EXCLUSIVE REPORT

Australia’s looming anaesthetist shortage

2,287 shortfall

2008  2028
Contents

The ANZCA Bulletin

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

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Photo: Jason Bull

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The ANZCA Bulletin

March 2009

President’s message

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

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

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

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

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

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

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

• Ensuring timely access and safe care in hospitals. This focuses on improving access to emergency care, (access to) elective procedures and treatment, and better hospital planning.

• Working for us: a sustainable health workforce for the future. The challenges identified are health professional shortages and unbalanced geographical distribution, predicted increased health needs of the community and professional boundaries.

ANZCA believes it can play a leading role working proactively in partnership with governments to deliver the best sustainable outcomes for the community. It is important to stress that the College is not the gatekeeper of numbers of specialist anaesthetists entering the profession. The College does not regulate the numbers of trainees in the system. That is determined by state departments of health / District Health Boards, which fund training positions in hospitals. In Australia, the College already trains more anaesthetists than the Australian Medical Advisory Committee, and I would expect our position to grow and that governments need to take action now to address a projected shortage in 2028.

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

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

Dr Leona Wilson

President

ANZCA responds to National Health and Hospitals Reform Commission report

ANZCA is responding to the interim report that was released in February, ahead of the final report due in June this year. Many of the key reform directions are consistent with recommendations from our original submission. They include the separation of “planning” and “emergency” procedures performed in public hospitals; the acknowledgement of clinical training and the need for dedicated teaching time, and a greater emphasis on rural and regional services (see page 12).

WA criticises national registration and accreditation scheme

Western Australia has left the option open of pulling out of the proposed national registration and accreditation scheme. Comments made by the Minister for Health, Kim Hames, are significant because it is the first time that a state signatory to the Council of Australian Government (COAG) agreement has publicly expressed concerns with the scheme. Dr Hames said unless the government’s concerns over bureaucratic and political interference in training standards were addressed “we have to consider whether we want to be part of the national system”. Dr Hames said that Western Australia would put a compromise proposal to a meeting of health ministers.

The proposal retains the Australian Medical Council beyond the first three years of the scheme and the composition of state medical boards would be unchanged with representatives filling the new national registration boards.

Governor-General supports ANZCA Foundation

Her Excellency Ms Quentin Bryce AC Governor General of the Commonwealth of Australia has accepted the College’s invitation to become the Patron of the ANZCA Foundation. ANZCA Foundation Director, Ian Higgins, recently visited Government House in Canberra to meet with key staff to introduce the Foundation and to outline ANZCA’s plans to raise ongoing funds for medical research.

New Chief Medical Officer

Distinguished cancer physician, Professor Jim Bishop AO, has been appointed Australia’s new Chief Medical Officer. Professor Bishop is Professor of Cancer Medicine at the University of Sydney, is a Fellow of the Royal Australasian College of Physicians, and a Fellow of the Royal College of Pathologists in haematology. He takes up his appointment after Easter.

ANZCA meets NZ Health Minister

ANZCA representatives including President, Dr Leona Wilson, Professor Alan Merry, and New Zealand Councillor, Vanessa Beavis, met with the New Zealand Health Minister, Tony Ryall recently. Matters discussed included the need for a Perioperative Mortality Review Committee, protected quality assurance activities status for activities undertaken as part of the CPD program, and workforce issues (see page 65).

Maternity services report

Following the release of the Federal Government’s maternity services report after a review of maternity services, ANZCA is preparing a further submission to government to ensure it is appropriately included. A key Group which is examining core competencies and the educational framework for maternity services. See “Maternity services report silent on analgesic and anaesthetic services, high-risk pregnancy and critical care” (see page 13).

Damning audit report on NSW health finances

The NSW Auditor-General has given New South Wales’ state health system a damning report card: “They are not paying their bills on time, they’re not managing their budgets report card: “They are not paying their bills on time, they’re not managing their budgets properly, they didn’t get their annual statements in on time and they are using trust fund money for reasons that were not intended”.

Health Practitioner Regulation Agency management committee appointed

Michael Gorton, ANZCA’s solicitor, is one of five committee members on the management committee of the new Australian Health Practitioner Regulation Agency which will commence operation in March 2009. The appointments were announced by the Australian Health Workforce Ministerial Council on March 5. Other members of the management committee include Peter Allen (Chair), Professor Genevieve Gray, Professor Constance Michael AO, and Associate Professor Marilyn Walton.

National Blood Supply Contingency Plan

The National Blood Supply Contingency Plan (NSBSP) was released in November 2009. The Plan aims to improve awareness and ensure appropriate planning in place for dealing with the impact of blood crisis in the health sector. The Plan covers three levels of accountability: national, operational and clinical. In this edition of the Bulletin, Professor Garry Phillips reviews the current plan (see page 52). A copy of the plan can be downloaded via the National Blood Authority’s website – http://www.nba.gov.au

News

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The ANZCA Bulletin March 2009

The ANZCA Bulletin March 2009
**AWARDS**

**Professor Alan Merry**

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

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

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

One of the highlights of Alan’s service to ANZCA has been his leadership of the campaign to amend the law regarding the conviction for manslaughter of those who owe a special duty of care, such as doctors.

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

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

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

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

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

**Dr Frank Junius**

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

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

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

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

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

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

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

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

**Brigadier Pezzutti**

Brigadier Pezzutti worked for four years as Assistant Surgeon-General in the Army. In that role he worked to improve Defence capability by improving recruitment of, and conditions of service for, specialist health officers in the Australian Defence Force. He was a member of the Legislative Council of NSW from 1998 to 2003 and was Parliamentary Secretary for Health from 1993 to 1995. He has been an anaesthetist in Lismore since 1976 and was Director of Intensive Care there from 1978 to 1988.

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The ANZCA Bulletin

People & Events

Combined TAS ANZCA/ASA Annual Scientific Meeting

SA/NT ANZCA and SA/NT RANZCOG joint event

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

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

This joint meeting of obstetricians and gynaecologists, anaesthetists and intensivists with visiting and local speakers served to reinforce the required nexus between the two specialities to effectively serve to women.

Gary Marra (Director of Education, ANZCA), and was followed by welcome drinks at Hadleys Hotel on Friday evening. The venue was particularly auspicious as this was the 75th birthday of the ASA. The meeting commenced with a registrars workshop conducted by Mary Lawson (Director of Education, ANZCA), and was followed by welcome drinks at Hadleys Hotel on Friday evening. The venue was particularly auspicious as this was the 75th birthday of the ASA and its first meeting was held at Hadleys.


Dr Agata Ancypa and Dr Mimi Darcey.
2. Dr Gabe Shuster, Dr Emily Lee and Dr Christopher Wilde.
3. Dr Julian Fuller, North Shore Hospital, NZ.

ANZCA/ASA Combined CME Committee of Queensland

Obstetric Anaesthesia Special Interest Group Conference 2020 – A Vision of the Future for Obstetric Anaesthesia

Blenheim, New Zealand 15–17 October

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

With 150 delegates in attendance, a wide array of local and international speakers including Steve Venta, Michael Pasch and Warwick Ngan Kee gave presentations on evidence based medicine and clinical audit and the likely developments in clinical practice in the decade to come. There was also a broad coverage on the future of training and simulation and communication skills from Allan Cyna, Alicia Dennis, Suvin Tan and Lara Hopkins as well as a perspective on Asia Pacific practice from Stephen Gatt.

Contributions from our obstetric colleagues via Dean Maharaj and a midwifery view from Robyn Maude were also greatly appreciated. It was also the official launch of what is hoped to be the ongoing development of the web-based clinical practice evidence base. Slides from the presentations are available on the ANZCA website via the Obstetric SIG webpage.

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

Dr Scott Simmons
Convenor

1. Dr Michele Moore, Dr Vicky Volvakas (and partner Craig behind), Dr Tim Parrish-Piper, Dr Julian Fuller, Dr Jenny Fabling and Dr Michaela Hamschmidt.
2. Dr Graham Sharpe, Wellington Hospital, NZ (left) and Prof Warwick Ngan Kee, Prince of Wales Hospital, Hong Kong.
3. Dr Julian Fuller, North Shore Hospital, NZ.

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

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

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

1. Dr Matthew Bryant, Dr Michael Stuyyn, Dr Di Khursandi, Dr Tess Crandorn and Dr Chris Bryant.
2. Dr Paul Suter, Dr David McCormack and Dr Michael Steyn.
3. Dr Stuart Burton, Dr David McCormack, Dr John Arbuckle, Dr Mark Gibbs and Dr Matthew Bryant.

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

Three prizes were awarded: the Tess Crandorn Prize of $900, The Axxon Health Prize of $500, this year named in honour of Dr Diana Khurramani, and a new prize offered by the ASA, the ‘ASA Chairman’s Choice’ prize of $500. This was the last official engagement for Dr Tess Crandorn who retired on 1 March. It was a timely and significant event in what has been a long and outstanding career.

1. Dr Matthew Bryant, Dr Michael Stuyyn, Dr Di Khursandi, Dr Tess Crandorn and Dr Chris Bryant.
2. Dr Paul Suter, Dr David McCormack, Dr John Arbuckle, Dr Mark Gibbs and Dr Matthew Bryant.
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Slides from the presentations are available on the ANZCA website via the Obstetric SIG webpage.

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

With 150 delegates in attendance, a wide array of local and international speakers including Steve Venta, Michael Pasch and Warwick Ngan Kee gave presentations on evidence based medicine and clinical audit and the likely developments in clinical practice in the decade to come. There was also a broad coverage on the future of training and simulation and communication skills from Allan Cyna, Alicia Dennis, Suvin Tan and Lara Hopkins as well as a perspective on Asia Pacific practice from Stephen Gatt.
ANZCA Council Meeting report

February 2009

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

Death of Fellows
Council noted with regret the death of the following Fellows:
Dr Lim Say Wan (Malaysia), FFARACS 1976, FANZCA 1992
Dr Brian Donald McKie (VIC), FFARACS 1968, FANZCA 1992
Dr Carlos Paraloe (Brazil), Honorary Fellow, FFARACS 1989, FANZCA 1992
Dr Nalin Rohitha Wijeyesekera (NZ), FFARACS 1986, FANZCA 1992

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

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

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

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

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

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

ANZCA Bulletin
ANZCA Council Meeting

December 2008

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

Death of Fellow

Council noted with regret the death of the following Fellows:

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

Education and Training

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

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

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

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

Dr Ray Hader Trainee Award for Compassion
This award was established to recognise Trainees or Fellows within three years of admission to Fellowship by Examination who have made a significant contribution to the welfare of an individual, a group or a system that promotes welfare and compassion. The award of $2000 per annum for five years has been donated by Dr Brandon Carp. The inaugural award was made to Dr Amanda Young (ViC), and was presented to her by Dr Carp at a function hosted by the President at ANZCA House on 12th December.

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

Establishment of Regulation 2.17 – Investment Committee
As the Investment Committee reports regularly to Council with updates on the performance of the Investment Portfolio, it has been agreed to formalise its functions in the College Regulations with the promulgation of Regulation 2.17. Membership of the Committee includes the President, the Honorary Treasurer, the CEO and the Director of Finance. In addition, Council may co-opt members who have high levels of financial literacy and are not Fellows of the College. The Committee is responsible for developing and reviewing investment strategies regarding the Investment Portfolio for approval by Council, and reviewing and reporting to Council on the performance of the Investment Portfolio.

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

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

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

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

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

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

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

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

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

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

The Medal will be presented to Professor Cousins by the President at the Annual Scientific Meeting in Cairns in 2009. An attachment on ‘Regulation 6 – Admission to Fellowship of the College’ can be found at www.anzca.edu.au in the News section under Council Reports.

Dr Leona Wilson
President
A/Prof Kate Leslie
Vice-President

Dr Ray Hader
Trainee Award for Compassion

Dr Ray Hader Trainee Award for Compassion
This award was established to recognise Trainees or Fellows within three years of admission to Fellowship by Examination who have made a significant contribution to the welfare of an individual, a group or a system that promotes welfare and compassion. The award of $2000 per annum for five years has been donated by Dr Brandon Carp. The inaugural award was made to Dr Amanda Young (ViC), and was presented to her by Dr Carp at a function hosted by the President at ANZCA House on 12th December.

Finance

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

Establishment of Regulation 2.17 – Investment Committee
As the Investment Committee reports regularly to Council with updates on the performance of the Investment Portfolio, it has been agreed to formalise its functions in the College Regulations with the promulgation of Regulation 2.17. Membership of the Committee includes the President, the Honorary Treasurer, the CEO and the Director of Finance. In addition, Council may co-opt members who have high levels of financial literacy and are not Fellows of the College. The Committee is responsible for developing and reviewing investment strategies regarding the Investment Portfolio for approval by Council, and reviewing and reporting to Council on the performance of the Investment Portfolio.

Fellowship Affairs
Annual Scientific Meeting – Cairns 2009
Organisation of the ASM is progressing
The ANZCA Bulletin (December 2008) key points made in ANZCA’s submission to the federal Government’s Maternity Services Review Discussion Paper were highlighted. The report of the Maternity Services in Australia Rural, Remote and Regional areas, established and led by The Obstetric Anaesthesia Special Interest Group scientific evidence guidelines now available on the ANZCA website are an example of a suitable resource that we have already developed. Second, as a member of the National Advisory Committee on Maternal Mortality, representing the College, I have been acutely aware of the current deficiencies in state-based mortality reporting in some form. It is therefore most welcome to see recommendations from the Federal Government, in consultation with states and territories, implement arrangements for national reporting, collection, monitoring and review of maternal and perinatal morbidity and mortality. Third, a recommendation to support local anaesthetic care, especially in rural and remote areas (where maternal mortality is higher), including targeting retention of GP anaesthetists, also fits well with ANZCA’s policy of enhanced specialist back-up and increased education and training for all local rural anaesthetists. Many Fellow are already involved in such initiatives and this recommendation can expand. Nevertheless, a number of the suggestions made in the ANZCA submission received little or no attention. The important role of the obstetrician, chronic pain management services, multidisciplinary team approaches, competency standards, and the issues related to public hospitals delivering maternity services, all failed to receive mention. The Report made repeated mention of the need to support procedural rural GP anaesthetists, but was silent about rural specialist anaesthetists. In relation to the pressure on the maternity workforce and the need to attract and retain health professionals, specialist anaesthetists were not mentioned. For those anaesthetists involved in maternity services, one recommendation that may affect you is the responsibility of ‘professional bodies’ to ensure that all staff involved in delivery maternity services receive cultural awareness training.

In the previous issue of the ANZCA Bulletin (December 2008) key points made in ANZCA’s submission to the federal Government’s Maternity Services Review Discussion Paper were highlighted. The report of the Maternity Services in Australia Rural, Remote and Regional areas, led by Chief Nurse and Midwives by February 21. The report followed a review led by Chief Nurse and Midwives by February 21. The report followed a review led by Chief Nurse and Midwives, Rosemary Bryant. The report focuses on the need to improve the choices available to pregnant women, access to high quality maternity services, and support for the maternity workforce. The review received more than 900 submissions.

Summary of findings and recommendations
• Australia remains one of the safest countries in the world in which to give birth.
• In 2006, 277,436 women gave birth to 282,169 babies in Australia – the highest number of births since 1977.
• Over 60 per cent of births take place in public hospitals.
• Improving choice for Australian women by supporting an expanded role for midwives.
• The development of new national cross-professional guidelines to support midwives.
• Continued consideration of professional indemnity insurance for midwives.
• The establishment of a single integrated pregnancy-related telephone support line.
• Improved data collection and analysis, and further research.
• Providing increased support for the maternity workforce, particularly in rural Australia.
• National Maternity Services Plan to be developed.

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

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

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

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

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

The 2001 AMWAC report noted that there were 369 specialist anaesthesiologist training positions in 1995. It identified the need for 312 trainees by 2005 in order to maintain adequate numbers of anaesthetists in the workforce (on the assumption of a 2.1% growth in demand for anaesthesia services).

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

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

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

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

**Key findings**

**There are considerable problems in undertaking medical workforce studies, in particular accessing robust, up-to-date and consistent data on which to build projections.** Access Economics developed a model split into two modules:

- a demand module, reflecting the use of anaesthesia services and
- a supply module reflecting the capacity of the workforce to provide anaesthesia services.

The latter was inferred by a survey of anaesthetists conducted in October 2007.

In addition, a Working Group of ANZCA and ASA members provided guidance on the project.

The methodology involved four stages (Box 1).

By way of comparison, Canada in 1996 had 1:15611 specialist anaesthesiologists per million population. The likely proportional decrease in the Specialist Anaesthesia Workforce in Australia would be: 1:20,470.

Australia had the highest SPR of 1:7290 in 2003. By way of comparison, Canada in 1996 had 1:15611 specialist anaesthesiologists per million population. The likely proportional decrease in the Specialist Anaesthesia Workforce in Australia would be: 1:20,470.

**References**


**Box 1 Methodology**

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

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

**Stage 3: Gap analysis involving a comparison of workforce and supply projections of FTE anaesthetists for the period 2006-28. Gap estimates were also made for urban and regional areas to identify any geographic imbalances in service provision.**

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

**Utilisation in 2006-07**

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

Converting the number of anaesthesia services used to hours, around five million hours would be required – an average of 55 minutes per person. Dividing by clinical hours per FTE (1176 hours per year) suggests that in 2006-07 there was a requirement for 4,286 FTE anaesthetists.

**Demand Projections**

Demand projections of anaesthetists, including a split by urban and rural areas, are presented in Table 1. The urban population share used in the study was based on 2006 census data and Access Economics’ estimates, and held constant for the projected timeframe. The number of FTE anaesthetists required was forecast to nearly double from 4,317 to 8,599 in the 20 years to 2028, representing an average increase of 208 FTEs per annum. Nearly half of the expected increase in demand can be attributed to demographic change, including ageing of the population. The balance can be largely attributed to rising incomes and raised community expectations.

The base case results reflect a number of assumptions (e.g., no net effect on demand from advances in medical technology, a public patient complexity factor of 1.5, income elasticity of demand of 1 and 80 per cent of clinical time captured by Medicare data). Alternative scenarios were also modelled to show the most sensitive to the assumptions regarding income elasticity of demand and technological change.

**1. The public patient complexity factor was applied to Medicare Tris data to allow for the greater time associated with the more complex care generally required of public patients.**

**2. The income elasticity of demand measures the relative responsiveness of demand (in this case for anaesthesia services) to a change in consumer incomes.**
SPECIAL FEATURE: AUSTRALIA’S LOOMING ANAESTHETIST SHORTAGE

Key findings

Continued

Table 1 Demand Projections for FTE Anaesthetists to 2028

<table>
<thead>
<tr>
<th>Year</th>
<th>Urban</th>
<th>Rural</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>3,242</td>
<td>1,195</td>
<td>4,437</td>
</tr>
<tr>
<td>2028</td>
<td>6,261</td>
<td>2,388</td>
<td>8,649</td>
</tr>
</tbody>
</table>

Average annual growth of FTEs from 2008

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>4,437</td>
</tr>
<tr>
<td>2028</td>
<td>8,649</td>
</tr>
</tbody>
</table>

Table 2 Base Case Projections of Supply (FTEs)

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Description</th>
<th>Percent Increase in FTEs</th>
<th>Projected FTE Supply Gap (2028)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base case</td>
<td>4.2%</td>
<td>2,287</td>
<td></td>
</tr>
<tr>
<td>Scenario 1</td>
<td>Training completions grow 4.4% pa</td>
<td>74%</td>
<td>883</td>
</tr>
<tr>
<td>Scenario 2</td>
<td>Increase feminisation</td>
<td>43%</td>
<td>2338</td>
</tr>
<tr>
<td>Scenario 3</td>
<td>Net migration inflow of 60 FTEs per annum</td>
<td>30%</td>
<td>1875</td>
</tr>
<tr>
<td>Scenario 4</td>
<td>Later retirement</td>
<td>35%</td>
<td>1522</td>
</tr>
<tr>
<td>Scenario 5</td>
<td>Increase in real remuneration by 20% in 2010</td>
<td>64%</td>
<td>1466</td>
</tr>
</tbody>
</table>

Table 3 Alternative Supply Scenarios

Figure 1 Growing Shortage of FTE Anaesthetists

Comparing Supply and Demand

In the base case, the projections suggest a widening gap between demand and supply, rising from a very small shortage of four FTE anaesthetists in 2008 to 2,287 in 2028 (Figure 1).

The results also indicated a significant redistribution of FTE anaesthetists between urban and rural areas. They revealed a current shortage in rural areas and an oversupply in urban areas. By 2028, shortages, under the base case scenario, are predicted in both urban and rural areas. The projected workforce of anaesthetists in 2028 should reach 6,412 FTEs, compared to a demand for 8,999 FTEs – a total potential gap of 2,587 FTE anaesthetists (i.e., there will be a requirement for 36 per cent more anaesthetists).

Survey results

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

A total of 1,168 responses were received, of which 75% were current anaesthesia service providers, 17% were in training and the remainder had not provided anaesthesia services in the last month. The response represented approximately one quarter of total potential respondents.

Conclusions

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

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

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

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

Meanwhile the supply scenarios tested indicated that the projected supply gap could be reduced by introducing one of a number of initiatives, such as maintaining training completions at current levels, increasing financial incentives, or increasing the net migration flow. Introducing a combination of such measures could serve to meet the future demands for anaesthesia services.
A chart of the distribution of current Fellows (including those who have retired) by Age and Gender, shows the population to be a relatively young one with the majority of Fellows lying between the ages of 30 and 45. While women make up 28% of the total current workforce, the average percentage of women Fellows in the last five years has been approximately 33% of total new Fellows. The Workforce Model assumes this percentage of women will enter the workforce has small but important implications for the future supply of services.

**Distribution of Australian FANZCA by age and gender**

<table>
<thead>
<tr>
<th>Age Cohort</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>70</td>
<td>20</td>
</tr>
<tr>
<td>25-29</td>
<td>50</td>
<td>15</td>
</tr>
<tr>
<td>30-34</td>
<td>40</td>
<td>10</td>
</tr>
<tr>
<td>35-39</td>
<td>30</td>
<td>9</td>
</tr>
<tr>
<td>40-44</td>
<td>20</td>
<td>6</td>
</tr>
<tr>
<td>45-49</td>
<td>10</td>
<td>3</td>
</tr>
</tbody>
</table>

**Years as a Fellow**
The table to the right shows the distribution of FANZCA by Gender and Years since qualifying as a Fellow of the College. While the proportion of women entering the profession fluctuates each year, over the past five years, 33% of all Fellows have been women (288 of 880 new Fellows). This ‘feminisation’ of the anaesthesia workforce has small but important implications for the future supply of services.

**Duration of Work**
Survey respondents worked an average of 43.7 hours a week, 38.2 hours of which were spent in direct contact with patients. Of this, an average of 22.1 hours per week was spent on call, but not providing services. In general, women worked fewer hours than men (36.0 hours per week compared to 43.8 hours). Both sexes worked a little over 45 weeks per year. Hours worked per week were relatively constant over age groups, but began to fall at aged 60 and over as anaesthetists approached retirement.

**Time Spent in Private and Public Hospitals**
Survey respondents who were Fellows of the College spent approximately 43% of time in Public Hospitals caring for ‘public’ patients, and a further 5% caring for ‘private’ patients. The remaining 52% of the time was spent in private practice. The four main reasons listed by anaesthetists for preferring the private system were (in decreasing order of importance):
- Remuneration
- Greater control over time
- Surgeon/anaesthetist relationship
- Ability of institution to provide a pleasant working environment

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

**Determining Factors in Practice Location**
Responses were asked to weight the top three factors they would take into account when deciding to move from their current practice location to a rural location. The six leading factors in descending order of importance were:
1. Locality/lifestyle preferences
2. Family issues – children
3. Family issues – partner
4. Remuneration
5. Professional development/educational opportunities
6. Access to high-quality hospitals/prestige of appointment

**Levels of Adequacy of Service Provision**
Survey respondents were asked to describe the general level of adequacy of the anaesthesia workforce in meeting current demand for anaesthesia services. Only 7% of respondents thought that supply was just over a third (38%) thought there was a shortage. The top recurring areas in which gaps were thought to exist were:
- Country or rural regions (18.1%)
- Emergency and ICU (6.8%), and
- Obstetrics (4.9%).
Australia’s worst bushfire disaster: the medical response on Victoria’s Black Saturday

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

Dr Moloney first heard about the fires mid-afternoon on Saturday when he was coordinating for Adult Retrieval Victoria (ARV). He was asked by Hamilton Hospital and then transferred to appropriate hospitals,' Dr Moloney said.

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

The Premier, John Brumby, said: “The sheer volume of patients was overwhelming and we were stretched to our limits but what came through was extraordinary teamwork between anaesthetists, intensivists, pain specialists and the burns department.’

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

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

FEATURE

Dr John Moloney, Head of Trauma Anaesthesia at The Alfred Hospital.

1. A slide from Dr John Moloney’s presentation to colleagues at the Alfred Hospital on the bushfires.
2. Doctors from the Alfred Hospital who worked over the weekend of Black Saturday: Back row – Dr John Moloney, Dr Alex Konstantatos, Dr Sarah McLeod, Dr Carolyn Arnold, Dr Joel Symons, Dr Hugh Anderson. Front row – Dr Wai Tam and Dr Cong Choong Tang.

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

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

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

“The conditions look set to be the worst in Victoria’s history’. The following day, the Premier added: ‘It’s just going to be probably by a long way the worst day ever in the history of the state in terms of temperature and winds.’”

On Saturday morning, 107 fires were still burning across the state. Record temperatures, up to 49 °C, extremely low humidity and hot gale force northerly winds set the stage for what was to follow. Townships were razed and many lives were lost when bushfires on a scale never before seen tore through many areas of Victoria. Townships like Marysville, Kinglake and Flowerdale almost ceased to exist. The current death toll is 210, with 30 people still missing. Forensic teams are still searching for human remains in some townships a month later, such was the extent of the destruction.

The Alfred Hospital in Melbourne is home to the State’s adult burns centre. Together with the Royal Children’s Hospital they took 24 patients, including the most severely burnt victims. Over the ensuing hours, days and weeks, Fellows and trainees of the College have been involved in their care. Initially this included pre-hospital triage and emergency department airway management and resuscitation. Operative management and intensive care are obvious sequelae. Less obvious was the ongoing need for anaesthesia for burns dressings and the significant pain management issues, made more difficult by complex psychosocial issues.

With the Alfred on ambulance bypass for everything except burns, other hospitals in Melbourne took on additional patient loads.
Australia’s worst bushfire disaster: the medical response on Victoria’s Black Saturday
Continued

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

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

Associate Professor Warwick Butt, intensivist, The Alfred Hospital

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

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

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

There are approximately 15 burns patients still being treated at The Alfred and the severe ones in intensive care will need further surgery over the coming weeks, months and, potentially, years. ‘Two or three years ago I re-anasthetised one of the illibical burns patients and that tragedy was six and a half years ago,’ Dr Moloney said.

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

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

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

Overall, Dr Moloney believes the acute health response worked well. ‘As is frequently the case in emergency response (disaster medicine) we had to manage initially with limited information, which in this instance was related to the speed of the fires. However, years of planning, training and exercising paid off,’ he said.

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

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

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

Dr Moloney says the best way of assisting the communities affected by the bushfires is by making a donation through the Red Cross or by supporting the local economies.

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

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

Dr Hugh Anderson, anaesthetist, The Alfred Hospital

‘Black Saturday was worse than anyone could imagine.’
Judith Killen: Living and working in rural New South Wales

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

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

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

“My regular lists include paediatrics, OBG, urology and colorectal surgery. Wagga is unique in rural areas in having a fully available work is in the large regional centre. This is varied and rewarding work. “Such centres are good places to live. They have vibrant communities with good educational, cultural and sporting facilities. There are rural clinical schools so clinicians can follow up interests in education and research,” she says. Dr Killen says ongoing professional development is essential. “We are big enough to have regular sessions, hopefully on topics identified as of interest to everyone. Recent topics have included Diabetes and Anaesthesia, Anticoagulants and Eye Blocks, Regional Anaesthesia, Anaesthesia for Radical Prostatectomy and the next will be on Major Haemorrhage. We occasionally have visiting speakers – for instance A/Prof David Baines from Westmead Children’s came down to speak on Paediatric Adenotonsillectomy and Obstructive sleep apnoea, and Dr Cliff Peady from Canberra on Fascia Iliaca Blocks.”

“However, we also have very regular flights to Sydney and Melbourne and are only two-and-a-half hours from Canberra. Thus, weekend meetings are easy to attend. Having said that, we all enjoyed the video conferences available a few years ago – this gave us access to mid-week city meetings and weekend ones when we had family commitments near home.”

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

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

A new direction for Dr Killen is involvement in writing a paper. This is on Type 1 Diabetes and Anaesthesia. Dr Killen’s interest in writing on diabetes is personal: “I was born in the Riverina and I always wanted to go into rural practice. When I first started medicine, I assumed that I’d be a general practitioner, but quickly decided that wasn’t for me and developed an interest in anaesthesia. I did an anaesthetic term as a resident in Wagga; also an emergency and a surgical term. I really liked the range of work that was available. You don’t get stuck in a subspecialty.”

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

“Within the next decade, there will be continuous glucose monitors, so diabetic patients will have a continual display of their blood sugar, right by the oxymetry and end tidal CO2,” Dr Killen says.

Diabetes when he was three. This has been a huge focus for her family since then – they have an annual fireworks display on the June long weekend which has raised over $100,000 over the years for research into Type 1 Diabetes. Dr Killen has also had her garden on display as part of the Australian Open Garden Scheme, with proceeds going to research into diabetes.

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

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

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The cool side of medicine

Expedition Medical Officer for Mawson Station, to visit. My opportunity came in 2006 and I was delighted to accept the position. I certainly knew that it was not all fun and games, but only as a biologist and as part of the Station Leader, so I thought that I had some idea as to what would be involved. I was not to be disappointed.

The position of medical officer with the Antarctic Division (AAD) is essentially that of a solo practice general practitioner. There are a variety of doctors that are employed by the AAD. Clinically, it was a wonderful experience as being able to work in Antarctica – though cold, it is a very dry environment, with no exposure to any new viruses. However, there is no place on earth that one could be more of a problem in the winter, as it becomes colder and, of course, darker so there is less inclination to spend time outside.

The equipment at the base was really good, and generally we had everything that we could possibly need in case of emergencies, from obstetric forceps and neonatal incubator (luckily they have never been needed), to craniotomy or rigid bronchoscopy instruments. There have been some major incidents, though only rarely. The commonest major injury is broken limbs – there were a couple of fractures at their largest – anywhere from 30 to 70 people. When they leave, there remains a core group which are mostly involved with maintenance of the stations, and the numbers drop dramatically. At Mawson in my year, there were only 14 winterers, most of whom are tradesmen. Unlike all things, working in Antarctica has its highs and lows. Everyone has different experiences, but for me the good certainly outweighed the bad. Medically, fortunately it was very mundane, with minor musculoskeletal complaints being the main problems, though the odd dental issue also raised its ugly head. I really enjoyed doing some minor dentistry. The isolation can be very hard, and that tends to cause the most troublesome medical issues, with somatisation of stress being a common problem, and very hard to treat. This tends to become more of a problem in the winter, as it becomes colder and, of course, darker so there is less inclination to spend time outside.

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Antarctica is a fascinating place and somewhere that I had always wanted to visit. My opportunity came in 2006 and 2007, when I was employed as the Expedition Medical Officer for Mawson Station, with a contract lasting 18 months. Both of my brothers had worked “down south” in the 1990s, one as a biologist and the other as the Station Leader, so I thought that I had some idea as to what would be in store. I certainly knew that it was not all a bed of roses. The job consisted of several months of training, a long ship journey through the infamous southern seas, followed by 12 months at the station. The position of medical officer with the Antarctic Division (AAD) is essentially that of a solo practice general practitioner. Australia has three stations on the Antarctic continent: Davis, Casey and Mawson. All these bases are very isolated: over the summer, which lasts from late November until late February, and the numbers at the stations during this period are below. We do have other responsibilities, such as maintaining all our equipment. As it is such a small community, there are numerous other jobs that need to be performed – my main job was looking after hydroponics, which was situated in its own building, and a wonderful source of vegetables and herbs and warm and light. It provided a nice change from the inevitable frozen or dried produce.

There were so many incredible experiences. The highlights for me were the wildlife – Emperor penguins, Adelie penguins, seals and sea birds. All of the Australian bases are close to Adelie penguin rookeries, but Mawson is the only one that is close to an Emperor penguin rookery. The rookeries are usually on sea ice, in areas that are protected by ice-bergs, so both the scenery and the colonies are spectacular. Since the birds start their nesting in winter when the sea ice is firm, there are no trips over the dark months to visit these superb creatures. To my surprise, I really enjoyed the winter, not only because one would visit the penguin colonies, but also seeing the incredible colours of the twilight, with regular views of the extraordinary aurora australis.

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

Dr Jo Mellick
Dr Jo Mellick is originally from Melbourne, starting her anaesthetics training in North Melbourne but finished it based at The Alfred in Melbourne, gaining her FANZCA in 2002. Originally she worked at Dandenong, but moved to Adelaide in 2004, where she remains – working at the Repatriation General Hospital. Since she has been a consultant, she has spent two weeks most years in Vanuatu, with the Pacific Island Project, with an orthopaedic team.
Doctors for the Environment Australia

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

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

DEA has developed policies, comprehensive reports and supported recent initiatives such as Green Clinic®, Bike Doctor® and a Green Hospitals group. Policy documents include the topics of climate change, energy production, public transport and forests (www.dea.org.au). “Climate Change Health Check 2009” is a report prepared by members for the Climate Institute of Australia in relation to World Health Day 2009 for which the WHO’s theme was “Protecting Health from Climate Change”. The report outlines and quantifies the direct effects of climate change on health, including heat stress and related deaths, trauma from extreme weather events, increases in allergic symptoms, respiratory problems, mental illness, post-traumatic stress disorders, infectious diseases and changes to the distribution of mosquito-transmitted diseases. DEA has also developed a range of educational material including pamphlets and posters.

Medical doctors are in a unique position to promote the need for action concerning our environment. We are well positioned professionally and in society to be heard and help influence others. Politicians have shown a willingness to listen to DEA members. The organisation actively engages politicians on both sides of politics, recently writing to all federal members and senators on the issues of renewable energy and the Carbon Pollution Reduction Scheme. Health professionals have a proud history of service to the community and have been instrumental in encouraging policy development to improve the health of present and future generations. This is evident with tobacco legislation and various road trauma initiatives (seat belts, blood alcohol levels, speed limits). DEA now builds on this foundation of service by addressing the global health implications of our lifestyle.

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

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

Australia is an affluent, secure country that should be showing leadership in addressing greenhouse gas emissions, rather than waiting for countries with millions of people living below the poverty line to act first. Per capita we are the highest greenhouse gas emitters in the world. The Australian government recently acknowledged the adverse health consequences of climate change with their allocation of $10 million into researching the health implications of climate change. The United Nations Secretary-General Ban Ki-moon has recently stated that climate change is the “one true existential threat to the planet” even in today’s current of multiple crises. He has called for a positive outcome in the Copenhagen Climate Conference and emphasised that “climate change threatens all our goals for development and social progress”.

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Personal experience: Initiating operating theatre plastic recycling programs

By Forbes McGain

After reading Dr Rod Westhorpe’s “Letter from the editor: Agents of change”, ANZCA Bulletin, March 2007, I was motivated to involve myself and quantify what our individual effect of using N₂O on greenhouse gas emissions is. As Dr Westhorpe wrote in this article, N₂O contributes about 5% to the total greenhouse gas effect. Although medical use is a minimal producer of greenhouse gases, relative to release from fossil fuel burning and farming, Dr Westhorpe questions whether using low flow closed-circuit anaesthetic delivery systems is adequate or whether Fellows of ANZCA should consider phasing out N₂O (and volatile anaesthetic agents)? My research astounded me: you are likely to be emitting far more greenhouse gas administering a 30-minute 1 L/min N₂O anaesthetic than driving to and from work (1 km of 0.5 L/min N₂O is equivalent to driving an average car 1 km). This initial research lead me to consider other questions concerning the sustainability of our practice e.g. total carbon footprint of disposable vs. reusable trays. It also gave me added motivation to initiate what changes I could within my current work places to improve their carbon footprints.

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

Case 1

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

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

Secondly, an appropriate recycler needed to be found. Limitations were soon discovered upon contacting possible recyclers i.e. volume was not considered to be large enough for the big recyclers, several recyclers would only take compacted material (smaller hospitals tend not to have compacters), other recyclers would only accept certain types of plastics (made by companies with whom they had contractual arrangements).

Fortunately, Thermoplastics Recyclers, a local Melbourne company was happy to take as much plastic as possible from the operating suite. Products recycled by this company into plastic wrap for flooring includes: saline and water impregnated intravenous fluid bag wraps, disposable warming blankets and wraps, syringes, intravenous cannula covers, suckers and surgical wraps (polypropylene and polyethylene types).

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

Case 2

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

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

Continued on page 30
As medical professionals we understand that “prevention is better than cure”, as anaesthetists and intensivists we are trained to pre-empt and avert potential disasters in our daily practices. Now is the time to address for the mitigation of green house gas emissions and environmental degradation, pre-empting and averting a truly global disaster that will affect us and future generations. Now is the time to reflect on how we can alter our personal and work practices for a lower carbon footprint. Now is the time to join an organization, such as DEA, empowering them with numbers and contributing as much as or as little as you wish. If nothing else, now is the time to seek us out at the next Annual Scientific Meeting in Cairns. DEA will have a display area and welcomes delegates to come and discuss environmental issues globally, in their area and welcomes delegates to come and discuss environmental issues globally, in their area and within our hospitals and within anaesthetics.

References:
2. www.actonline.org.au/greenclinic
7. www.climateinstitute.org.au
8. www.corporatecitizen.nhs.uk/index.html
9. www.ihea.org.au
10. www.gghc.org

Table 1. Practical steps towards sustainability for the anaesthetist

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Alter your gases! Stop using Nitrous Oxide. For every minute of 0.5L/min. N2O you’ve driven the equivalent of 1km in an average car.1</td>
</tr>
<tr>
<td>2.</td>
<td>Conserve your gases! Use low flow anaesthesia (sevoflurane nephrotoxicity in humans has been shown not to occur at low flows).2,3</td>
</tr>
<tr>
<td>3.</td>
<td>Reduce. Are two disposable anaesthetic trays per patient necessary?</td>
</tr>
<tr>
<td>4.</td>
<td>Re-use. Disposable routinely use more energy and water to produce than re-usable. Re-usable plastic drug trays require around 1.3 the energy and 1/10 the water to reprocess compared with similar disposable plastic trays (unpublished research by author).</td>
</tr>
<tr>
<td>5.</td>
<td>Recycle. Twenty five per cent of theatre waste is of anaesthetic origin (paper submitted for publication). More than 50% of all anaesthetic waste is recyclable, mostly plastic. Recyclable medical plastics are referenced.4</td>
</tr>
<tr>
<td>6.</td>
<td>Procure more sustainable products. Fifty per cent recycled paper is a start.</td>
</tr>
<tr>
<td>7.</td>
<td>Form / join a Theatre/Hospital Environment Committee. Theatre produces anywhere between 5-20% of all hospital waste.</td>
</tr>
<tr>
<td>8.</td>
<td>Minimise lighting costs with timers and energy efficient fluorescent lamps.</td>
</tr>
<tr>
<td>9.</td>
<td>Turn off the theatre ventilation and air conditioning when not in use, with hospital engineering involvement.</td>
</tr>
<tr>
<td>10.</td>
<td>On your bike! If ever there was a medical profession that was sartorially suited to lycra and blues it’s anaesthesia! Facilitate bike use by advocating for bike parking and form a BUG (bicycle users’ group).</td>
</tr>
</tbody>
</table>

Personal experience: Initiating operating theatre plastic recycling programs

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

ANZCA Green Committee

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

• To take greater care of our environment for current and future generations by reducing the College’s consumption of energy and other consumables.
• To ensure all staff (including regions) are involved and committed by promoting enthusiasm and education.
• To promote sustainable cultural change via management and from the ground up.
• To be seen as a leader in environmental sustainable practices.

The committee meets monthly and comprises members from ANZCA management, administration, and Council, including A/Prof Kate Leslie. So far the Green Committee has:

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

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Visiting Anaesthetist
The Alfred & Austin Hospitals, Melbourne

Dr Forbes McGain
Staff Anaesthetist and Intensivist
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Anaesthesia and the environment: How big is our footprint?

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

**Sustainability**

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

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

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

So who cares about healthy functioning ecosystems anyway? We all should. We need a healthy environment to sustain our way of life. We need the fresh water, the clean air and the productive soils that a healthy environment supplies. We need the wood that grows in healthy forests and the fresh clean air and the productive soils a healthy environment comes from the 2.3 million hectares of forest, 157 million hectares of land and sea, 5.5 million hectares of agricultural land and 390,000 hectares of developed. It measures the area of biologically productive space available to meet our economic demands. The concept was developed by William Rees and Mathis Wackernagel of the Global Footprint Network (GFN) in Canada.

**Ecological Footprint**

To determine exactly what impacts humans are imposing on the environment, the concept of the ecological footprint has been developed. It measures the area of biologically productive land and ocean required to provide the resources we use and to absorb the waste we create. Using this concept, the World Wide Fund for Nature (WWF) 2008 report is a stark contrast. In comparison, the current footprint of the GEC in 20054. In comparison, the US uses 0.9 gha per-capita, England and Wales 0.39 gha per-capita. If you divide the total biologically productive area of the world by the world population you get 2.1 gha available for each person alive in 20054. In comparison, the NHS uses 0.49 gha per-capita, England and Wales 0.39 gha, Australia 0.28 gha and the US 0.94 gha. For a stark contrast, China only uses 0.22 gha per-capita5.

Thus, the NHS per-capita footprint uses 4.7% of the global available footprint per person and its total impact contributes 1.7% to the UK’s global footprint. Given that the proportion of GDP spent on health care in Australia is similar to the UK (just under 10%) and that our standard of patient care is also similar, it is likely that our health care system makes a similar contribution of around 2% to Australia’s global footprint.

Our footprint and the future

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

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

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

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

**References**


5. Kelly, P, 1996 “From little things, big things grow”, Comedy, Mushroom records, Australia

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**Feature**

It is apparent that we do have an impact because the practice of anaesthesia is by necessity an activity that consumes large amounts of resources and produces considerable quantities of waste. The operating theatre setting multiplies these impacts. The need for sterility, safety and infection control has seen the development of copious amounts of packaging and a myriad of single-use items that are made from both plastics and metal. The cleaning of equipment and linen requires electricity, water and sometimes toxic chemicals.

Biological and chemical waste must be disposed of in ways that do not endanger current or future generations. Theatre air-conditioning and ventilation consume massive amounts of energy. Further, a hospital itself is like any other business. Its commercial activities consume resources and create greenhouse gases.

**Quantifiable impacts**

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

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

The best current estimate of the overall impact the health care sector has is from the 2005 Material Health report: It examined in depth the ecological footprint of the National Health Service (NHS) in England and Wales.

**Ecological Footprint**

To determine exactly what impacts humans are imposing on the environment, the concept of the ecological footprint has been developed. It measures the area of biologically productive land and ocean required to provide the resources we use and to absorb the waste we create. Using this concept, the World Wide Fund for Nature (WWF) 2008 Living Planet Report 2008 shows that we are currently turning resources into waste faster than nature can turn the waste back into resources6. Using a financial analogy, rather than living off the interest a bank account is accumulating, nature, we are making withdrawals that are eating into our financial capital. Our account balance at the “Ecobank” is going backwards.

The WWF estimates that we currently need about 1.3 earths to supply the resources for our current lifestyles and at the existing rate of consumption we will need two earths to sustain us by about 20507. In other words we will soon be looking for another planet to provide the resources we require.

So how does the provision of health care fit into this picture? The Material Health report found that the NHS in England and Wales has a footprint of 4.9 million global hectares (gha) where one global hectare is one hectare of biologically productive space on earth. To put this into perspective, the UK has a total footprint of 137 million gha, Australia 157 million gha and the US 2,803 million gha8.

If you divide the total biologically productive area of the earth by the world population you get 2.1 gha available for each person alive in 20054. In comparison, the NHS uses 0.49 gha per-capita, England and Wales 0.39 gha, Australia 0.28 gha and the US 0.94 gha. For a stark contrast, China only uses 0.22 gha per-capita9.

Thus, the NHS per-capita footprint uses 4.7% of the global available footprint per person and its total impact contributes 1.7% to the UK’s global footprint. Given that the proportion of GDP spent on health care in Australia is similar to the UK (just under 10%) and that our standard of patient care is also similar, it is likely that our health care system makes a similar contribution of around 2% to Australia’s global footprint.

Our footprint and the future

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

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

I am advocating that instead of despairing and continuing with the status quo, we should act now and begin to reduce the boot size of our anaesthetic footprint.
Operation Open Heart in Papua New Guinea

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

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

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

This year marked the 15th year of the project in PNG. Over 530 cases have been performed, with a mortality rate of less than 1.9%. The last three years have been mortality free, with an average of 60 cases being done each week. Local surgeons and anaesthetists perform most of the classical procedures such as PDA’s. We help them for shunts and coartations and pacemaker insertions. The Australian team mainly performs open heart surgical cases, for the most part ASDs, VSDS, Fallot’s tetralogy, Anomalous Pulmonary return and valve reconstructions or valvotomies. Most patients are children or young adults with children. We do not do any “lifestyle diseases” such as coronary artery grafting.

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

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

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

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

Matthew Crawford
Director of Anaesthesia & Surgery, Sydney Children’s Hospital, PANZCA, FFPMANZCA

For the latest information on the NSC 2009 in Darwin, please visit www.asa2009.com

Keynote Speakers

Prof. John Sear
Huddersfield Dept. of Anaesthesiology, University of Oxford, Oxford, UK

Prof. Mark Warner
Mayo Clinic: College of Medicine, Rochester, Minnesota, USA

Margaret Bresnahan
One of the ICU nurses, Sir Michael Somare and Papua New Guinea Prime Minister

Dr. Archie Brain
FFRCSI, FRCA (Hon), FANZCA (Hon), Seychelles

Dr. John Loadsman
Royal Prince Alfred Hospital, Sydney, NSW

Dr. Orlando Hung
Dalhousie University, Halifax, Canada

5th-8th September 2009
Darwin Convention Centre
The ANZCA Bulletin

The ANZCA Bulletin

Audit of up to Next Triennial Cycle Annual Return

• Recording reflection notes of your own
• Your CPD Portfolio can be used for
• The Reflection toolkit explains

Program for claiming credits:
conferences, there are other elements of the

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

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

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

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

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

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

Q: I live and work in regional Australia as a private practitioner, how can I meet the minimum requirements for my CPD Portfolio?
In the case of the remote practitioner who finds it difficult to travel to meetings and conferences, there are other elements of the Program for claiming credits:
• The Reflection toolkit explains mechanisms for gaining credits under Category 3/Level 2.
• Your CPD Portfolio can be used for written records and your activity can be recorded on the online CPD Portfolio.
• Recording reflection notes of your own experiences is claimable under Category 3/Level 2, for three credits per hour and could assist the private practitioner in gaining important quality assurance activities and credits.

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

While this is a flexible three-year process, some jurisdictions already require evidence of annual participation and we fully expect this to be the universal requirement in Australia with the introduction of national registration. The table below explains the current situation with regional registrations. ANZCA staff are available to provide assistance and answer any questions. This includes help in navigating the online program. Staff can talk you though what you need to record and how to record it.

They can also assist with determining where the activities you undertake fit within the program. Please do not hesitate to call the CPD Coordinator, Teresa Brando-Starkes, on +61 3 9510 6299 or email cpd@anzca.edu.au.
The ANZCA CPD Program Flowchart (at right) explains the CPD process in more detail and can help you answer the questions on your individual situations.

Summary of CPD Participation for Registration

<table>
<thead>
<tr>
<th>Region</th>
<th>Compulsory</th>
<th>Comments</th>
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<td>CPD Statement of Participation by birthdates</td>
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<td>No</td>
<td>Certificate of Good Standing</td>
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</tr>
<tr>
<td>New Zealand</td>
<td>Yes</td>
<td>CPD Statement of Participation submitted quarterly depending on birthdates</td>
</tr>
</tbody>
</table>

Dr Frank Moloney
Chair, CPD Committee

CPD Program Flowchart

Application
Not necessary for Fellows
Non-Fellows need to apply

Enrolment
Documentation is forwarded

Start of Participation
Develop CPD Plan based on individual needs assessment
Choose activities to best suit:
• CPD Plan
• Learning style
• Practice type
• Accessibility

Triennium Year 1
40 credits minimum
Cat 1, 2, 3 minimum of 10 credits each,
• 3 Reflection
• Portfolio keeping
• Documentation

Annual Return
for Statement of Participation

Retirement or Non-Clinical Practice
20 credits per year
• CPD Plan
Cat 1 & 2 minimum of 10 credits each,
• 3 Reflection
• Portfolio keeping
• Documentation

Triennium Year 2
40 credits minimum
Cat 1, 2, 3 minimum of 10 credits each,
• 3 Reflection
• Portfolio keeping
• Documentation

Certificate of Completion

Next Triennial Cycle

Triennium Year 3
40 credits minimum
Cat 1, 2, 3 minimum of 10 Credits each,
• 3 Reflection
• Portfolio keeping
• Documentation
• Evaluation

Final Annual Return

Audit of up to 5% Triennium returns

Region Compulsory Comments

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

Summary of CPD Participation for Registration

Dr Frank Moloney
Chair, CPD Committee

The ANZCACPD Program
Your questions answered

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of the frustration, disorientation and the medical community; better handling of error and mishap; better integration into handling of conflict and the consequences suggest a multitude of advantages such as:

• Mentoring has become commonplace in explanations:
  "We didn't need it in my day".
• "We didn't need it in my day". and could perhaps be excused for having had little, if any, experience of it, may seem like a good idea. But for many, as mentoring may go some way towards providing support for our trainees.

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

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

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

There are a number of possible explanations:

• Mentoring has become commonplace in the business world as a means of nurturing and supporting potential prestige.
• There is a strong intuitive appeal in terms of support for our colleagues and the organisation and promoting self-respect and personal fulfilment.
• Management of stress. Trainee anaesthetists are often exposed to negative situations and can feel stressed or overwhelmed.

The lack of adequate evidence for its effectiveness might make one wonder whether it is necessary. But perhaps mentoring does not have such advantages attributed to mentoring:

• Greater career satisfaction than those without a mentor.
• Greater satisfaction with training.
• Important in career advancement.
• Likelihood of promotion.
• Important in career advancement.
• Greater satisfaction with training.
• Interest in academic medicine.

Mentoring has also been shown to have the following advantages:

• Selection of a specialty.
• Interest in academic medicine.
• Education in academic medicine.

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

How can it be put into practice?

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

So what is it?

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

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

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

It is interesting to note that in general, the mentors chosen are the “likely candidates” – consultants with an outgoing personality, interest to others and with a proven track record of success in their careers and personal lives. Instruction is given on how a mentoring relationship is set up, how to conduct meetings and regular handouts on topics of interest. No formal training is given and mentors are expected to rely on their own abilities to foster the relationship, something made somewhat easier by the fact that trainees choose them as role models. Nonetheless, the relationship between mentor and trainee does not happen overnight. It requires at least a moderate amount of time and effort.

To be effective, a bond of trust between mentor and trainee needs to develop, just as in any relationship. Once that bond is established, a long term association of benefit to both parties results.

Conclusion

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

Monthly in order to establish a relationship such that when needed, the mentor is the one to turn to. This happens in most cases.

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FANZCA Module Sign-Off

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

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

Module 1 Introduction to Anaesthesia and Pain Management
Module 2 Professional Attributes
Module 3 Anaesthesia for Major and Emergency Surgery
Module 4 Obstetric Anaesthesia and Analgesia
Module 5 Anaesthesia for Cardiac, Thoracic and Vascular Surgery
Module 6 Neuroanaesthesia
Module 7 Anaesthesia for ENT, Eye, Dental and Maxillofacial Surgery
Module 8 Paediatric Anaesthesia
Module 9 Intensive Care
Module 10 Pain Medicine – Advanced Module
Module 11 Education and Scientific Enquiry
Module 12 Professional Practice

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

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

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

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

Module sign-off on completion
Once a trainee feels they have fulfilled the requirements for completion of a module, they should seek out the relevant module supervisor, with their learning portfolio, and spend some time together reviewing it. The trainee needs to be able to validate that they have completed the specific clinical experience, have self-assessed that they have achieved the core aims (and their own goals as set out in their learning plan) and that they have completed any module-specific assessments. Once satisfied that the trainee has confirmed all these with the module supervisor, they both sign the Module Completion Form K. This must also be countersigned by the Supervisor of Training.

A module supervisor can recognise prior module experience from another term or rotation, provided there is sufficient evidence of such in the portfolio and the other module supervisor has signed it. Overall, however, module sign-off is not just about completing a number of sessions or cases, it is a demonstration by the trainee that they have been exposed to a sufficient depth and breadth of clinical experience in a particular area, that significant learning has occurred, that knowledge has been acquired and skills have been gained.

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

Dr Genevieve Goulding
ANZCA Councillor

International Medical Graduate Specialists

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

A number of new documents have been posted on the ANZCA IMGS website. Minor but important changes have been made to the IMGS documents already on the website. The newness clarifies IMGS entering temporary Area of Need positions or entering the IMGS process directly.

Key points
• To be considered “Substantially Comparable” to FANZCA, an IMGS must have had substantially comparable training and assessment to FANZCA. The curriculum must be comparable to that of ANZCA, carried out in institutions which meet standards set by the accrediting body, following two years of post MBBS Prevocational Medical Education and Training (PMET). The duration of anaesthesia training must be at least five years of structured training leading to a qualification recognised by national government agencies as qualifying the individual for specialist anaesthesia practice. Assessments must include regular in-training formative assessments, and summative examinations in both basic sciences (CPD), (with satisfactory evidence), and clinical/professional practice. All candidates require 12 months of Clinical Practice Assessment under oversight and a workplace-based assessment to be eligible for recommendation for specialist recognition and eligibility to apply for FANZCA.

• Definition of IMGS is a medically qualified person who has undergone specialist anaesthesia training in their own country, graduated, and become eligible to work as a specialist in that country.

• Continuing Professional Development (CPD), (with satisfactory evidence), is a requirement for consideration of classification of both substantially comparable and partially comparable.

• Those IMGS who have received two years of post MBBS Prevocational Medical Education and Training and completed a three- or four-year specialist qualifying program in their country of origin may have considered by the Interview Panel one year of additional post-specialist qualification training under supervision in a tertiary/academic institution.

• Assessors for workplace-based assessment, Areas of Need on-site assessment and Clinical Practice Assessment visits may claim credits under the ANZCA CPD program.

Enquiries regarding the IMGS process should be directed to Jill Humphreys or Renee Formal Project. Trainees may be eligible for an exemption from the Formal Project as per TE11. This requires an application in writing to the Director of Professional Affairs Assessor. All other modules are signed off by a module supervisor.

• “Partially Comparable” are people who are recognised as IMGS, but judged to need up to 24 months of additional supervised training, plus examination, and workplace-based assessment in order to achieve recommendation for specialist recognition and eligibility to apply for FANZCA.

Professor Garry Phillips
Chair, IMGS Committee
The project was to somehow get the pig to turn round and present his buttocks to me at the open window at the back of the panel van. I was convinced that caressing and caressing failed, but showing and prodding finally got the buttocks within range and I was able to intubate. Using a stabilizing motion, reserved for intramuscular injections into violent and cooperative adults, I plunged a hypodermic needle deep into the nearest buttock and emptied my preloaded syringe of 1 g ketamine — hopefully into a glandular muscle — before quickly moving to a safe distance away.

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

Much haste was now required. Four able-bodied, myself included, quickly lifted the unconscious pig out of the panel van and placed him on a sheet on the ground. He was then rapidly placed down before being transferred to a clean sheet. By lifting the sheet at each corner, we carried our snoring pig huddled into the hospital. The noisy, obstructed, breathing pattern intensified as we ascended the stairs to the animal laboratory. Appalled at the thought of having now bested a male and mouth-to-mouth ventilation, we quenched our pace. I was greatly relieved to finally get there and the pig's strange and unexpected airway.

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

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

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

Flushed with success and now armed with the experience, I anaesthetised another piglet, this time with two of my junior status within the Department of Anaesthesia. I was selected for the task not on the basis of any experience, skills or knowledge, but because of my junior status within the Department of Anaesthesia. I was an anaesthetist. I was selected for the procedure because of my junior status within the Department of Anaesthesia. We were also informed of the surgical staff. We were also informed of the availability to obtain split skin for grafting.

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

Pigs are susceptible to malignant hyperthermia, not only in association with anaesthetic agents but even with significant exercise and stress. Landrace pigs are particularly susceptible to stress, and risk becoming “toast pork” if sufficiently stressed.

Pigs are more sensitive than humans to non-depolarising muscle-relaxant drugs. These drugs need to be titrated carefully to avoid the need for prolonged positive-pressure ventilation.

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

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

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

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

In the early 1970s, the Burns Unit at the Royal Children’s Hospital in Melbourne was suddenly faced with the management of a number of children presenting with massive burns by the lack of donor sites for one important observation that sadly remains little known even today. I discovered that when piglets were adequately anaesthetised (ie, did not respond to surgical stimulation), their curled tails became straight. I took it on myself to call this the “Mullins sign”, with the hope of making a name for myself in the paediatric porcine anaesthesia literature. But despite quite brazen self-promotion of this sign over the past 30 years, the Mullins sign has failed to receive due recognition. With the acceptance of this article for publication by the MAJ, I can now say with a mixture of pride and humility that the Mullins sign is finally “in the literature”.

Pigs, burns and curly tails

Mullins Geoffrey C. MBBS, MBANZ, Port, WA


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Quality & Safety

PICC lines re-visited – Episode 3

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


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

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

• National
• Operational
• Clinical – ‘the role of clinicians and pathologist providers in managing demand through strong triage and vetting processes based on clinical needs.’

Each institution is required to have in place an emergency blood management plan to assist all players when supply is short. This is an excellent document which deals with the normal blood sector arrangements; blood and blood product management; crisis planning; preparation for and mitigation of a crisis; and response at all levels.

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

Two annexes deal with:

A. Red Blood Cell Response, and

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

See www.nba.gov.au/nbcp

A review process of the Contingency Plan is already underway.

Garry Phillips

South Australia

Changes to Medical Oxygen Connections

Background

Until now, large medical oxygen cylinders, i.e. size B, E, F and G have been supplied with a screw-thread connection (AS240 Type 10). This connection is also used on nitrogen, industrial air and argon cylinders and with these gases connected to cylinders with those gases connected to oxygen lines remains.

The problem was solved by providing all sizes of medical air cylinders with a screw-thread connection (AS240 Type 10 screw connection). Mix-ups between air and oxygen occurred. This problem was solved by providing all sizes of medical air cylinders with a pin-indexed connection.

However, the problem of possible misconnection of large oxygen cylinders to nitrogen, industrial air or argon lines and cylinders with those gases connected to oxygen lines remains.

The Solution

All medical oxygen cylinders will be pin indexed in accordance with the recent AS473.3 amendment. The conversion will be done by all suppliers on a State by State basis over the next two years. The regulators used on the current large cylinders will not fit the new pin indexed cylinders and must be changed.

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

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

Problems

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

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

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

John Russell

South Australia

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

Over the past decade, the Victorian Consultative Council on Anaesthetic Mortality and Morbidity has received a small number of case reports of complications related to the use of transoesophageal echocardiography (TOE) in cardiac surgery (perforations or tears of the oesophagus or upper stomach). Several international studies had estimated the incidence of TOE-related complications to vary from 1.7 per 10,000 to 5 per 10,000.

To assess risk factors for TOE-related complications, a review process of the Contingency Plan

Cardiac and Thoracic Surgeons database between 2001 and 2007, we sought to define the local incidence and outcome from TOE-related complications, and assess any possible risk factors, such as age or sex.

Figure 1 summarises the key findings. Overall, the incidence of TOE-related complications was higher, at 9 per 10,000, with a mortality rate of 2 per 10,000.

Patients aged over 70 years had a relative risk of 3.7 compared to those under 70 (95% CI 1.2-11.7). Women had a relative risk of 6.5 compared to men (95% CI 2.0-21.1). Females over 70 had a relative risk of 2.2 compared to men under 70 (95% CI 1.8-18.2).

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

Reference:


Mathew Piercy

Victoria

Legislation in relation to incident reporting

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

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

It should be noted that the ANZTADC incident recording and reporting activity is completely separate from local hospital incident recording systems and also separate to open disclosure requirements of the state or country in which you practice. The ANZTADC program will place considerable emphasis on analysis of the results and on feedback. We hope that the majority of anaesthetists will report regularly, so that we can all learn from each other’s experience and improve patient safety.

Alan Merry, New Zealand

Martin Galwick, Queensland

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Monash University
Medicine, Nursing and Health Sciences

ANZCA Education Innovation Funding 2010

Request for Proposals
The ANZCA Education and Training Committee has established an Education Innovation Funding to support small workplace-based projects with modest budgets that are directly relevant to the ANZCA Training Programs.

Proposals will be reviewed, in de-identified format, by two reviewers selected by the Education Innovation panel. Funding will be made available on 1 January 2010, with a final report due by 1 February 2011.

Closing date for proposals: 1 June 2009 at 5pm.

The 2009 funding priorities are:
• The track record of the investigators, in particular the ability to deliver high quality work according to specified timeframes.
• Value for money to the College.
• Quality of the evaluation plan.

Proposals must be received in electronic format (MS Word or PDF) as an email attachment, including signatures by all named researchers by 5pm AEST on 1 June 2009. Late or incomplete applications will not be accepted.

For further information please refer to http://www.southernhealth.org.au/simcentre/about.html

The resource kit was the original idea of the Southern Health Simulation and Skills Centre2. These kits were designed as a guide and a practical memory aid and it has been developed with the help of expert opinion, the application of all or some of the advice in the kit is appropriate. The resource kit can be downloaded from the website www.southernhealth.org.au/simcentre or from the college website www.anzca.edu.au (search term – malignant hyperthermia).

1. Address for correspondence: MHNZ Group,
c/o Dr Robyn Gillies,
Department of Anaesthesia and Pain Management,
Royal Melbourne Hospital,
Grattan Street, Parkville 3050.
Phone: +61 3 9342 7540
robyn.gillies@mh.org.au

2. Southern Health Simulation and Skills Centre,
Monash University, MCB, Centre Road,
East Bentleigh, Victoria 3165.
Phone: +61 3 9288 8314
brendan.flanagan@monashhealth.org.au
www.southernhealth.org.au/simcentre/

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

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

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

Against this background, the Third National UK Audit Project of the Royal College of Anaesthetists on Major Complications of CNB is an extraordinary achievement. This is the largest ever reported prospective audit of complications following CNB with a unique and ‘robust’ data base. The denominator data were obtained from a consensus, which achieved a remarkable 100% return rate from all NHS hospitals in the UK! However, the denominator was derived from a comprehensive audit of major reported complications over a 12 month period led by a network of local reviewers in every hospital, supplemented by reports from other specialties such as radiology and neuro- and spinal surgery. This was further cross referenced against litigation and indemnity fund databases supplemented by literature and internet searches.

Reflecting the uncertainty and ambiguity inherent in assessing some of the case reports, the results are reported in a ‘pessimistically’ and ‘optimistically’, but in either case are generally very reassuring. With a denominator of over 700,000 cases, the incidence of permanent injury following CNB was 0.2 per 100,000 cases in the worst-case scenario or 0.0 per 100,000 in the best case. The incidence of death or paraplegia was 1.8 per 100,000. Further, two-thirds of the injuries resolved fully.

Mining the data reveals further information. CNB includes epidurals and spinal anaesthetics as well as caudal techniques. Perioperative epidurals were associated with a higher incidence of complications (8 and 17 per 100,000, best and worst case, respectively) and CSE techniques accounted for 15% of permanent injuries and deaths yet were only 6% of CNB performed. Although obviously the use of these techniques in this situation may simply reflect an older, higher-risk population than, for example, the obstetric subgroups. Sub group comparisons must be made with caution and may not be valid.

The article and accompanying editorial2 make very informative reading. However, the Clinical Reviews of the project published online by the Royal College of Anaesthetists are even better. The clinical aspects of the project are reviewed by complication type and include, in individual case studies and quantitative analysis as well as expert comment. The learning points are then highlighted. The individual risk-benefit analysis, which underpins clinical decision making and subsequently informs consent, is always going to be complicated and difficult where CNB is involved. We are all well assisted, however, by reliable resources such as this quite awesome project from the UK and its report.

Patrick Hughes
Victoria

References
1. Major complications of central neuraxial block: report on the Third National Audit Project of the Royal College of Anaesthetists
T.M. Cook, E. Counselor, J.A. Wilksdorph, and on behalf of The Royal College of Anaesthetists Third National Audit Project
3. Available from http://www.rcpla.co.uk/


South Australia / Northern Territory

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

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

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

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

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

Regions

AustralIan Capital Territory

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

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

Tasmania

Joint ANZCA/ASA Committee and Presidents:
Back row from left: Dr Mark Bevose (Chair, ANZCA Tas.), Dr David Brown (Treasurer ANZCA/ASA Tas.), Dr Richard Waldron (Treasurer ANZCA), Dr Stuart Day (Chair, ASA Tas.). Dr Stephen Beld (Director of Anaesthesia, Royal Hobart Hospital), Dr Chris Wilde (Chair, Training Committee Tas.). Front row from left: Dr Susannah Sherlock (ANZCA Committee), Dr Leona Wilson (President of ANZCA), Dr Liz Feeoney (President of the ASA), Dr Lia Freestone (Secretary of ANZCA/ASA Tas.), Dr Andrew Mulcahy (ASA Vice-President).

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

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

Continuing Medical Education (CME) and events
April 29: Matthew Chan (ANZCA House) – Topic: ‘Hot Air – Full Steam Ahead’
May 16: Airway Workshop for Fellows and trainees (ANZCA House)
September 25: Anaesthetic Registrars Scientific Meeting (ANZCA House)

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

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

Victoria

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

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

OPATS positions for 2010 will not be advertised in the newspaper in 2009. For information about selection for the 2010 program and/or an application form (once applications open), please contact:
Dr. Maggie Wong
Supervisor of Training
Department of Anaesthesia
The Royal Women’s Hospital
Phone: 9373 2000
Email: maggie.wong@therowmens.org.au

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

1. Dr Abhay Umranikar, Dr Michael Shaw and Dr Tony Leaver.
2. Dr Rachel Shank, Dr Liam Broad, Dr Audra Menzies and Dr Ravi Ramadas.
3. Dr Rick Horton and Dr Maggie Wong.

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

Important Dates for Obstetrics and Paediatric Anaesthesia Training Scheme (OPATS) 2010
Applications open: May 30 2009
Applications close: July 3 2009
Interview (to be held at ANZCA House): July 30 2009

Email applicants interim selection results: August 6 2009
Email applicants final rotations: September 30 2009

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

1. Dr Vian Auday Hasan and Dr Ravi Ramadas.
2. Dr Rachel Shank, Dr Liam Broad, Dr Audra Menzies and Dr Ravi Ramadas.
3. Dr Rick Horton and Dr Maggie Wong.

3. Dr Rick Horton and Dr Maggie Wong.
Queensland

Part Zero Course – ‘Zero to Hero’, an introduction to anaesthesia

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

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

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

Overseas Trained Specialist Anaesthetists Network (OTSAN)

OTSAN is an organisation formed by Overseas Trained Specialist Anaesthetists in 2006 as a non-profit, self-help group, aiming to facilitate professional and social integration in Australia. The aim is to assist in the areas of the FANZCA exam, immigration and visas, jobs and industrial relations, liaison with local and national bodies, integration and social networking. OTSAN met on February 21 and 22 at ANZCA House in Melbourne. Delegates from South Australia, Northern Territory, Tasmania, Victoria, New South Wales and Queensland attended, making this OTSAN’s tenth education meeting and its most successful yet.

Dr Sanjay Sharma, based at Ballarat Hospital, convened the meeting and organised a contingent of capable speakers to present a broad base of educational topics over the two days. Dr Rajesh Brijball, president of OTSAN, and Dr Sanjeev Sawhney were also involved with the organisation of the meeting remotely from Queensland. Dr Michael Steyn, originally from Scotland and Director of Anaesthesia at the Royal Brisbane and Women’s Hospital, and Jill Humphreys, Executive Officer of IMGS, made a speech (her last official engagement as she retired on March 1, 2009) and presented the doctors with their certificates.

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

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

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

New South Wales

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

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

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

- May 5–15: Primary Refresher Course in Anaesthesia (Royal Prince Alfred Hospital)

Date to be advised for the Part Zero ‘Introduction to Anaesthesia’ Course

The 2009 Part Zero Course, convened by the Group of ASA Anaesthesia Clinical Trainees (GASACT) Senior Representative Dr Ana Licina, was held at the Western Australian office on Thursday, January 29. Coinciding with their orientation week, 15 first-year trainees attended the course. The aim of the course was to provide trainees with an introduction to the anaesthetic program – where to start, what to expect and a few hints on finding their feet.

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

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

Western Australia

WA Part Zero Course

The 2009 Part Zero Course, convened by the Group of ASA Anaesthesia Clinical Trainees (GASACT) Senior Representative Dr Ana Licina, was held at the Western Australian office on Thursday, January 29. Coinciding with their orientation week, 15 first-year trainees attended the course. The aim of the course was to provide trainees with an introduction to the anaesthetic program – where to start, what to expect and a few hints on finding their feet.

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Thanks to Dr Suzanne Bertrand, Dr Rob Edeson, Dr Linda Roberts, Dr Jodi Graham, Dr Daniel Ellyard and Dr Kevin Hartley for their participation.
Follow on from the success of the Rural Special Interest Groups Inaugural Conference ‘the Accidental Intensivist’, it is with pleasure I wish to announce the 2nd Annual Rural SIG Conference to be held at the Crowne Plaza, Hunter Valley.

The meeting will provide an update for all doctors (Specialists and GP’s) providing anaesthetic services for obstetric patients outside metropolitan areas. The program will include best practice updates for routine patients as well as reviewing management of the more common obstetric emergencies (including the obstetric perspective) and a neonatal resusc workshop.

So mark the dates in your diary as it would be unfortunate to miss this invaluable opportunity to network with your fellow rural practitioners in this magnificent location with all it has to offer.

I look forward to seeing you there.

David Rowe, Convenor

REGISTRATIONS ARE NOW OPEN!

For further information please contact Marta Dziedzicki  
mdziedzicki@anzca.edu.au  or visit www.anzca.edu.au/fellows/sig/rural-sig/2009-rural-sig-conference

'The Rural Special Interest Group Conference ‘Gumnuts and Joeys’ Delivering Anaesthesia in the Bush

- CHANGE OF VENUE NOTICE -

Please note that due to recent flight cancellations to and from Norfolk Island, the Venue for the 2009 Rural Special Interest Group conference has changed. The meeting will now be held at the Crowne Plaza in the Hunter Valley, NSW. The meeting will still be held from the 23-25 July, 2009.

The Hunter Valley is one of Australia’s premier wine growing districts and also a varied and interesting tourist region in New South Wales. Whether you’re a lover of wine and great food, an enthusiast of natural beauty and wildlife, or a keen golfer, the Hunter Valley has it all. Less than two hours drive from Sydney and 45 minutes from Newcastle Airport, the destination is easily accessible.

Surrounded by picturesque vineyards and its own golf course, the Crowne Plaza offers deluxe hotel and villa style accommodation and boasts the only full-time, purpose-built supervised space for children of any accommodation in the region, offering indoor and outdoor play equipment, evening cinema and supervised activities.

 Rohan McPhee, Secretary

THE RURAL SPECIAL INTEREST GROUP
Australian and New Zealand College of Anaesthetists
Australian Society of Anaesthetists
New Zealand Society of Anaesthetists

New Zealand

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

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

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

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

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

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

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

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

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

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

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

The progress made towards the establishment of the College of Intensive Care Medicine of Australia and New Zealand (CICM) has been chosen to allow all procedures to take on the challenges that face any new enterprise.

**Timelines**

With the above in place, there is now much hard work to be done to make sure the systems that support CICM functions are put into place over the coming months, so that a smooth transition is effected. The office bearers of the CICM Board are PV van Heerden, President, J. Myburgh, Vice-President, and B. Venkatesh, Treasurer. The new Board members have had initial instruction in their duties, responsibilities and liabilities as directors of CICM and are ready to take on the challenges that face any new enterprise.

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**Message from the Joint Faculty of Intensive Care Medicine**

The ANZCA Bulletin

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Dean’s Message

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

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

Roger and I were invited to attend the AAPM and ARPM Board Meeting and also their Examination Committee Meeting, and Colin Goodchild and Roger attended the Editorial Board Meeting. The Faculty started liaison with the American Academy and the American Board of Pain Medicine (ABPM) in 2000 through our journal Pain Medicine. The impact factor of this journal has risen from .68 in 2003 to 2.251 in 2007.

Michel Dubois, the President of the ABPM attended our examination at St Vincent’s Hospital in Sydney in November of last year and was very impressed with the whole process and the time and dedication put in by all examiners. At this point the ABPM believe the cost of transporting that process to North America to be prohibitive. Interestingly, they have approximately 200 Fellows attending their examination each year and their examination comprises two, three-hour multiple choice question papers. It became obvious in discussion that their training program is also not as structured as ours and does vary across North America, and so I think we, as a small Faculty, can be incredibly proud of the training and assessment process that we have developed for our young doctors.

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

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

Ten years since the Faculty was formed, we have come a long way and this has been due to the hard work of our Board, and I would like to acknowledge in particular, Roger Goucke and Milton Cohen who have decided after 10 years on the Board that they want to retire to allow new young blood to come on and also to allow succession planning to occur. I thank them for their contribution which has been immense and although they are both retiring from the Board I know they are going to be continuing to contribute to the Faculty in a number of ways. It is also my pleasure to announce that we had six nominations for the six vacancies on the Board this year and therefore do not have to go to election. The two new Board Members are Raymond Garrick from Sydney, who has been on the Examination Panel for a number of years and for the last 12 months has been the Chair of Examinations, and Guy Bashford from Wollongong, who has been a contributor to Pain Medicine in Australasia for many years. Ray and Guy are both Fellows of the Royal Australasian College of Physicians; Ray is a neurologist and Guy through the Rehabilitation Faculty, and I think this is extremely timely as we as a specialty need to involve our parent colleges more. I’m hoping that Ray and Guy, with input from Carolyn Arnold (who was recently elected to the Board), can work with the RACP to raise our profile and to encourage its younger Fellows to get involved with the Faculty.

Leigh Atkinson has been working diligently with the Royal Australasian College of Surgeons; he has also served as the Chair of the RACS for a number of years and for the last 12 months has been the Chair of Examinations, and, in fact, has negotiated a memorandum of understanding to the sum of $23,500 over the 2009-2011 triennium for a Pain Medicine Program as part of their Annual Scientific Congress

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

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

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

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

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

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

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

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

The ANZCA Bulletin

News

Continued

Refresher Course Day – May 1 2009

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

Spring Meeting in Melbourne

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

NSW Regional Committee Faculty of Pain Medicine

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

Faculty Board

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

Following a recent call for nominations for the Faculty Board, there were six nominations for the six vacancies, therefore a ballot will not be required. The New Board will take office following the Annual General Meeting in May and will comprise:
- Carolyn Ann ARNOLD, FAFRM RACP, Victoria
- Rupert Leigh ATKINSON, FRACS, Queensland
- Penelope Anne BRISCOE, FANZCA, South Australia
- Christopher HAYES, FANZCA, New South Wales
- David JONES, FANZCA, New Zealand
- Brendan Joseph MOORE, FANZCA, Queensland
- Edward Archibald SHIPTON, FANZCA, New Zealand
- Raymond GARRICK, RACP, New South Wales
- Carolyn ANN ARNOLD, FAFRM RACP, Victoria

Re-elected unopposed

Dr Roger Goucke and A/Prof Milton Cohen did not seek re-election and will retire from the Board in May. Regions are to be encouraged to form a Regional Committee and if they are not represented on the Board, the Chair of that Committee can be invited to attend.

Relationships Portfolio

Physician representation on the Board

To reflect the recent reorganisation of the Royal Australian College of Physicians and the fact that the predominant physician group in the FPM is rehabilitation medicine, it was resolved to revise Regulation 1.3 pertaining to representation on the Board to read: “At least two shall be Fellows of a Division or a Faculty or a Chapter of the Royal Australasian College of Physicians (RACP).”

Divisions: Adult Medicine; Paediatrics and Child Health

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

Chapters: Addiction Medicine; Palliative Medicine

Liaisons with Colleges

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

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

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

The working paper on Prescription Opioid Policy: Improving management of chronic non-malignant pain and prevention of problems associated with prescription opioid use, developed by the Australasian Chapter of Addiction Medicine with FPM input, has been published and is about to be launched. The Faculty has provided support to Canadian-based Fellows in their efforts to establish Pain Medicine as a recognised specialty in Canada.

Trainee Affairs Portfolio

International Medical Graduates

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

FACULTY OF PAIN MEDICINE

News

Continued

16 February 2009

Report from the Board Meeting held on

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FACULTY OF PAIN MEDICINE

Report from the Board Meeting held on 16 February 2009

Continued

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

ANZCA Curriculum Review

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

Training Unit Accreditation

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

During a review of chronic pain management services in Victoria it has become evident that funding for chronic pain is a real concern in creating positions for pain specialists. Funding arrangements within the state vary significantly and the government has expressed reluctance to increase available funds. The Department of Human Services has engaged Aspex within the state to vary significantly and the government has expressed reluctance to increase available funds. The Department of Human Services has engaged Aspex to re-examine the fee schedule in a state which will need to be addressed.

New Admissions

Fellowship

Six new Fellows were admitted to Fellowship taking the number of Fellows admitted to the ANZCA Bulletin in 2009.

Alternative Pathway

Further to earlier advice that the Board was exploring reestablishment of the Alternative Pathway for applicants for Fellowship who have been working in Pain Medicine, have a qualification acceptable to the Board, but whose knowledge base is not clearly known to the Board, Regulation 3.1 has now been amended. Applicants are invited to apply for election by the normal process under Regulation 3.2. The Board may then either award Fellowship directly (Regulation 3.2.1) or following satisfactory completion of examination and case report requirements without further training (Regulation 3.2.2). Applicants will be considered through the Election to Fellowship application process.

Honours and Appointments

The Board acknowledged and congratulated the following recipients:

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

Pain Medicine Specialist

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

Research

Standardised Outcome Measures in Persistent Pain

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

Professional

Recognition of Pain Medicine as a Specialty – New Zealand

The application is now in the final stages of drafting with the support of Dr Stuart Henderson, ANZCA Director of Professional Affairs, and is being processed as a matter of urgency.

National Pain Summit

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

AMC Good Medical Practice: Code of Conduct

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

Continuing Education & Quality Assurance

Scientific Meetings

2009 ASM

Registration brochures for the Refresher Course “Unravelling the Chaos of Pain” have been circulated and registrations have commenced. Dr James Seymour has been invited to speak on Irudandy at the 2009 Faculty Dinner.

2009 Spring Meeting

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

10 April Meeting

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

Resources Portfolio

Finance

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

At the February Board Meeting, the Financial Reports to 31 December 2008 were accepted. The Board noted that the higher than budgeted surplus was a result of the high level of attendance at Faculty CME events and a successful cost reduction program.
Russell Geoffrey Cole, who died on November 2, 2008, was born in Melbourne on October 28, 1920. He was educated at Scotch College and graduated MB, BS from the University of Melbourne. He is well-remembered by fellow medical students as an engaging, modest, and convivial companion.

He graduated as MB BS in 1944 and forthwith elected to serve in the country in the Royal Australian Navy as medical officer in MAS Bataan until 1948 and became a Surgeon Lieutenant. Throughout his career, Russell Cole maintained his association with the Royal Australian Navy (RAN) after being appointed Senior Anaesthetic Specialist to the RAN in Victoria, and was a member of the Volunteer Reserve with the rank of Surgeon Lieutenant Commander. In 1964 he was awarded the Volunteer Reserve Officers Decoration, RAN and in 2000 the Australian Service Medal 1945–75. During the Vietnam War, he further served for a period on secondee from the navy to the army in Vietnam where he worked as an anaesthetist at the Vung Tau Hospital in Vietnam and participated in many hair-raising episodes of helicopter retrieval of injured soldiers.

In 1949 he returned to Melbourne and was appointed house physician in anaesthesia with the University of Melbourne and clinical supervisor at The Alfred Hospital. Soon after, in 1950, he commenced his long association with the Royal Melbourne Hospital up to his retirement in 1987. At that time Russell was the Director of Anaesthetics at The Alfred Hospital, and in 1953 became Acting Director of Anaesthetics at the Royal Women’s Hospital. Just as the management of cancer pain was pioneered in Sydney by Brian Dwyer, Russell Cole became his counterpart in Melbourne, having had a long interest in the anaesthetic basis of nerve blocks and having published informative articles on the relief of intractable pain by nerve block.

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

In 1965, Russell Cole was appointed Director of Anaesthetics at the Royal Melbourne Hospital, succeeding the legendary Norman James, a post which he held until 1980. Thereafter he remained as a senior staff specialist until his formal retirement in 1985, after which he was appointed a Consultant Anaesthetist to the Hospital. He continued medical activities for a further several years, including medical officer to Pentridge Prison, endoscopy lists and surgical assistance. Russell Cole was an invertebrate traveller. In addition to his time at St Thomas’ Hospital, he held appointments as a Fellow at the Mayo Clinic, Rochester NY, as a Visitor Professor at the South Western Medical School in Dallas, TX, and he delivered popular lectures on chronic pain management in many centres in South Africa and South East Asia. He also provided anaesthetic support for surgery on indigenous patients in the Northern Territory, Australia.

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

Physically, Russell Cole was an extremely robust individual who strongly believed in the benefits of physical exercise. He was never to be seen catching a lift, despite the location of the operating theatres on the ninth floor of the hospital. His numerous sporting activities included tennis, skiing and golf, all undertaken at a high level. Although always courteous and accommodating and easy to communicate with, he did not compromise on his standards of personal hygiene. Although always sympathetic to, and maintaining a lifelong interest in cricket, Russell Cole was a pleasure to Wijey, and he took genuine pity that was truly remarkable.

He is survived by his much-loved wife Deepti who predeceased by his adored wife Deepthi who died three years before his illness. Her loss deeply affected Wijey, although of course that would not have been obvious except to those who knew him well. Wijey was a great traveller and intensely interested in what was happening in other countries. He tended to couple his travelling with work as an anaesthetist and would use his annual leave to travel, doing this work in Canada, the Netherlands, Sweden, Australia and South Africa. In his younger days he was a keen track athlete and maintained a lifelong interest in cricket.

Russell Geoffrey Cole will be greatly missed by generations of Wellington anaesthetic trainees. Wijey was of the school of anaesthesia where unless you looked carefully you would never be aware of his actions; he was the antithesis of anaesthetic flamboyance. This did not mean that his skills were not of the highest order, quite the contrary. In his last 10 years of practice, Wijey divided his time between Wellington Hospital and private anaesthesia practice. He continued in private practice after his retirement and was still working clinically until a few months before his final illness.

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

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

Dr Brian Donald McKie

1939–2009

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

After his resident jobs undertaken in Geelong, he went to New Guinea where he worked for two years. On his return, he undertook his anaesthetic training in Melbourne gaining his FRARACS in 1968. He was appointed to an Uncle Bobs fellowship in the Anaesthetic Department at the Royal Children’s Hospital in 1969. He participated in intensive care and in anaesthesia and became one of the cardiac team. After four years, he decided to move to private practice in Geelong. He continued on the sessional staff at the Royal Children’s Hospital for 25 years, even after he changed course in middle and went into the church.

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

Brian was a quiet, unassuming man who had a deep commitment to both his careers. He played an important role as conciliator in the Anzac Task Force. He contributed, with Anne Thorp, the only paper published for about 30 years on awareness during anaesthesia in children. It was probably the first such study.

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

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

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

Dr Kester Brown
FANZCA
February 2009
FELLOWSHIP AFFAIRS

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

PS51 (2007) Statement on Smoking as Related to the Perioperative Period
PS55 (2008) Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery
PS56 (2008) Statement on the Standards of Practice of a Specialist Anaesthetist
PS58 (2008) Recommendations on Monitoring During Anaesthesia
PS59 (2009) Recommendations on Monitored Care by an Anaesthetist
PS60 (2009) Recommendations on Responsibilities of the Anaesthetist in the Post-Anaesthesia Period
PS31 (2003) Recommendations on Checking Anaesthesia Delivery Systems
PS36 (2004) Regional Anaesthesia and Allied Health Practitioners
PS47 (2008) Guidelines for Hospitals Seeking College Approval of Posts for Vocational Training in Diving and Hyperbaric Medicine
PS50 (2004) Recommendations on Practice Re-entry for a Specialist Anaesthetist

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Professional documents
IC-6 (2002) The Role of Supervisors of Training in Intensive Care Medicine
IC-7 (2006) Secretarial Services to Intensive Care Units
IC-8 (2006) Quality Assurance
IC-9 (2002) Statement on the Ethical Practice of Intensive Care Medicine
IC-10 (2003) Minimum Standards for Transport of the Critically Ill
IC-12 (2003) Examination Candidates Suffering from Illness, Accident or Disability
IC-13 (2008) Recommendations on Standards for High Dependency Units Seeking Accreditation for Training in Intensive Care Medicine
IC-14 (2004) Statement on Withholding and Withdrawing Treatment

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Professional documents
PM2 (2005) Guidelines for Units Offering Training in Multidisciplinary Pain Medicine
PM3 (2002) Lumbar Epidural Administration of Corticosteroids (Analgesics/Adjuvants/Antispasmodics)
PM4 (2005) Guidelines for Patient Assessment and Implantation of Intrathecal Catheters, Ports and Pumps for Intrathecal Therapy
PM6 (2007) Guidelines for Longterm Intrathecal Infusions
PM38 (2004) Statement Relating to the Relief of Pain and Suffering and End of Life Decisions

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Professional documents
PM5 (2006) Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery
PM25 (2006) Recommendations on the Health of Specialists and Trainees
PM28 (2005) Guidelines on Infection Control in Anaesthesia
PM30 (2004) Handover of Responsibility During an Anaesthetic
PM37 (2005) Guidelines on Consent for Anaesthesia or Sedation for Fellow who Practice Major Extracorporeal Perfusion
PM40 (2005) Guidelines for Patient Assessment and Implantation of Intrathecal Catheters, Ports and Pumps for Intrathecal Therapy

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Professional documents

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