. A record number of 43 candidates were examined this year, a significantly larger number than ever before. Utilising the new assessment system for OSCE and Viva sections of the exam has accommodated this growth, but with the increased workload further additional recruitment of examiners has been required.

I would like to record the Board's appreciation of Professor Ken Hillman and Dr George Skowronski, who have both retired as examiners this year.

**August/September 2000 Fellowship Examination**

The written section was held in Adelaide, Brisbane, Sydney, Melbourne, Cairns, Auckland, Hamilton and Hong Kong and the Oral Sections were held at the Royal Melbourne Hospital and the Royal Australasian College of Surgeons. A record number of 26 candidates sat and 13 were successful.

<table>
<thead>
<tr>
<th>Successful Candidates</th>
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<tbody>
<tr>
<td>A. Aziz, NSW</td>
</tr>
<tr>
<td>S. Newell, QLD</td>
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<tr>
<td>M.J. Davis, NSW</td>
</tr>
<tr>
<td>N. Ramakrishnan, VIC</td>
</tr>
<tr>
<td>J. Foy, NZ</td>
</tr>
<tr>
<td>P. Scott, QLD</td>
</tr>
<tr>
<td>J. Fraser, QLD</td>
</tr>
<tr>
<td>J. Seppelt, NSW</td>
</tr>
<tr>
<td>A. Karnik, QLD</td>
</tr>
<tr>
<td>R. Sistla, SA</td>
</tr>
<tr>
<td>A. McKee, NZ</td>
</tr>
<tr>
<td>P. Stewart, NSW</td>
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<td>E. Merry, SA</td>
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**August/September 2000 Paediatric Intensive Care Fellowship Examination**

The third Paediatric Examination was held at the Royal Children's Hospital in Melbourne. The single candidate, Dr Fiona Miles, NSW, was successful.

**April/ May 2001 Fellowship Examination**

The written section was held in Adelaide, Brisbane, Perth, Sydney, Melbourne, Auckland and Hong Kong. The Oral Sections were held at the St George Hospital. Ten of the sixteen candidates were approved.

<table>
<thead>
<tr>
<th>Successful Candidates</th>
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<tbody>
<tr>
<td>M. Daley, NSW</td>
</tr>
<tr>
<td>D. Lowe, NSW</td>
</tr>
<tr>
<td>A. Delaney, NSW</td>
</tr>
<tr>
<td>C. Schneider, NZ</td>
</tr>
<tr>
<td>D. Evans, SA</td>
</tr>
<tr>
<td>C. Simpson, NZ</td>
</tr>
<tr>
<td>G. McGrath, WA</td>
</tr>
<tr>
<td>M. Sutherland, ACT</td>
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<tr>
<td>R. Plant, Vic</td>
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<tr>
<td>S. Velandy Kootayi, Vic</td>
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**The G.A. (Don) Harrison Medal**

The G.A. (Don) Harrison Medal for 2000 was awarded to Dr Colin Brett McFadyen, NSW, for his performance in the Fellowship Examination.

**Accreditation of Units**

Representatives of the Board and Regional Committees reviewed a total of 14 Intensive Care Units since June 2000. Currently accredited units comprise the following:

- 27 units accredited for the full 24 months of core intensive care training
- 15 units for 12 months of training
- 18 units for 6 months of training
- 6 units accredited for 3 months on secondment programs.

The issue of accreditation of private intensive care units is currently being reviewed, along with units accredited as S3.

Following a recent visit to Singapore, the Board is investigating the possibility of accreditation of training in Singapore.

**Joint Specialist Advisory Committee — Intensive Care**

This Committee continues to provide supervision of all individual intensive care trainees, assess applications for specialist recognition, and to streamline policy towards a single training program in intensive care. The following issues were discussed:

- Vocational Registration in New Zealand. The New Zealand JSAC-IC has undertaken lengthy negotiations with the New Zealand Medical Council regarding the issue of oversight. A document entitled ‘Recognition for Vocational Registration in Adult Intensive Care Medicine in New Zealand’ was approved.
- The Criteria for Recognition as a Specialist in Adult Intensive Care were promulgated.
- The results of a survey undertaken of trainees and recent graduates in 1999 on the quality of intensive care teaching and supervision were considered by JSAC-IC at its June meeting. Overall the responses indicate that quality of training is good, but that it can be reliant on individual supervisors and the nature of the Unit.

A New Zealand Joint Specialist Advisory Committee in Intensive Care (NZJSAC-IC) has been established, with its main...
responsibility being assessment of specialist recognition on behalf of the New Zealand Medical Council.

**Professional**

The Board is developing its policies on the following:

- Assessment of overseas trained specialists. This involved a number of submissions to the CPMC and attendance at seminars.
- Intensive Care Services for Area of Need. This is another issue with which liaison with the CPMC has been beneficial.

**Rural Focus Group**

Dr Daryl Catt has established a Rural Focus Group, whose aim is to encourage training in rural intensive care units, provide a rural voice within the Faculty and to consider key issues relating to rural intensive care.

**Policy Documents**

The following policies were revised and promulgated in the past year:

- IC-2 ‘The Duties of an Intensive Care Specialist in Hospitals Accredited for Training in Intensive Care’
- IC-6 ‘The Role of Supervisors of Training in Intensive Care’
- IC-8 ‘Quality Assurance’

The following documents are under review:

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

**Faculty Representation on external organisations**

I wish to thank Fellows for their participation and involvement in the following bodies:

- Australian Casemix Clinical Committee
- ACHS Clinical Indicators Working Party
- ANZCA/ACEM Liaison Committee
- ANZCA Council and its sub-committees
- ANZICS Safety and Quality Committee
- Australians Donate
- Australian Resuscitation Council
- Committee of Presidents of Medical Colleges
- CPMC Aboriginal Health Sub-committee
- Intensive Care Medical Liaison Committee
- Joint Specialist Advisory Committee – Intensive Care
- Medical Specialist Outreach Assistance Program
- RACS Trauma Committee
- RACS CCrISP Committee

**CONTINUING EDUCATION**

**Annual Scientific Meeting, May 2001, Hong Kong**

The Combined Scientific Meeting with the Hong Kong College of Anaesthetists was successfully held in Hong Kong this year. Three international speakers presented; Laurent Brochard from the University of Paris, Mitchell Levy from Rhode Island Hospital in Providence, USA and Randall Chesnut from Portland Oregon. The scientific program featured a debate on Human Albumin administration, neurointensive care, organ donation, ventilation, sepsis and Asian ethical issues.

**New Fellows’ Conference**

This year the Conference was held at the Beas River Country Club, Hong Kong New Territories, and the theme was ‘Which Doctors’. The following delegates represented the Faculty:

<table>
<thead>
<tr>
<th>A/Professor Jack Havill</th>
<th>New Zealand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Rob Young</td>
<td>South Australia</td>
</tr>
<tr>
<td>Dr Richard Newman</td>
<td>South Australia</td>
</tr>
<tr>
<td>Dr John Torrance</td>
<td>New Zealand</td>
</tr>
<tr>
<td>Dr Michael Davis</td>
<td>New South Wales</td>
</tr>
<tr>
<td>Dr Anne Leung</td>
<td>Hong Kong</td>
</tr>
</tbody>
</table>

**Modules**

The Board resolved to develop modules for use by Trainees and Fellows on specific topics such as communications, management, teaching, research, health and welfare and information technology. Regional Committees have also been requested to work up a resource package for one subject each to be placed on the Web as CME material.

**Maintenance of Professional Standards**

At present the Faculty has 214 registered participants in its Maintenance of Professional Standards Program. 189 of these are Fellows. The Program was re-structured in January 2000 to provide an annual statement of MOPS participation. Work is continuing on the development of an electronic return that it is hoped will be accessed via the Website.

**Finance**

The Faculty has continued to define its income, and with the introduction of a separate subscription in 2001, the Faculty will have a dedicated source of funds for the first time. A number of concessions have been approved for Fellows with dual certification and who no longer practise in their ‘secondary’ specialty.

**Research**

The following intensive care related projects were supported by ANZCA for 2001:

- Clinical A/Professor B. Venkatesh
  - A study of the dynamics and temporal profile of cortisol secretion in critical illness.
  - $11,860

- Clinical A/Professor B. Venkatesh
  - Tissue gas tensions and tissue energy charge in an animal model of endotoxnic shock.
  - $14,600

**INTERNAL AFFAIRS**

**Attendance of Regional Chairmen at Board meetings**

The Board resolved to invite Chairmen of Regional Committees to observe Board meetings, to enable closer liaison with regions.
Physical Facilities
With the move of ANZCA to the new building in May 2001, the Faculty now has some additional office space. The new building offers an auditorium, and sufficient room to accommodate the examinations.

Faculty Website
Once again our thanks go to Dr Mark Finnis for his assistance in maintaining the Faculty's Website.

Faculty Staff
Ms Lindy McPhee left the office to have her first baby and was replaced by Mr Andrew Coghill, as the Faculty's Administrative Assistant.

Board of Faculty
The following members comprised the Board of Faculty for the previous year:
Dr Felicity H. Hawker, Vic
Dr Neil T. Matthews, SA
Dr Peter D. Thomas, SA
A/Professor Jack H. Havill, NZ
Dr Richard P. Lee, NSW
Dr Robert J. Barnett, Qld
Dr Gillian F. Bishop, NSW
Dr Alan W. Duncan, WA
Professor Telik E. Oh
Dr Ray, F. Raper
Dr Jonathan Gillis

Meetings were held in June and October 2000, and March 2001.

This year Drs Alan Duncan and Rob Barnett advised they would not be re-standing for election this year. Alan commenced with the interim Board in 1993 and was also elected to the Inaugural Board of Faculty in June 1994. He continued in his role as Chairman of the Fellowship Examination from 1993-94, then took the role of Censor until 1997 when he was elected Dean. His term finished in June last year. I would like to express my personal thanks to the contribution Alan has made, not only to the Faculty, but to ANZCA and the Faculty of Anaesthetists, RACS. A paediatric intensive care specialist, Alan developed and successfully implemented the world's first paediatric intensive care training program and examination, the first of which was held in 1997. I think his most notable achievement was the effort he put into negotiations with the RACP which was a key factor in the progress which has been made with the Joint Faculty. This is no small achievement when considered that this has been the aim of many intensivists since the early 1970's.

My thanks also go to Rob Barnett, who after initially being co-opted representative for Queensland in 1997, was elected in 1998 and has served as ASM Officer and Communications Officer in that time.

Following a call for nominations earlier this year, two nominations were received for two vacancies, so an election was not necessary. I am pleased to advise that the following Fellows have therefore been declared members to take office from the Annual Meeting on 5th July.
Dr P.V. van Heerden
Dr R.L.S. Pascoe

In May this year Council confirmed the continued appointment of the College President, Professor Teik Oh as its representative to the Board.

A Joint Faculty of Intensive Care Medicine
Last year, the Councils of the RACP and ANZCA achieved in-principle agreement for the formation of a Joint Faculty of Intensive Care Medicine. In November 2000, the Board resolved that a working party should be established to develop criteria for election to Foundation Fellowship of the new Faculty. The working party was composed of four representatives each of the Faculty and the RACP. Draft criteria for Foundation Fellowship were developed and submissions and correspondence from Fellows noted. The draft criteria have now been endorsed by the Board, ANZCA Council and RACP Council although some negotiations regarding current RACP trainees are continuing.

The next steps involve endorsement of the formation of the new Faculty at the Annual General Meeting of the RACP to be held later this month, drafting of the Regulations for the new body and acceptance of these Regulations by the Councils of RACP and ANZCA. The next meetings of these bodies will be held during the last week in August and first week of September respectively. Consequently I hope that applications for Foundation Fellowship of the new body will be sought soon afterwards and that the new Faculty will be up and running next year.

In closing I would like to thank Members of the Board, Regional Committees, Supervisors of Training, Examiners, and representatives on Hospital Visits for their efforts over the past year. The support of the Council and in particular Joan Sheales, and Professor Garry Phillips is also gratefully acknowledged. Lastly I would like to thank the Executive Officer and Administrative Assistant, and regional staff for their continuing support and assistance.

F.H. HAWKER (DR)
DEAN
JUNE 2001
Retirement of Board Members

At the Annual General Meeting held on 5th July, the Board of Faculty welcomed two new additions to the Board, Dr Ranald Pascoe, representing Queensland, and Dr Vernon van Heerden, of Western Australia. Both have served on their Regional Committees.

They replace Dr Rob Barnett and Dr Alan Duncan. The Dean presented both with gifts in appreciation of their contributions to Faculty affairs.

Dr Alan Duncan commenced his involvement with the Faculty in 1993, in the role of Chairman of the Fellowship Examination, Censor and Dean from 1997-2000. In a short speech the Dean highlighted his most notable achievements as being the development and implementation of the world's first paediatric intensive care training program and examination, and playing an integral role in negotiations with the RACP towards a Joint Faculty.

A photographic portrait was unveiled following the meeting.
Honours and Appointments

The Board congratulated Professor Teik Oh on his recent award of Honorary Fellowship of the College of Anaesthetists, RCSI.

Education and Training

Examination Dates

The Faculty Fellowship Examination dates for 2002 were ratified and are published elsewhere in this section of the Bulletin.

Educational Support for Supervisors of Training

The Board noted progress on the development of greater support for Faculty Supervisors of Training, with assistance from the College's Education Unit.

Review of In-Training Assessment Process

Changes in policy currently under consideration by ANZCA and the RACP will have an impact on the revision of the Faculty's In-Training Assessment process. The process will aim to complement the principles required for anaesthesia and physician trainees.

Giving Feedback to Trainee Registrars

A document which would be developed into an educational resource to assist Supervisors of Training was approved by the Board. This will be available to Supervisors and placed on the Faculty's website.

Courses available to Trainees

The Board has reviewed the courses available to intensive care trainees and their relevance to training. The issue of mandatory attendance of some courses will be further considered as part of the proposed review of the intensive care training program.

Review of Training Program

The Board established a working group to review the intensive care training program. The Group will consider the various components of training in the light of the development of the Joint Faculty.

Accreditation of Private Intensive Care Units

The Board resolved the following principles regarding the process of accreditation of private intensive care units for training:

1. As from July 2001, private intensive care units that are co-located with a public C24 unit will be reviewed concurrently.
2. The private intensive care unit will be accredited according to the Faculty's guidelines for accreditation for training (Policy Document IC-3). This defines the maximum amount of time a trainee can spend in the private unit in their two core years.
3. If training is undertaken in the private unit within the trainee's continuous core intensive care year then this time must be made up in a C24 unit so at the end of the two core years of training the trainee has at least one year in a C24 unit.
4. The conditions that must be met for the public C24 unit and the co-located private hospital to be accredited as one are contained in the document 'Accreditation of intensive care training in Private Intensive Care Units.'

The Administrative Instructions were amended in accordance with this (see separate notification in this section of the Bulletin).

Professional Affairs

Areas of Need

The Board ratified its policy regarding intensive care services for Areas of Need. The policy involves the Faculty working with employers, health authorities and Medical Boards to establish whether a particular post should be designated as AON, advise on the appropriateness of the post to provide intensive care services, assess the suitability of applicants to the post, and to facilitate the provision of intensive care services to the population served by the Area of Need post.

A Joint Faculty of Intensive Care Medicine

Negotiations regarding Foundation Fellowship of a Joint Faculty of Intensive Care Medicine are continuing between the Faculty, ANZCA and the RACP. It was considered that subject to clarification of these issues and finalisation of a formal agreement between the two Colleges, a Joint Faculty should be a reality by the end of the year.

The Board supported the title of the new body to be 'Joint Faculty of Intensive Care Medicine'.

Review of Policy Documents

The Board is currently reviewing Policy Document IC-1 'Minimum Standards for Intensive Care Units'. Discussion
focused on the aim of a nationally consistent system of classification for levels of intensive care units, and the review of definitions of each level.

A review is also underway of the policy for transport of the critically ill.

CONTINUING EDUCATION

ASM 2002, Brisbane

Dr Robert S Munford was appointed the Faculty's Foundation Visitor for 2002. Dr Munford is an infectious diseases physician whose research focus is physiologically reactive immunity in sepsis.

INTERNAL AFFAIRS

Re-constitution of the Board

Drs Alan Duncan and Rob Barnett retired from the Board at this meeting. Dr Vernon van Heerden (WA) and Dr Ranald Pascoe (Queensland) were appointed as new Members.

Faculty Historian

Professor Garry D Phillips has agreed to act as Faculty Historian. Any material or documents which would assist the Faculty in maintaining an accurate record of our history would be welcome, and should be directed to Professor Phillips, care of the Faculty office.

ADMISSION TO FELLOWSHIP

The following have completed all requirements for admission to Fellowship by examination and were admitted by the Board:

- Andrew Derrick McKee NZ
- David Arthur Lowe NSW
- Colin Brett McFadyen NSW
- Catherine Margaret Simpson NZ
- Michael James Sutherland ACT
- Sathyajith Velandy Koottayi Vic

Amendment to Administrative Instructions

At the July meeting the Board of Faculty reviewed its policy regarding accreditation of co-located public and private intensive care units. Directors of Intensive Care, Supervisors and Trainees should note the following amendment to the Administrative Instructions.

AI 4.3.1.2 One year must be continuous and undertaken in one unit, or one co-located public/private unit complex. The continuous year and cannot include an external S3 rotation. If time is spent in the private unit in the continuous core year then this time must be made up in a C24 unit so at the end of the two core years of training the trainee has at least one year in a C24 unit.
Evidence Based Guidelines and Pain

Fellows will be aware of the NHMRC Guideline 'Acute Pain Management: Scientific Evidence' published in 1999. It is worth reiterating that this Guideline contains a large amount of evidence based material which is relevant, not only to acute pain, but also to the progression from acute to persistent pain. Many of our trainees have found it to be an invaluable source for obtaining condensed information and it is available to Fellows for their continuing education.

Over the last few years, there have been a substantial number of guidelines developed internationally. These include the CSAG study from the United Kingdom and the Guideline on Acute Low Back Pain from the USA. For quite some time the AHCPR has made available a clinical practice guideline on cancer pain. Some of these guidelines have been strongly based upon careful analysis of the strength of evidence (NHMRC Acute Pain) whilst others have relied heavily upon consensus (AHCPR Cancer Pain).

Over the past three years no less than a further eight Practice Guidelines have been developed for the management of various aspects of persistent non-cancer pain. These include: Migraine Headache; Pain Associated with Sickle Cell Disease; Complex Regional Pain Syndrome; Chronic Pain in an Older Persons; and persistent pain in general. These Guidelines have been developed in the USA, but unfortunately there has been inadequate communication among some of the varying groups developing the Guidelines with the result that there are some recommendations that are in conflict with respect to patient selection and application of treatment. Fortunately in Australia and New Zealand, to date our Clinical Practice Guidelines have been channelled through the National Health and Medical Research Council in Australia or the MRC in New Zealand. Clearly it is highly desirable that this situation continues in order to preserve the credibility of the field of pain medicine in our two countries, to provide consistent guidance to health care professionals for the treatment of patients, to Governments and to the health insurance and workers compensation industry.

Pain and Injury

World wide, there is a realisation that the massive escalation of costs of compensation for injured workers cannot continue. There is a reasonable assumption that there is something wrong with the way patients are assessed and treated and with the way the compensation system operates. Such problems are under strong scrutiny in Australia and New Zealand, the latest being the overhaul of the New South Wales Workers Compensation system. A crucial component of any potential advances in this area lies in the rational assessment of pain and injury. An internationally accepted guide has been the American Medical Association 'Guides to Evaluation of Permanent Impairment'. In the first four editions of this document, there was no separate assessment of pain. The emphasis was on finding the extent of 'mechanical failure' which in turn was used to determine the deficits in functioning eg the activities of daily living (ADL) and other spheres. The publication of the 5th edition of the AMA Guide represents a potential major watershed in this field in the form of the chapter on pain prepared by Dennis Turk, James Robinson and John D Loeser. This new chapter points out that the assumption of a close relationship between the degree of tissue injury and pain is fatally flawed. For example 85% of patients with back pain have no evident tissue injury, while 30% of asymptomatic people have apparent 'pathology' on MRI/CT scan. Furthermore patients with severe headache can only be assessed in terms of the severity of their pain since there is no...
evident tissue injury at all; nevertheless such individuals may have extremely severe associated disturbances varying from mental and cognitive impairment to focal neurological deficits as severe as hemiparesis and ataxia. Clearly the older concept of mind/body dualism is extremely problematic and a bio/psycho/social model is the only logical approach. Thus the AMA 5 chapter has acknowledged that nociception, nerve damage, pain, suffering, pain behaviour must all be assessed to provide a logical determination of impairment in injured patients with pain.

A major departure from AMA 4 is that the pain chapter in AMA 5 recommends, that under appropriate circumstances, ADL deficits due to pain should be separately assessed from ADL deficits due to mechanical failure. Having made these separate determinations a method of combining the assessment to obtain an overall deficit is given. Further, it is acknowledged that in some patients there may be no evidence of mechanical failure at all and in such individuals an assessment of ADL deficits due to pain must be made as the sole method of assessment.

The chapter gives a detailed methodology for selecting those patients whose impairment should be rated according to the principles described in the chapter, and how to determine the extent of pain related impairment in such patients. The methodology described makes a great deal of sense but is by no means simple and will require substantial training for individuals planning to use it. To date it has not been accepted by all States of the USA, but has already been implemented by some. It seems likely that following its initial use, there will be a need to modify the methodology based upon experience. Nevertheless the chapter represents a major milestone in the assessment of pain and injury. It is likely that this approach will have an impact on the assessment of patients with pain and injury in Australia and New Zealand in the near future.

References

1. NHMRC Acute Pain Management: scientific evidence. NHMRC 1999
3. AHCPR (1994a) Clinical Practice Guideline: Acute Low Back Problems in Adults. AHCPR Pub No.95-0642, Rockville

MICHAEL J COLLINS, AM
Faculty of Pain Medicine

PROFESSIONAL DOCUMENTS

PM2 (2000) Requirements for Multidisciplinary Pain Centres Offering Training in Pain Medicine
PS38 (1999) Statement Relating to the Relief of Pain and Suffering and End of Life Decisions

College Professional Documents adopted as Faculty Professional Documents with the amendment to the title for PS15 (2000)

PS7 (1998) The Pre-Anaesthesia Consultation
PS8 (1998) The Assistant for the Anaesthetist
PS10 (1999) The Handover of Responsibility During an Anaesthetic
PS15 (2000) Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery with amendment to title to read “Recommendations for the Perioperative Care of Patients Selected for Day Care Procedures”
PS18 (2000) Recommendations on Monitoring During Anaesthesia
PS31 (1997) Protocol for Checking the Anaesthetic Machine

Australian and New Zealand College of Anaesthetists
ANZCA ORGANISATION CHART

COUNCIL

EXECUTIVE & FINANCE

REGIONAL COMMITTEES and NZNC

DIVISION OF EDUCATION

FACULTY OF INTENSIVE CARE

BoAT

Education & Training Committee
General Examinations Committee
Hospital Accreditation Committee

Education & Training Committee

FACULTY OF PAIN MEDICINE

BoAD

Primary Exam Subcommittee
Final Exam Subcommittee

DIVISION OF CONTINUING PROFESSIONAL DEVELOPMENT

CE & QA Committee
ASM Committee
MOPS Committee
SIGs (ACECC)

Courses Subcommittee

DIVISION OF RESEARCH

Research Committee
Library Committee

Multi Centre Trials Subcommittee

DIVISION OF PROFESSIONAL AFFAIRS

Communications & Fellowship Affairs Committee
Rural Education & Services Committee
Workforce Committee
IT Committee
Overseas Trained Specialists Committee
Asia-Pacific Committee (JOLC)

JCCA Subcommittee
(+ASA) RARS Subcommittee

DIVISION OF COLLEGE AFFAIRS

Management Committee
Constitution Review Committee
Salaries Review Committee
House Committee

Interview Panel
Performance Assessment Panel
AON Assessment Panel

Australian and New Zealand College of Anaesthetists
Council Officers And Committees

2001/2002

Officer Bearers, Officers of the Council and Committees of Council – Executive Committee, Education and Training Committee, Hospital Accreditation Committee, Continuing Education and Quality Assurance Committee, Research Committee, Communications and Fellowship Affairs Committee and Workforce Committee, are listed on the back page of this Bulletin:

Membership of the following Committees of Council and Representatives to other outside organisations are as follows:

General Examinations Committee
Chairman of Examinations (Chairman) Greg E Knoblanche
President Telk E Oh
Chair of Education and Training Committee Leona F Wilson
Chairman Primary Examination Committee Neville M Gibbs
Deputy Chairman Primary Examination Committee David B F Cottee
Chairman Final Examination Committee David A Scott
Deputy Chairman Final Examination Committee Anthony M Weeks
Chairman Faculty of Intensive Care Fellowship Examination Richard P Lee
Chairman Faculty of Pain Medicine Examination Committee Penelope A Briscoe

Primary Examination Committee
Chairman Neville M Gibbs
Deputy Chairman David B F Cottee
Chairman of Examinations Greg E Knoblanche
Chairman of Faculty of Intensive Care Fellowship Examination Richard P Lee
Chairman Faculty of Pain Medicine Examination Committee Penelope A Briscoe
Council Member R Steuart Henderson
and four Members Gillian F Bishop
Tony Gin
Paul S Myles
Noel V Roberts

Final Examination Committee
Chairman David A Scott
Deputy Chairman Anthony M Weeks
Chairman of Examinations Greg E Knoblanche
and four Members Penelope Briscoe
Edward Loughman
Craig A Morgan
David A Pybus

Co-opted Member Roman Kluger
Council Member Leona F Wilson

Information Technology Committee
Chairman Michael Martyn
President Telk E Oh
Treasurer Michael Martyn
CEO Joan M Sheales
Representative from the Faculty of Intensive Care Mark E Finnis
Representative from the Faculty of Pain Medicine Terence F Little
Administrative Officer (IT) Karen J Monette
and two other Members James L Derrick

Salaries Review Committee
President (Chairman) Joe Novella
Vice President Teik E Oh
Treasurer Michael Martyn
CEO Joan M Sheales
Dean, Faculty of Intensive Care Felicity H Hawker
Dean, Faculty of Pain Medicine Michael J Cousins

Constitution Review Committee
President (Chairman) Teik E Oh
Vice President Richard J Willis
Chairman of the Executive Richard J Willis
Representative from the Faculty of Intensive Care Felicity H Hawker
Representative from the Faculty of Pain Medicine Michael J Cousins
CEO Joan M Sheales
and two other Members as appointed by Council Michael Gorton
Garry D Phillips

ASMC Committee
Chairman Walter R Thompson
President Telk E Oh
Chair of Communications and Fellowship Affairs Committee Anthony M Weeks
Chair of CE & QA Committee Rodney N Westhorpe
Representative from the Faculty of Intensive Care To be advised
Representative from the Faculty of Pain Medicine Pamela E Macintyre
Past CSM Scientific Convenor (Hong Kong) Joan M Sheales
Past CSM Convenor (Hong Kong) Anthony M Weeks
Current ASM Scientific Convenor (Brisbane) John M Low
Current ASM Convenor (Brisbane) Stephen J Bruce

Future ASM Scientific Convenor (Hobart) Kerry J Brands
Future ASM Convenor (Hobart) Philip Brown
ANZCA Chair of CE & QA Committee
(Chairman) Rodney N Westhorpe
ANZCA QA/MOPS Officer Leona F Wilson
ANZCA Chair of Education and Training Committee Leona F Wilson
Faculty of Intensive Care Education Officer Jack H Havill
Faculty of Pain Medicine Education Officer Milton L Cohen

ASA Continuing Education Officer James P Bradley
CECNZ Director Trevor L Dobbinson
ANZICs Representative To be advised
Regional Combined CME Chairman
Peter McCall (VC)
Peter I Klineberg (NSW)
David B Kinchington (ACT)
Lisa J McEwin (SA)
Richard J Waldron (Tas)
Michael J Paech (WA)

Australian Society of Anaesthetists NSW Officer James P Bradley
Medical Director of CECANZ Trevor L Dobbinson

House Committee
Councillor and Chairman Rodney N Westhorpe
Member of the Board of Faculty of Intensive Care Felicity H Hawker
Representative from the Faculty of Pain Medicine Graham J Rice
Curator, Geoffrey Kaye Museum Rodney N Westhorpe
CEO Joan M Sheales
Librarian Shanti N Nadaraja
Staff Representative Helen M Morris

Asia Pacific Committee
Chairman (Fellow) Garry D Phillips
President Teik E Oh
Representative from the Faculty of Intensive Care To be advised
Representative from the Faculty of Pain Medicine C Roger Goucke
Member R Steuart Henderson

Anaesthesia Continuing Education Coordinating Committee
ANZCA Chair of CE & QA Committee (Chairman) Rodney N Westhorpe
ANZCA QA/MOPS Officer Leona F Wilson
ANZCA Chair of Education and Training Committee Leona F Wilson
Faculty of Intensive Care Education Officer Jack H Havill
Faculty of Pain Medicine Education Officer Milton L Cohen

ASCA Continuing Education Officer James P Bradley
CECNZ Director Trevor L Dobbinson
ANZICs Representative To be advised
Regional Combined CME Chairman
Peter McCall (VC)
Peter I Klineberg (NSW)
David B Kinchington (ACT)
Lisa J McEwin (SA)
Richard J Waldron (Tas)
Michael J Paech (WA)

Library Committee
Councillor and Chairman Rodney N Westhorpe
Faculty of Intensive Care Representative To be advised
Faculty of Pain Medicine Representative To be advised
Trainee Representative To be advised
Members To be advised
Librarian Shanti N Nadaraja

MOPS Committee

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Chairman (QA/MOPS Officer) Leona F Wilson
President Teik E Oh
Director of Professional Affairs Garry D Phillips

OTS Committee
Chairman (Assistant Assessor) Anthony M Weeks
Assistant Assessor (NZ Vocational Registration) Malcolm E Futter
Chairman of Examinations Greg E Knoblanche
Chairman of Final Examination David A Scott
Two other Fellows nominated by Council Peter Roessler
Steven G Katz

Ex-officio Member John M Gibbs

Gilbert Brown Prize Adjudicators
Chairman of Adjudicators (Chair of Research Committee) Michael J Cousins

Formal Project Prize Adjudicators
Chairman of Adjudicators (Chair of Education and Training Committee) Leona F Wilson

Council Representative on Board of Faculty of Intensive Care Teik E Oh

Council Representative on Board of Faculty of Pain Medicine John M Gibbs

Joint Consultative Committee on Anaesthesia (JCCA)
Councillor Walter R Thompson
Councillor Diana CS Khursandi
Frank X Moloney
Daryl R Catt

Mortality Committee
Chairman (President) Teik E Oh
State Mortality Committee Chairman

ANZCA/ASA Infection Control Working Party
Representatives Greg E Knoblanche
Co-opted Representative James L Derrick

ANZCA/ASA Liaison Committee for National Anaesthesia Day
President ANZCA Teik E Oh
Chair of Communications and Fellowship Affairs Committee Anthony M Weeks
ANZCA Communications Consultant Eddie Dean
President ASA Michael J H Hodgson
Chair of ASA Public Relations Committee Gregory P Wotherspoon
ASA Public Relations Consultant Geoff Michels

Board of the Anaesthesia, Intensive Care and Pain Medicine Foundation
Chairman Michael J Cousins
Members To be advised

Rural Recruitment Committee
Chairman Daryl R Catt
Councillor Richard J Willis
Councillor Diana C S Khursandi
Representative from the Rural SIG to be advised

Clinical Indicators Working Party
Chairman (Chair of CE & QA Committee) Rodney N Westhorpe
Members To be advised

Courses Sub-Committee
Chairman and Councillor Walter R Thompson
Chair of CE & QA Committee Rodney N Westhorpe
Chair of Education and Training Committee Leona F Wilson
Three Fellows Brendan T Flanagan
Jennifer M Weller
Leonie M Watterson

ANZCA/ACEM Liaison Committee
ANZCA Representative Garry D Phillips
ANZCA Representative Walter R Thompson
Faculty of Intensive Care Representatives Neil T Matthews
Ann M Whittle

New FANZCA Program Working Party
Chairman Teik E Oh
Members R Steuart Henderson
Peter C A Kam
Edward Loughman
Lindy J Roberts
Anthony M Weeks
Leona F Wilson

Faculty of Intensive Care Representative Richard P Lee
Co-opted Member Michele A Joseph

REPRESENTATIVES/NOMINEES TO OTHER OUTSIDE ORGANISATIONS

Royal Australasian College of Surgeons
Observer to RACS Council Teik E Oh

EMST Committee
Chairman, Courses Sub-Committee Walter R Thompson

Trauma Committee D James Cooper

RACS Infection Control Committee Greg E Knoblanche

Australian Resuscitation Council
Victor I Callanan
Alan Rainbird

Australian Medical Association Anesthesia Co-ordinating Committee
President
Chairman of Executive

National Conference President or nominee

Australian Society of Anaesthetists
Executive President or nominee

Overseas Aid Committee Chair of Asia Pacific Committee Garry D Phillips

Committee of Presidents of Medical Colleges Committee of Presidents President Teik E Oh

Australian Council on Healthcare Standards College Representative on ACHS Council Garry D Phillips

Australian Day Surgery Council Andrew K Bacon
Glenda E Rudkin

National Health and Medical Research Council Infection Control Committee Greg E Knoblanche

Joint Committee re Guidelines for Autopsies Patricia Mackay
Associated with Operative Deaths Christopher L Borton

External Standards Committees Co-ordinator of Anaesthesia Representatives W John Russell

Australasian Board of Cardiovascular Perfusionists Richard G Walsh

To be advised
Academic Anaesthesia Enhancement Grant

The Council of the College calls for applications for a Grant up to $75,000 to assist with the enhancement of an Academic Department of Anaesthesia/Intensive Care.

This Grant is open to occupants of newly established Chairs in Anaesthesia and/or Intensive Care, new occupants of established Chairs in Anaesthesia and/or Intensive Care and to incumbents of Chairs in Anaesthesia and/or Intensive Care commencing new initiatives.

For Chairs in specific areas where there is priority established, the Council may commit two years of support in advance. An information sheet is available from the College CEO for intending applicants.

CLOSING DATE FOR APPLICATIONS IS 29 MARCH 2002

FACULTY OF INTENSIVE CARE
ABN 82 055 042 852

POLICY DOCUMENTS

IC-3 (2000) Guidelines for Intensive Care Units Seeking Faculty Accreditation for Training in Intensive Care Bulletin Nov 98, pg 70
IC-12 (1996) Examination Candidates Suffering from Illness, Accident or Disability Bulletin May 96, pg 66
**PROFESSIONAL DOCUMENTS**

**E = Educational**

**P = Professional**

**T = Technical**

**EX = Examinations**

**PS = Professional Standards**

**TE = Training and Examinations**

| TE4 | (1997) Duties of Regional Education Officers in Anaesthesia Bulletin Nov 97, pg 88 |
| TE5 | (1997) Supervisors of Training in Anaesthesia Bulletin Nov 97, pg 89 |
| TE7 | (1999) Secretarial and Support Services to Departments of Anaesthesia Bulletin Nov 99, pg 69 |
| E13 | (1996) Guidelines for the Provisional Fellowship Year Bulletin Nov 96, pg 66 |
| EX1 | (1996) Examination Candidates Suffering from Illness, Accident or Disability Bulletin Nov 96, pg 70 |

| P6 | (1996) Minimum Requirements for the Anaesthesia Record Bulletin Mar 96, pg 48 |
| PS12 | (1996) Statement on Smoking as Related to the Perioperative Period Bulletin Nov 97, pg 78 |
| P16 | (1994) The Standards of Practice of a Specialist Anaesthetist Bulletin Nov 94, pg 45 |
| PS17 | (1997) Endoscopy of the Airways Bulletin Nov 97, pg 80 |
| P19 | (1995) Monitored Care by an Anaesthetist Bulletin Nov 95, pg 60 |

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