EXCLUSIVE REPORT

Australia’s looming anaesthetist shortage

2,287 shortfall

2008

2028
Call for Abstracts

The Organising Committee invites you to submit abstracts on cardiothoracic, vascular, perfusion and echocardiography for a poster presentation at the 2009 CVP SIG conference. All accepted abstracts will be published in the meeting Abstract Book.

A prize and certificate will be awarded for the best poster at the meeting.

The closing date for submissions is the 4th September 2009. All abstracts (max 300 words) must be submitted in MS word format via email to Kate Briggs, kbriggs@anzca.edu.au
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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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Cover: Plenary session, Australian and New Zealand College of Anaesthetists Annual Scientific Meeting, Sydney, 2008.

Photo: Jason Bull

Looming anaesthetists shortage

ANZCA and ASA workforce study.

Victoria’s bushfires

The Alfred Hospital’s role in the midst of Victoria’s worst natural disaster.

Environment special

Anaesthesia and the environment – how big is your footprint and what can we do?

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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 reform directions are consistent with recommendations from our original submission. They include the separation of “planned” 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 Workforce Committee and the composition of state boards. 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 says we should but our position has always been that if state health departments create increased numbers of training posts, we will provide the training. In New Zealand, we have trained more than funded by the Clinical Training Survey. The study shows that the demand for anaesthesia services will continue 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 demographic and economic factors can 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 changes, allowing us to identify the impact on workforce/ workload and to implement strategies to address these shortfalls.

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. ANZCA believes it can play a leading role working proactively in partnership with governments to deliver the best surgical 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 says we should but our position has always been that if state health departments create increased numbers of training posts, we will provide the training. In New Zealand, we have trained more than funded by the Clinical Training Survey. The study shows that the demand for anaesthesia services will continue to grow and that governments need to take action now to address a projected shortage in 2028.

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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 Anaesthesia.

Dr Leona Wilson

President

The ANZCA Bulletin
The ANZCA Bulletin

AWARDS

Professor Alan Merry

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.

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 New Zealand Society 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’.

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Dr Frank Junius

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.

Dr Frank Junius

Dr Frank Junius was awarded the Conspicuous Service Cross for outstanding achievement as a specialist anaesthetist and advisor to the Defence Health Service Division.

Brigadier Pezzutti

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 Banda Aech after the earthquake and tsunami devastated the area in 2005.

In the 2009 Australia Day Honours List, Brigadier the Hon Brian Pezzutti CSC RFD was recognised for his services to defence.

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 1997 to 1999. He has been an anaesthetic practice in Lismore since 1976 and was Director of Intensive Care there from 1978 to 1988.

ANZCA Training Scholarships for 2010

ANZCA will make available 20 scholarships each year to assist anaesthesia trainees who are suffering severe financial hardship. Each scholarship will be awarded in the form of a 50% reduction in the Annual Training Fee for the following year. Applicants must be registered trainees of ANZCA.

Applications must be submitted on the prescribed 2010 ANZCA Training Scholarship Application Form, copies of which are available from the College.

Please contact:

Hannah Burnell
Australian and New Zealand College of Anaesthetists
630 St Kilda Road
Melbourne Vic 3004
Ph: +61 3 8317 5392
Email: hburnell@anzca.edu.au

The closing date for applications for 2010 is Friday, 7 August 2009. Successful applicants will be notified in October 2009.

ANZCA International Scholarship for 2010

The Australian and New Zealand College of Anaesthetists invites suitable applicants for the ANZCA International Scholarship for 2010.

This prestigious award is directed at anaesthetists of the highest quality who are destined to be leaders in their home countries. The Scholarship is offered to a young anaesthetist (up to 40 years of age) from Papua New Guinea, Fiji or the South Pacific Islands. Applications from Myanmar, Vietnam, Laos or Cambodia will also be considered. It is intended to provide an opportunity for the anaesthetist to develop skills to manage a Department and to become competent in the teaching of others in their home country. The Scholarship is tenable generally for one year in a Department of a major hospital in Australia or New Zealand. It covers travel expenses between the home country and Australia or New Zealand and may also include the scholar’s spouse and children under 16 years. A living allowance will be provided.

The closing date for this Scholarship is Friday, 7 August 2009. No late applications will be considered. To obtain additional information on the Scholarship and a copy of the application form, please contact: Janelle Talley
Australian and New Zealand College of Anaesthetists
630 St Kilda Road
Melbourne Vic 3004
Ph: +61 3 9091 0913
Email: jtalley@anzca.edu.au
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 developing worldwide to counter the continuing 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 specialties to effectively implement critical care. The day was well supported by Fellows and trainees from both colleges and was oversubscribed.

1. Professor John Sivigo, Dr Scott Simmons and Dr Kym Osborn.
2. Dr Paul Herreen and Sue Imgraben.

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 Agata Ancypa and Dr Mimi Darcey.
2. Dr Gabe Shuster, Dr Emily Lee and Dr John Archdeacon.
3. Dr Michaela Hamschmidt.

Three prizes were awarded: the Tess Crandom Prize of $900, The Axxon Health Prize of $500, this year named in honour of Dr Diana Khursandi, 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 Crandom 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 Steyn, Dr Di Khursandi, Dr Tess Crandom and Dr Chris Bryant.
2. Dr Paul Suter, Dr David McCormack, Dr John Archdeacon, Dr Mark Gibbs and Dr Matthew Bryant.

There was also a broad coverage on the future of training and simulation and the likely developments in evidence based medicine and clinical audit and the ongoing development of the web-based clinical practice evidence base.

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.

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

The Obstetric Anaesthesia SIG satellite meeting of the 2009 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 Yentis, Michael Paech and Warwick Ngan Kee gave presentations on evidenced 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, Suyn Tan and Lara Hopley 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 Mauve 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
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 Parolae (Brazil), Honorary Fellow, FFARACS 1989, FANZCA 1992
- Dr Nalin Rohitah Wiwiyoviseraka (NZ), FFARACS 1984, FANZCA 1992

Honours and Awards

Prof Alan Merry (NZ) was awarded the New Zealand Order of Merit (ONZM) in the New Year’s Honours 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 Honours List for outstanding achievement as a specialist anaesthetist and advisor to the Defence Health Service Division.

Dr Brian Pezzuti (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.

Quality and Safety

QoS Editorial Advisory Body (EAB)

The Quality and Safety Committee established a communications and liaison portfolio, chaired by Dr Patricia Mackay. The initial activity involved the provision of a special section of the Bulletin devoted to safety and quality issues. It was always recognised that with the development of the College website, this would be an important medium for such communication. In addition, the College has developed a regular e-newsletter to Fellows and trainees. As a result of these developments, Council has approved the establishment of an informal editorial advisory group to provide advice on all QoS issues to be published via all three mediums.

In conjunction with the Director of Communications, the EAB will review all QoS issues for the Bulletin, website and e-newsletter, and will determine the type of information and priorities for each medium to avoid unnecessary duplication.

World Health Organisation – Safe Surgery Checklist

‘Safe Surgery Saves Lives’ is part of the Second Global Challenge for Patient Safety of the World Health Organisation. One of the initiatives resulting from this project led to the development of a three-phase WHO checklist (the Checklist) for use before the induction of anaesthesia (sign in), before the surgical incision (time out) and at the end of the procedure (sign out). Following the evaluation of a study comparing 4000 patients undergoing surgery over eight sites around the world prior to the introduction of the Checklist with those in 4000 patients after its introduction, mortality and morbidity were substantially and significantly reduced. In an effort to encourage wide adoption of the Checklist, ANZCA, in conjunction with RACS, will develop and promulgate a suitably modified version as a College Professional Document, indicating those elements they consider essential in Australia and New Zealand. In addition, the College has agreed to work with RACS towards establishing the universal adoption of the Checklist in Australia and New Zealand, with support and input from the ASA and NZSA.

Fellowship Affairs

Annual Scientific Meeting

Council supported the initiative that each member of the ASM Regional Organising Committee be awarded an ASM Certificate in recognition of their contribution to the meeting. The certificates will be presented by the President at the College Dinner.

New Fellows’ Conference

This year’s NFC will be held at Thala Beach Resort, Port Douglas from 29 April to 1 May. Council ratified ANZCA nominations to attend the Conference as follows:

- Dr David Brimley, Vic
- Dr Alexandra Douglas, Qld
- Dr Bruce Hammonds, Qld
- Dr Tomoko Hara, NZ
- Dr Mohua Jain, NZ
- Dr Kwok Yee Patricia Kam, HK
- Dr Irina Kurowksi, WA
- Dr Irene Ng, Vic
- Dr Timothy Porter, SA/NТ
- Dr Tanya Selak, NSW
- Dr Alice Summons, NSW
- Dr Michael Thumm, SA/NТ
- Dr Andrew Watson, ACT
- Dr Diana Webster, Qld
- Dr Sarah Wyatt, WA
- Dr Genevieve Goulding has been appointed Councillor in Residence to the Conference.

Quality and Safety

Regulation 16 – Trainee Committee

This Regulation was amended as a result of deliberations by the Trainees Committee. The revisions were designed to emphasise the relationship between the ANZCA Trainees Committee and the Regional/National Trainee Committees, while strengthening the communication between these committees. The updated Regulation appears on the College website.

Professional

Professional Documents

Withdrawal of PS48 – Statement on Clinical Principles for Procedural Sedation

PS48 was promulgated in February 2003 and was due for review in 2008. On review, it was considered that PS48 is less definitive than the new PS9 – Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical or Surgical Procedures, which has no evidence-based references and does not adequately address many sedation issues such as staffing, monitoring, medication, training and accreditation. There are also some contradictions generated because of these differences between PS9 and PS48.

As a result, Council agreed to withdraw PS48.

Process for review of Professional Documents

A draft process for the review of College Professional Documents was supported by Council and is to be circulated to the Regional/National Committees for input.

International Medical Graduate Specialists

The IMGs Assessment Process was introduced, and Regulation 23 updated from 1 January 2009 for the assessment of IMGs via the AMC process. Some Partially Comparable applicants have sought to have their pre-2009 requirements ‘recognised’ under the new rules.

Following receipt of legal advice, it has been clarified that applicants assessed under the pre-2009 regulations may not be ‘recognised’ under Regulation 30 – Reconsideration and Review, but rather, should be invited to submit a new application. As a result of this advice, Council approved a new application fee of $1000 to cover the associated administrative costs.

A/Prof Kate Leslie

Vice-President

ANZCA Council Meeting report
ANZCA Council Meeting

December 2008

Report following the Council Meeting of the Australian and New Zealand College of Anaesthetists held on 11 December 2008

Death of Fellow
Council noted with regret the death of the following Fellows:
Dr John B McCarthy (Qld) FFARACS 1984, FANZCA 1993, FFiOM 2002.

Honours and Awards
Dr Phoebe Mainland has been awarded Fellowship of the Australian College of Legal Medicine (FACLM), ANZCA CEO, Dr Mike Richards, recently regained 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 (VC), 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 ‘formal 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 RCoA or CARCSI by training and examination with CET, 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 was given until December 2008 to recommend a new process for IMGs, based on AMC requirements, taking into account New Zealand requirements, and guided by initial documents prepared by Prof Tek Oh. As a result, the following resolutions 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 6.31 (Eligibility 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
ANZCA responds to National Health and Hospitals Reform Commission (NHHRC) Interim Report

The NHHRC recently released its interim report after more than 500 submissions and countless consultations across the country. ANZCA contributed a 35-page submission to the Commission with a list of 22 recommendations covering the health system, education, training in relation to the health workforce, and rural health. The final report is due for completion by the end of June. ANZCA congratulates the NHHRC on the interim report that outlines a comprehensive suite of mainly sensible reform directions. ANZCA is preparing a follow-up submission.

Ensuring timely access and safe care in hospitals

In our earlier submission we recommended special arrangements for emergency surgery to improve patient throughput and safety and prevent “bed-block” of inpatients. It is pleasing to see acknowledgment of this serious issue and the recommendation that consideration be given to separate “planned” procedures from “emergency” procedures by ensuring dedicated planned procedure units are established as separate facilities. This also has the added advantage, if properly planned, of improving clinical training and supervision. We concur with the need for greater support for training. However, we do have concerns about centralising all clinical placements at a national level.

Delivering better health outcomes for rural and remote communities

ANZCA endorses the directions for rural and remote health in our submission that provide access to care, including specialist health care that is often hard to reach by these communities. ANZCA supports proposals that provide support for improvements to access to care, including specialist health care that is often hard to reach by these communities. ANZCA supports the separation of the costs of training from service provision is not an exact science. Also, another layer of bureaucracy would need to be funded at taxpayer’s expense.

National Health and Hospitals Reform Commission – Interim Report – Key points

• Acknowledgement of access to universal health care
• Establishing a national health promotion and prevention agency to improve community health and well-being
• Safe and timely access to hospitals
• Universal dental care (Dentacare Australia)
• Commonwealth assuming responsibility for all primary health care policy and funding
• Reshaping hospital roles (greater delineation such as separating planned and emergency services) and reflecting this in the use of activity-based funding for private and public hospitals
• Establishment of Comprehensive Primary Health Care Centres
• Prioritising and investing in sub-acute services
• National Access Guarantees and Targets for hospitals
• Remote and rural health – equitable and flexible funding, innovative workforce models (including locum relief, role expansion, and telehealth services) and reflecting this in the use of activity-based funding for private and public hospitals
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Working for us: a sustainable health workforce for the future

ANZCA favours a team-based approach to care. Anaesthetists have been at the forefront in utilising nurses as assistants as part of the anaesthetic team. There may be roles, and responsibility is made to the scarcity of workers in rural and regional areas, which anaesthetists feel are appropriate for delegation to others. However, the composition of any team, and their specific roles, must be adaptable to the Australian context, especially with consideration of workforce projections for all healthcare workers, and not just anaesthetists. The current pilots in Victoria and Queensland on nurse clinicians and physician assistants will provide valuable guidance on some of these alternative roles.

The establishment of a National Clinical Education and Training Agency may perhaps superficially attractive is not proven in practice. A key consideration is that the separation of costs from training service provision is not an exact science. Also, another layer of bureaucracy would need to be funded at taxpayer’s expense.

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 and Territories, the Australian College of Anaesthetists, and Australia) and the Australian Society of Anaesthetists (doH& Ageing (DoHA) and led by the Australian Medical Association. In 2009, the report followed a review led by Chief Nurse and Midwifery Officer Rosemary Bryant. The report focused on the need to improve the choices available to pregnant women, access to high quality maternity services, and support for the maternity workforce. The report received more than 900 submissions.

Summary of findings and recommendations

• Australia remains one of the safest places in the world in which to give birth
• In 2006, 277,476 women gave birth to 282,896 babies in Australia – the highest number of births since 1979. Over 60 per cent of births take place in public hospitals
• Improving choice for Australian women by supporting an expanded role for midwives
• Consideration of 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

HEALTH POLICY

Maternity services report silent on analgesic and anaesthetic services, risk pregnancy and critical care

Professor Mike Paech
King Edward Memorial Hospital for Women, Perth

The Federal Government’s Maternity Services report was released on February 23. The report followed a review led by Chief Nurse and Midwifery Officer Rosemary Bryant. The report focused on the need to improve the choices available to pregnant women, access to high quality maternity services, and support for the maternity workforce. The report received more than 900 submissions.

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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.

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Key findings

‘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.’

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.

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.

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 informed 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).

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 and 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 modelled demand and supply projections of FTE anaesthetists for the period 2006–28. Gap estimates were also made for rural 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 inpatients. 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 unlikely to be underestimated 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 hour. Dividing by clinical hours per FTE (576 hours per year), it was found 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 4,437 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 1.3, income elasticity of demand of 1.0 and 80 per cent of clinical time captured by Medicare data). Alternative scenarios were also modelled to reflect the most severe cases of the assumptions regarding income elasticity of demand and technological change.

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

2. The income-price elasticity of demand measures the relative responsiveness of demand (in this case for anaesthesia services) to a change in consumer incomes.
Estimate of Current Supply
ANZCA headcount data in 2007 recorded 2963 active Fellows and 1083 Trainees. Data from the ASA and the Joint Consultative Committee on Anaesthesia (JCCA) suggested a further 564 non-Fellows and 460 GP anaesthetists. Medicare data indicated that GP anaesthetists tend to work in rural areas and provide approximately 2.7 per cent of anaesthesia services overall. Trainees tend to be located in public hospitals in urban areas. Based on headcounts of anaesthetists and an estimated average clinical time of 1176 hours per year, the model suggested that in 2008 there were 4433 FTE anaesthetists in Australia. Over 90% of these were ANZCA Fellows and Trainees.

Supply Projections
The number of FTE anaesthetists working in Australia was projected to increase by 4.7% to 6312 by 2028 (Table 2).

Figure 1 Growing Shortage of FTE Anaesthetists

Figures 2 and 3 show the potential impact of increasing remuneration and regional migration on the anaesthesia workforce.

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 2887 in 2028 (Figure 3).

Table 2 Base Case Projections of Supply (FTEs)

<table>
<thead>
<tr>
<th>Year</th>
<th>Urban</th>
<th>Rural</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>4,433</td>
<td>4,063</td>
<td>8,496</td>
</tr>
<tr>
<td>2028</td>
<td>6,312</td>
<td>5,786</td>
<td>12,098</td>
</tr>
</tbody>
</table>

Table 3 Alternative Supply Scenarios

Scenario | Description | Percent Increase in FTEs (2008–28) | Projected FTE Supply Gap (2028) |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Scenario 1</td>
<td>Training completions grow 4.4% pa</td>
<td>75%</td>
<td>883</td>
</tr>
<tr>
<td>Scenario 2</td>
<td>Increase feminisation (19% in 2008 to 40% in 2028)</td>
<td>41%</td>
<td>2738</td>
</tr>
<tr>
<td>Scenario 3</td>
<td>Net migration inflow of 60 p.a.</td>
<td>10%</td>
<td>1875</td>
</tr>
<tr>
<td>Scenario 4</td>
<td>Later retirement</td>
<td>55%</td>
<td>1522</td>
</tr>
<tr>
<td>Scenario 5</td>
<td>Increase in real remuneration by 20% in 2010</td>
<td>8%</td>
<td>1466</td>
</tr>
</tbody>
</table>

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.

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.

Table 4 Survey Sample

<table>
<thead>
<tr>
<th></th>
<th>All ANZCA Fellows</th>
<th>Survey Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Age</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td></td>
<td>51.6</td>
<td>46.6</td>
</tr>
</tbody>
</table>

Age and Gender
The average age of respondents to the survey was 51.4 years for men and 48.8 years for women. This was not too different from the current age distribution of Australian-based Fellows which is 51.6 for men and 46.6 for women.
Past five years, 33% of all Fellows have been women (288 of 880 new Fellows). The proportion of women entering the profession fluctuates each year, over the five years, 15% of women entered the profession in future years, and explores the scenario where this percentage increases to 40% in the next 20 years.

While women make up 28% of the total workforce, the average percentage of women in the last five years has been approximately 33% of total new Fellows. The Workforce Model assumes this percentage of women will enter the profession in future years, and explores the scenario where this percentage increases to 40% in the next 20 years.

Distribution of Australian FANZCA by age and gender

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 35 and 54. 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 profession in future years, and explores the scenario where this percentage increases to 40% in the next 20 years.

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.

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.

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 more than adequate, with a large proportion of these responses from anaesthetists in private medical facilities. About half of respondents (55%) thought the number of anaesthetists adequate, and the remainder, just over a third (38%) thought there was a shortage.

While the survey results in themselves are of interest, their main value from a strategic perspective lies in the qualitative and quantitative insights they provide to the Workforce Model. Survey input provides critical demographic data that facilitates cross-tabulation analysis and provides estimates of parameters for use in the Workforce Model, e.g. working hours, elasticity of workforce supply.

The experience gained in the process, and the careful scrutiny and analysis of data, will allow the College to further refine the model in future years, and provide valuable input into developing strategies that can be used by the College to address future needs of the profession.

**Summary**

**Access Economics study**

The Access Economics’ workforce study monograph “Supply and Demand for Anaesthesia Services” is available on ANZCA’s website www.anzca.edu.au
South-eastern Australia is one of the most bushfire prone areas in the world. Wet winters, long dry summers and eucalyptus-based bush make fire a part of the natural landscape. Previous disastrous fires occurred in 1939 (Black Friday, with 71 deaths) and 1983 (Ash Wednesday, 75 deaths).

The summer of 2008-9 was particularly hot. In the last week of January, land surface temperatures in Victoria and South Australia were well above recent summer averages. Melbourne had three consecutive days with temperatures above 43 degrees, South Australia had four. Tasmania broke temperature records on two consecutive days.

In the days leading up to what has become known as Black Saturday (February 7, 2009), meteorologists and politicians were warning of major bushfire threats. The Premier, John Brumby, said: “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.

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 in western Victoria to move a patient who suffered 50 per cent burns, having been caught in a fire in his shorts and t-shirt. ARV was involved in another incident around 7pm. Dr Moloney was on the phone to Bendigo Hospital and heard the bushfires were two kilometres away from the hospital.

Soon after, he received a text message from the FEMO Program mobilised six specialists with experience in emergency and disaster medicine. Dr Moloney and the team at the Casualty Collecting Post saw about a dozen patients. One was dead on arrival. There were also numerous patients with minor injuries such as smoke inhalation and minor burns who were sent to Box Hill Hospital, in order to take the pressure off the hospitals closest to the fires.

It later became obvious that where we were stationed wasn’t where the majority of patients were coming to, so our convoy of more than seven vehicles moved up the hills by police, ambulance or private vehicles, being assessed, treated as needed 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’.”

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The Burns Unit managed its staff better despite the influx of major burns patients, Dr Moloney said. “The Burns Unit managed its staff better and the nurses coped well with the burns patient load. ‘Additional anaesthetic staff were called in during the early hours of Sunday morning so that instead of having only one consultant in the hospital we had four. We ran two burns theatres all day on the following Sunday, Monday and Tuesday and then ran one burns theatre for the rest of the week. Normally we would have one burns theatre running for less than three half days a week,’ he said.

‘We put 10 burns patients through the ICU and another 10 into the burns ward. By Monday morning we were able to accept other patients into ICU. Within 36 hours, despite the influx of major burns patients, we were able to take ‘normal’ ICU patients, which astounded me.

‘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 ourselves 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.
Australia’s worst bushfire disaster: the medical response on Victoria’s Black Saturday

The cooperation was exceptional on Saturday night and Sunday. Administration asked what we needed and it was as if we had asked; this meant we could as a group request what we needed and it was as if we had asked. Administration asked what we needed and it was as if we had asked.

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-anasthesiated one of the bushfire 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 Narbethong. The Department of Human Services (DHS) facilitated the placement of GPs utilising the Rural Workforce Administration 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, Maroondah 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 FEMO Program were facilitating, and to establish how best to provide ongoing support. Supporting 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 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 in Melbourne and the rest of Victoria also treated victims of the bushfires. Black Saturday was worse than anyone could imagine.’

Dr Hugh Anderson, anaesthetist, The Alfred Hospital

‘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 Moloney says Black Saturday wasn’t specifically a burns response but a mass casualty incident with multiple victims that needed health and recovery personnel with expertise and experience in dealing with multiple patients. The Alfred and Royal Children’s Hospital treated most of the patients with major burns but many other hospitals in Melbourne and the rest of Victoria also treated victims of the bushfires.

Black Saturday was a ‘super fire’. The heat energy was unprecedented because of the extremely dry conditions, low humidity, record temperatures and strong winds. ‘People were injured from 200 metres away from the flames (compared to normal fires – 50 metres away) and there were embers the size of forearms,’ Dr Moloney said.

‘Most anaesthetists would be able to deal with one of these burns patients. The question is how you best organise the system to deal with five, 10, 50 or 100. That’s the challenge and my area of interest.’

Dr Joel Symons, an anaesthetist, at work at the Alfred Hospital.

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.
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 has actually 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 week in ICU, and all my on-call is for intensive care.”

“My regular lists include paediatrics, OB/GY and colorectal surgery. Wagga is unique in rural areas in having a fully equipped ICU in both the public and private hospitals, so we can feel comfortable anaesthetising the frail and elderly in both locations.”

Dr Killen has long been interested in the issue of rural workforce shortages. The increasing problems became very apparent during the 1990s and have been at crisis point this century. There are 14 anaesthetists based in Wagga Wagga, three of whom cover Intensive Care. There is a need for about 20, and the shortfall is made up with locums. Not all anaesthetists are suited to rural locum work. They need to be confident anaesthetising the extremes of age, obese patients, trauma, often with unfamiliar equipment and without the luxury of knowing the staff’s strengths and weaknesses. “A lot of new Fellows aren’t very happy anaesthetising small children, but in a rural area we can’t afford even one three-year-old with a broken arm,” Dr Killen says.

“The College has responded to this situation by increasing trainee numbers and the Federal Government has increased medical student numbers. In the next decade, more anaesthetists will be trained, but they need to realise that much of the available work is in the large regional centres. 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 and I have regular consultations with the forwards and backwards. One of my mentors is Prof David Baines in Sydney who is un failingly 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 special anaesthetist going there and can give advice on standards and education. My support there allows them to continue to earn their living – they have around 150 deliveries per year, and the alternative is travelling to the over stretched 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; her younger son, now 17, developed Type 1 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 seminar 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 undertook 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...”

“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 a ‘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 oximetry and end tidal CO2,” Dr Killen says.

“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.”
The cool side of medicine

The Antarctic 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, and 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 of these bases are isolated: over the summer, which lasts from late October to late February, and the numbers at the stations during this period are 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 15 wintemers, most of whom are tradesmen.

Like all things, working in Antarctica had its highs and lows. Everyone has different experiences, but for me the good certainly outweighed the bad. Medically, fortunately it was pretty 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.

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 in the past, though only rarely. The commonest major injury is broken limbs – there were a couple of fractures the year I was down there – one broken ankle and a fractured humerus. Both were treated conservatively, as we had no other treatment available. About every 10 years someone has an appendicectomy – my predecessor performed this surgery on the ship on the way down to the surgery. Luckily, on the ship there are usually a lot of useful people around – other doctors, nurses, so there is help. His patient did so well that she recovered quickly and went back to work within days. There have been some major traumas – the last was about 10 years ago, when an expeditioner was crushed by her quad bike as it fell through a crevasse. She sustained abdominal trauma, requiring several returns to theatre both in Antarctica and also once we returned to Australia. Let me stress, however, these incidents are rare, and most doctors have nothing more exciting happen than losing a filling. And as it is such an isolated environment, over the winter, expeditioners do not even get the common cold, as there is no exposure to any new viruses. However, that soon changes once the summer arrives and the viruses are brought in with the next crew.

As all expeditioners should be fit and healthy, there is often not a lot for the doctor to do. We do have other responsibilities, such as maintaining all of our equipment (each base effectively has a mini hospital), stocktaking all items and reordering for the following year plus also checking the quality of the drinking water every month. 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, but so both the scenery and the colonies are spectacular. Since the birds start their nesting in winter when the sea ice is firm, there were numerous trips over the dark months to visit these superb creatures. To my surprise, I really enjoyed the winter, not only because of the penguin colonies, but also seeing the incredible colours of the twilight, with regular viewings of the spectacular aurora australis.

A year such as this one is not one that is easily forgotten. Each base has its own magic, every year its own experiences. For me, I think these challenges need to be taken up occasionally, as they are rarely regretted. Will I go down again? 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 1998. Originally she worked at Dandenong, but moved to Adelaide in 2005, 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.

Dr Jo Mellick doing some minor dentistry work in Antarctica.

Emperor Penguin rookery.
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 made 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 Doctor3 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 2008 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, 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 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. 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 certain types of plastics (made by companies with whom they had contractual arrangements), other recyclers would only accept certain types of plastics (polyvinylchloride (PVC) plastic only). PVC forms about 25% of all operating suite plastics, other plastics are detailed in Table 1. Researching the 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 measures 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.

After reading Dr Rod Westhorpe’s “Letter from the editor: Agents of change”, ANZCA Bulletin, March 2007, I was motivated to investigate and quantify what our individual effect of using N2O on greenhouse gas emissions is. As Dr Westhorpe states in his 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 min 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, inviting 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 2
At the Western Hospital, we embarked on a pilot project to recycle polystyrene (PS) plastic only. PS forms about 25% of all operating suite plastics, indeed one could argue that it is of utmost importance.

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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 advocate for the mitigation of greenhouse 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 our hospitals and within anaesthetics.

References:
2. www.actonline.org.au/greenclinic

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Visiting Anaesthetist
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Dr Forbes McGain
Staff Anaesthetist and Intensivist
Western Health, Melbourne

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

FEATURE
Doctors for the Environment Australia

Continued from page 28

Personal experience: Initiating operating theatre plastic recycling programs

Continued from page 28

Table 1. Practical steps towards sustainability for the anaesthetist

- Alter your gaseous! Stop using Nitrous Oxide. For every minute of 0.5L/min, N2O you’ve driven the equivalent of 1km in an average car.1
- Conserve your gaseous! Use low flow anaesthesia (sevoflurane nephrotoxicity in humans has been shown not to occur at low flows).2,3
- Reduce. Are two disposable anaesthetic trays per patient necessary?4
- Re-use. Disposables routinely use more energy and water to produce than re-usables. 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).5
- 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.6
- Procure more sustainable products. Fifty per cent recycled paper is a start.
- Conserve your gases! Reducing the duration of anaesthesia decreases oxygen demand, thereby reducing the amount of waste generated.

References:
5. Dettenkofer M, Schermer M, Hoch V et al. Shutting down operating theatre ventilation when the theatre is not in use: infection control and environmental aspects. Inf Cont Hosp Epi 2003; 24(8): 596-600.

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.
- To ensure short-term and longer-term actions are implemented with clear deliverables.

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 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 by staff of environmentally sustainable practices.
FEATURE

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 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 unsustainable land use practices. 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 fresh clean air and the productive soils a healthy environment supplies. We need the fresh water, the biologically productive land and sea that the ocean provides year after year, and the high-quality food that the ocean provides year after year. We need for sterility, safety and the productive soils a healthy environment supplies. We need the fresh clean air and the productive soils a healthy environment supplies. We need the fresh water, the biologically productive land and sea that the ocean provides year after year. We need a healthy environment to sustain our way of life.

**How big is our footprint?**

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 deployment 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 company logos, the units used vary between metric and imperial, and the units themselves vary between volumes and weights, instead 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 on the environment comes 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 water required to provide the resources we use and to absorb the waste we create. Using this concept, the World Wide Fund for Nature (WWF) Living Planet Report 2008 shows that we are currently turning resources into waste faster than nature can turn the waste back into resources. Using a financial analogy, rather than living off the interest from our bank account, nature, we are making withdrawals that are eating into our financial capital. Our ‘account’ 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 2050. 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 317 million gha, Australia 157 million gha and the US 2,803 million gha.

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 2005. In comparison, the NHS uses 0.09 gha per-capita, England and Wales 0.59 gha, Australia 0.28 gha and the US 0.94 gha. For a stark contrast, China only uses 0.12 gha per-capita.

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**

The Earth is 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. 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 bacteria 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. 1991 “From little things, big things grow”, Comedy, Mushroom records, Australia
Honours for 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 cardiothoracic surgeons, perfusionists, anaesthesia 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 airfares, 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. Simultaneously the project has taken on a life of its own, and has become important politically.

This year marked the 15th year of the 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.

This has certainly been one of the most challenging and rewarding experiences of our time in medical practice, and we would urge others to become involved in these outreach projects. Being able to work in a situation where everyone has the same goal, no clipboards, minimal if any hospital politics, and being able to sit down at night with your work mates for dinner, a beer or glass of wine, has much to recommend it. The Australian team mainly performed open heart surgical cases, for the most part ASDs, VSDs, Fallot’s tetralogy, Anomalous Pulmonary veno 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 200–350 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, thus not blocking another patient from their operation, have a “low mortality” risk, be able to live a normal or markedly improved lifestyle afterwards, and be a valuable 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 off, 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.

This has certainly been one of the most challenging and rewarding experiences of our time in medical practice, and we would urge others to become involved in these outreach projects. Being able to work in a situation where everyone has the same goal, no clipboards, minimal if any hospital politics, and being able to sit down at night with your work mates for dinner, a beer or glass of wine, has much to recommend it.

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

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

Keynote Speakers
Prof. John Bear
Huddifield Dept. of Anaesthetics, University of Oxford, Oxford, UK
Dr. Orlando Hung
Dalhousie University, Halifax, Canada

Prof. Mark Warner
Mayo Clinic College of Medicine, Rochester, Minnesota, USA
A/Prof. Pam Macinctyre
Royal Adelaide Hospital, Adelaide, SA

Dr. Archie Brain
PFARC(S), FIACCA (Hon), FANZCA (Hon), Sydney, Australia
Dr. John Loadsmen
Royal Prince Alfred Hospital, Sydney, NSW

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

5th-8th September 2009
Darwin Convention Centre

FEATURE: IN THE FIELD

Right: Darren Wolfers with a satisfied customer, taken two post-VSD repair in Port Moresby General Hospital.
Come to Cairns in 2009!

The 2009 ANZCA ASM will be bigger than ever before. With five concurrent scientific streams it will guarantee something for everyone.

This year will feature:
• More small group learning than ever before
• Crocodile Anaesthesia
• Comedy duo, Amateur Transplants sing the “Anaesthetists’ Hymn”
• Completely CPD accredited
• Last conference in Australia for 3 years
• Free Childminding

Tours include: Great Barrier Reef, Daintree Rainforest, Kuranda Skyrail/Train, White water rafting and many other activities unique to Tropical North Queensland.

Bring a friend, bring your family.

Do whatever it takes – just don’t miss this one!
It will be an unforgettable, brilliant experience.

Put the Cairns 2009 ASM in your diary now!
Register online now at www.anzca2009asm.com
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 send in 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 through 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 Brandao-Stranks, on +61 3 9510 6299 or email cpd@anzca.edu.au.

Dr Frank Moloney
Chair, CPD Committee

The ANZCA Bulletin
March 2009

FELLOWSHIP AFFAIRS

The CPD Program

Your questions answered

Summary of CPD Participation for Registration

<table>
<thead>
<tr>
<th>Region</th>
<th>Compulsory</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>Yes</td>
<td>CPD Statement of Participation by birthdates</td>
</tr>
<tr>
<td>Victoria</td>
<td>No</td>
<td>Certificate of Good Standing</td>
</tr>
<tr>
<td>Queensland</td>
<td>No</td>
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<tr>
<td>South Australia</td>
<td>No</td>
<td>CPD Question on Registration Form</td>
</tr>
<tr>
<td>Tasmania</td>
<td>No</td>
<td>CPD participation questions on Registration Form</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>No</td>
<td>CPD Question on Registration Form</td>
</tr>
<tr>
<td>ACT</td>
<td>No</td>
<td>Certificate of Good Standing</td>
</tr>
<tr>
<td>Western Australia</td>
<td>No</td>
<td>Certificate of Good Standing</td>
</tr>
<tr>
<td>New Zealand</td>
<td>Yes</td>
<td>CPD Statement of Participation submitted quarterly depending on birthdates</td>
</tr>
</tbody>
</table>

The ANZCA Bulletin
March 2009
There is a strong push in our medical fraternity, and others, to foster professionalism among our trainees. Concepts such as honesty and integrity, practicing ethically and dutifully, communicating effectively and empathically are being advocated in order to produce responsible, accountable, caring individuals who can contribute as well as benefit from their roles in medicine.

Producing anaesthetists with the above attributes sounds like a tall order, but the implementation of techniques such as mentoring may go some way towards promoting these issues in addition to 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 foreign 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”.
• “We didn't need it in my day”.

But can mentoring actually achieve all this? The evidence is not strong, and most positive studies are poorly designed. A systematic review in JAMA of 35 papers, many of which had methodological limitations, revealed the following advantages attributed to mentoring:

- Greater career satisfaction than those without a mentor.
- Greater satisfaction with training.
- Important in career advancement.
- Likelihood of promotion.

Mentoring has become commonplace in the medical fraternity; better handling of stressful situations and should have a group that are regularly exposed to this? The evidence is not strong, and most positive studies are poorly designed. A systematic review in JAMA of 35 papers, many of which had methodological limitations, revealed the following advantages attributed to mentoring:

- Greater career satisfaction than those without a mentor.
- Greater satisfaction with training.
- Important in career advancement.
- Likelihood of promotion.

Mentoring has also been shown to influence:

- Selection of a specialty.
- Interest 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.

The lack of adequate evidence for its effectiveness might make one wonder why bother. But perhaps mentoring does lend itself well to academic study. Our trainees say that the mentoring program provides acknowledgment, back-up and, more importantly, the assurance that there is someone at a senior level that has their interests at heart. Just as in any relationship, these are difficult concepts to study.

Can we be sure that mentoring, as opposed to other forms of personal development, is the best method of supporting our trainees? Mentoring, in fact, is only part of the overall development of the individual, which is based on multiple inputs, good and bad. What it does provide perhaps, is “at the coal face” management of evolving issues, which any number of preemptive courses and disciplines may prove inadequate for.

So what is it?

Classically, it refers to personal and professional development by a wise and trusted guide. There are multiple roles ascribed to 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.

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 continuously 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 thought to be role models. Most were given their first choice. Each consultant was limited to no more than two trainees. The participants are 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.

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 magic 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. However, it may be desirable in order to produce individuals who act professionally, who have a rewarding career and who are making a contribution to the community. These are blatantly old-fashioned notions. But, if we look around us at those who have the most fulfilling lives in our fraternity, it may be that these and other “noble” attributes underpin that fulfillment. In addition, personal experience and simple observation tell us that these are the very characteristics that our patients value in us. If a mentoring relationship can contribute to this, it may be of significant value.

References


Dr Greg Downey
Anesthetist, Westmead Hospital, New South Wales
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 sub-specialties. 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 TE1, Policy on the Formal Project. Trainees may be eligible for an exemption from the Formal Project as per TE1. 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 required to be done as dedicated rotations (except for ICU Module 5, 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, degree 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 period 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 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

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 by the ANZCA IMGS website. Minor but important changes have been made to the IMGS documents already on the website. The ANZCA 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 Postgraduate 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 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 ability to apply for FANZCA.

• “Not Comparable” is the classification for those IMGS who are judged on paper assessment, or by the IMGS Interview Panel as being unable to satisfy the standard required of a College Fellow within two years. These IMGS still have the ability to seek to satisfy AMC requirements, to enter the ANZCA training program, and to request recognition of prior learning.

• “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 recommendations 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 Postgraduate 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 the Formal Project. Trainees may be eligible for an exemption from the Formal Project as per TE1. This requires an application in writing to the Director of Professional Affairs Assessor. All other modules are signed off by a module supervisor.

Professor Garry Phillips
Chair, IMGS Committee
In the early 1990s, the Burns Unit at the Royal Children’s Hospital in Melbourne was suddenly faced with the management of a number of children presenting with extensive full-thickness burn injuries. This prompted a renewal of interest in the use of fresh pigskin as a temporary cover for burn wounds.

While early debridement and split skin autografts offer the best form of wound coverage, this approach is limited in massive burns by the lack of donor sites available to obtain split skin for grafting. The aim of temporary cover of burns with pigskin is to reduce excessive fluid loss, act as a barrier to prevent wound sepsis, protect the wound from mechanical trauma, and help control pain.

Plans to obtain pigskin were met with some degree of urgency. The State Research Farm at Werribee agreed to supply a pig to the hospital, on a weekly basis, for harvesting of a large split skin graft taken from one side of its body. This would be performed under anaesthesia by a member of the surgical staff. We were also informed that these were valuable “pathogen free” pigs and were to be used for research and intact (minus, of course, the split skin from their side) to the research farm after the procedure was completed.

All that was needed to complete the plan was an anaesthetist. I was selected for the task not on the basis of my veterinary training, skill or knowledge, but primarily because of my junior status within the Department of Anaesthesia and Perioperative Medicine. I was under the impression that all the other members of the Department had suddenly developed an intense interest in veterinarian, animal rights, Judaism or any other cause they could find that would preclude them being selected.

Having no knowledge of pig anaesthesia, I consulted what literature I could find on the procedure. There were limited references available but most of them indicated clearly that there would be no time for trials, and we reasoned that, if the pigs did indeed feel locked in, this would make unpalatable behaviour even less likely.

Pigskin was in short supply, with only one untoward event: one piglet had a short episode of profound hypoxaemia and appeared to have some sort of “cerebral” grant for the first 24 hours after surgery, but then reverted to behaving in a normal piggy way.

The research study on the piglets did not produce any breakthroughs in surgical practice, but did demonstrate that pericardium is probably not a suitable material to bridge the gap in the oesophagus when repairing oesophageal atresia.

There was very little science in my pig anaesthesia experience either, except 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 MJA, I can now say with a mixture of pride and humility that the Mullins sign is finally “in the literature”.

Geoffrey C Mullins, MBBS, FANZCA, Perth, WA


The Medical Journal of Australia — reproduced with permission.
Changes to Final Examination (August/October 2009)

ANZCA Council has approved the following changes to the allocation of marks to each section of the Final Examination. The weighting of the Short Answer Questions section will be increased to 20% and the Multiple Choice Questions section will be decreased to 20% from the second sitting of the Final Examination in 2009.

The aim of this change is to improve the way candidates learn and study. As the Short Answer Questions paper will carry equal marks to the Multiple Choice Question paper, candidates are encouraged to spend more time preparing for the Short Answer Questions.

Format of the Final Examination to commence from the August/October 2009 Examination

The examination consists of four sections; Written Section consisting of a Multiple Choice Questions Paper (MCQ) and a Short Answer Questions Paper (SAQ), Medical Vivas and Anaesthesia Vivas.

From the August/October 2009 Final Examination, of the one hundred (100) marks allocated for the whole examination, 20 will be for the Multiple Choice Questions, 20 for the Short Answer Questions, 12 for the Medical Vivas and 48 for the Anaesthesia Vivas as outlined below:

<table>
<thead>
<tr>
<th>Section</th>
<th>Format</th>
<th>Duration</th>
<th>% Total Marks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Multiple Choice Questions</td>
<td>150 questions • Each question has a stem followed by five options • No marks deducted for incorrect answers</td>
<td>150 mins</td>
<td>20%</td>
</tr>
<tr>
<td>2. Short Answer Questions</td>
<td>15 questions • A short written response is required for each question (10 minutes each)</td>
<td>150 mins</td>
<td>20%</td>
</tr>
<tr>
<td>3. Medical Clinicals</td>
<td>2 Medical Vivas</td>
<td>18 mins each</td>
<td>12%</td>
</tr>
<tr>
<td>4. Anaesthesia Vivas</td>
<td>8 Anaesthesia Vivas • An introductory case scenario is often used to start the Viva • Examiners assess candidates’ ability to “synthesize” their factual knowledge</td>
<td>15 mins each</td>
<td>48%</td>
</tr>
</tbody>
</table>

To pass the examination, candidates must achieve an overall mark of at least 50% as well as pass the Anaesthesia Viva section and at least one other section of the examination. It follows that candidates who have failed the MCQ, SAQ and medical Viva sections will have failed the examination. Historically, this has applied to very few candidates. It is a requirement to have passed at least one of these sections to be eligible to attend the anaesthesia viva section of the examination. All candidates will be notified as soon as possible after the written and medical clinical sections (approximately three weeks prior to the anaesthesia viva) of their eligibility to attend the anaesthesia viva section.
The ANZCA Bulletin

2-6 May 2009 • Cairns Convention Centre • Cairns Queensland Australia

Australian and New Zealand College of Anaesthetists • Faculty of Pain Medicine • Joint Faculty of Intensive Care Medicine

Anesthesia: Branching Out

The Cairns ASM shows you the way to create a myriad of opportunities while advancing your career

The Organising Committee invites you to submit an expression of interest for the 2009 Annual Scientific Meeting of the Australian and New Zealand College of Anaesthetists and its Faculties of Intensive Care Medicine and Pain Medicine. Register your interest at www.anzca2009.asn.com

ASM 2009 Invited Speakers:

Dr Andrew Lumb, St James’s University Hospital, Leeds, UK
Dr Andrew Rice, Chelsea and Westminster Hospital, London, UK
A/Prof Matthew Chan, Prince of Wales Hospital, Hong Kong
Prof Dan Ramey, Boston Center for Medical Simulation, Massachusetts, USA
Prof Joe Brimacombe, Cairns Base Hospital, Cairns, Australia

Put the Cairns 2009 ASM into your diary now

Anesthesia Position

Only once in a while do positions appear that may change your life. Such a position will become available in mid 2009 or earlier.

The location

The Southern Gold Coast is arguably the finest place in Australia in which to live. It has a sub-tropical climate, kilometres of world renowned beaches; a plethora of sporting activities ranging from surfing, fishing, golf, cycling to bush walking. Cultural activities are supported by its population of 500,000 people. A wide range of high quality schools and tertiary institutions and close proximity to Brisbane make this a prized location that once experienced, few choose to leave.

The position

You will become the 13th Associate in a practice that has been established on the southern Gold Coast since 1993. The majority of work is performed at the 230 bed John Flynn Hospital, with work also performed at other hospitals and day surgeries on the Gold Coast. Other than neuroanaesthesia, all specialties are covered. A public appointment is available if desired. Remuneration is excellent and a generous on call allows for a fulfilling lifestyle outside work. In house education and quality assurance help us achieve what we feel is the highest quality of anaesthesia.

Contact

For further enquiries please contact Dr Gerard Handley 0417754262.

If you are concerned about yourself or a colleague, contact

The Doctors’ Health Advisory Service

Hotline

Nearest to you

Australia:

New South Wales/NT 02 9437 6552
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Queensland 07 3833 4352
Victoria 03 9495 6011
Western Australia 08 9321 3098
Tasmania 03 6223 2047 (business hours) 03 6235 4165 (after hours)
South Australia 08 8273 4111

New Zealand:

04 471 2654

Senior Staff Specialists or Staff Specialists (Anaesthetist)

Department of Anaesthetics, Mackay Base Hospital, Mackay Health Service District, Queensland, Australia.

Remuneration value up to A$380 492 p.a., comprising salary between A$156 049 - A$315 409 p.a. Remuneration value up to A$302 345 p.a., comprising salary between A$119 625 - A$186 279 p.a. (Applications will remain current for 12 months) JAR: H09MK02150.

Duties/Abilities: Mackay Health Service District, Anaesthetic Department (currently six (6) specialists and six (6) registrars) seeks an additional 2 specialist anaesthetist. The Department trains Fellowships of Australian and New Zealand College of Anaesthetics (FANZCA) and Australian College of Rural and Remote Medicine (ACRRM). Registration and medical education provided for a variety of surgical specialties (including obstetrics/excluding cardiac and neurosurgery). Department trains acute pain service and per-anaesthetic clinic. Involvement in the Intensive Care Unit (ICU) can be negotiated. Applicants are to assist the Director in high quality clinical services, education of Medical staff and nurses, Allied Health, numerous Community Groups and Nursing Staff. Must participate in patient safety, audit, research and service planning activities.

Enquiries: Dr Tony Jenkins +61 7 4968 6000.

Application Kit: +61 7 4968 3777 or www.health.qld.gov.au/workforus

Closing Date: Monday, 30 March 2009.

You can apply online at www.health.qld.gov.au/workforus

You are urged to check that you are the appropriate person for the job. A non refundable processing fee applies to Queensland Government buildings, offices and motor vehicles.
Research notices

Academic Enhancement Grant
ANZCA provides enhancement grants which aim to foster the advancement of the academic disciplines of Anaesthesia, Intensive Care Medicine and/or Pain Medicine. Support is provided for proposals encompassing broad areas of research; details of initial areas of investigation need to be outlined. Thus the grant aims to enhance foci of research activity.

Applications must have University status at level of Professor/Clinical Professor or Associate Professor/Clinical Associate Professor but do not have to have administrative responsibility for a clinical department.

Research foci eligible for support include: a new Chair; an existing Chair with new incumbent; an existing Chair pursuing a new research direction; a second Chair in an existing department; a Professor/Associate Professor (or Clinical Professor/Associate Professor) who Heads a research group. Reapplication by a previously successful applicant within five years will receive a lower priority unless exceptional circumstances exist for the reaplication.

Research Awards are made on the application form for Academic Enhancement Grant. An Application Guide and Form will be available from the College website (www.anzca.edu.au) from 1 December 2008.

Novice Research Grant Applicants
It is a major goal of the College and its Faculties to encourage and foster novice investigators. Writing research applications can be a daunting task for the uninitiated. The ANZCA Research Committee therefore invites novice investigators to apply (by email) for mentoring during the application process.

One the application is approved, the College must receive a complete grant application by the closing deadline. A mentor, who is an experienced investigator, will be appointed by the Research Committee. This mentor will assess the application and provide positive feedback. The applicant must then resubmit their application to the College by the usual deadline. Late applications for either deadline will not be accepted. All mentoring provided to the applicant will be confidential and not available to the Research Committee.

For the purposes of this process, a novice is an investigator who: 1) has not been awarded a peer-reviewed research grant in the past; 2) has not published more than five research papers in the five years prior to the year of application, and 3) does not have an experienced investigator as a co-investigator or associate investigator on the proposed grant.

Applications will only be accepted on the prescribed forms. The Application Form and Guide to Applicants will be available from the College website (www.anzca.edu.au) on 1 December 2008.

2010 Simulation/Education Grant
Applications are invited from Fellows and registered Trainees for the Simulation/Education Grants for 2010. Projects that will be considered may be in the field of medical simulation and education of relevance to anaesthesia, intensive care or pain medicine.

An Application Guide and Form will be available from the College website (www.anzca.edu.au) from 1 December 2008.

Research Awards for 2010
Applications are invited from Departments of Anaesthesia and/or Intensive Care, Pain Medicine Centres, Fellows and registered Trainees of ANZCA, the Joint Faculty of Intensive Care Medicine and the Faculty of Pain Medicine for research awards for projects related to anaesthesia, resuscitation, peri-operative medicine, intensive care medicine or pain medicine. In general, the work must be carried out in Australia, New Zealand, Hong Kong, Malaysia or Singapore. However, ANZCA Fellows or Trainees who are temporarily working in other countries for research experience may be considered for research support under special conditions.

The ANZCA Research Policy, which provides full details on the ANZCA Grant Program, is available on the College website and should be considered in detail by all applicants. Two types of research awards are offered:
1. Research Project Grants
   Awarded to support the salary of a research assistant and/or to assist in the purchase of research equipment. Projects that will be considered may be in the field of basic scientific research, clinical investigation or epidemiological research.

Grants are usually awarded for one year, however, consideration will be given to the provision of two- or three-year Grants for applications under special conditions. 2. Research Fellowships/Scholarships

Awarded to Fellows or registered Trainees for salaries to support full-time or part-time research in a recognised university or research institute in Australia, New Zealand, Hong Kong, Malaysia or Singapore. Scholarships are available to individuals enrolled as senior degree students of any university in Australia, New Zealand, Hong Kong, Malayasia or Singapore. They are available for one to three years, subject to category of award made and subject to satisfactory reports.

Applicants are also encouraged to apply for NHMRC, NZ HRC or equivalent funding. Any applicant gaining such funding will be considered by ANZCA for ‘top up’ funding. The stipend and allowances are similar to those provided by the NHMRC. The basic stipend is approximately $40,000 inclusive of allowances.

Applications will only be accepted on the prescribed forms. The Application Form and Guide to Applicants will be available from the College website (www.anzca.edu.au) on 1 December 2008.

Further information: Jill Humphreys, Executive Officer Australian and New Zealand College of Anaesthetists 630 St Kilda Road, Melbourne Victoria 3004 Ph: +61 3 9510 6299 Fax: +61 3 9510 6931 Email: j Humphreys@anzca.edu.au Deadline: 5pm EST, 1 April 2009

PHILANTHROPY

The ANZCA Foundation
An initiative of the Australian and New Zealand College of Anaesthetists

Three-year business plan 2009–2011
Earlier this month The ANZCA Foundation board met in Sydney to consider a three-year business plan covering the activities of the Foundation and to approve the various financial targets.

The deteriorating economic conditions in Australia, New Zealand and overseas as a result of the credit collapse in the latter half of 2008 are going to continue to have a profound impact.

At this time there is little clear evidence of the impact that the current economic conditions are having on philanthropy and sponsorship here in College. Some anecdotal input suggests that the impact (if economic conditions deteriorate further) will be greater in the 2009/2010 financial year. It is clear that The ANZCA Foundation’s activities over the next three years will be adversely affected by the current and likely ongoing difficult economic conditions.

The three main sources of support for The ANZCA Foundation over the three-year plan period are:
- Ongoing (and increased) sponsorship by major pharmaceutical companies
- Development of the notified bequest program. A bequest program by its very nature is not directly subject to current economic conditions such as donations or grants, but may experience the flow-on effects of a cautionary economic climate.

Establishing The ANZCA Foundation Patrons Program and encouraging people (particularly College Fellows) to come to the support of the Foundation.

These images will be featured in The ANZCA Foundation audio visual presentation that is currently in development. Many of the people who view this presentation will know little, if anything, about anaesthesia. Images such as these are a powerful way to highlight the work of anaesthetists, intensivists and pain medicine specialists.

A bequest to The ANZCA Foundation
A bequest to The ANZCA Foundation will greatly enhance ANZCA’s ability to undertake important medical research that will significantly improve outcomes for the health of future generations.

You might consider a bequest to The ANZCA Foundation whether as a specific amount of money, a proportion of your estate, the residual of your estate, or other specific property.

Your will and financial planning are intensely personal, and the Foundation respects your privacy. However, if you wish to allocate an amount to the Foundation, or to honour or commemorate a named individual, the staff at the Foundation are readily available to discuss this with you and provide assistance.

All discussions will, of course, be confidential.

We strongly recommend that you seek professional advice regarding your will. A solicitor will help you make a clear, concise will, which is easily located and causes no misunderstanding.

For all enquiries please contact: Ian Higgins Director, The ANZCA Foundation ANZCA House 630 St Kilda Road Melbourne VIC 3004 Tel: +61 3 9933 4900 Fax: +61 3 9510 5693 Email: ihiggins@anzca.edu.au

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The ANZCA Bulletin

Not another survey! The Trials Group and surveys

The ANZCA Trials Group, in addition to our primary role of supporting multicentre clinical research trials, aims to facilitate survey research by Fellows and Trainees while at the same time reducing ‘survey’ fatigue and protecting the privacy of College Fellows and Trainees. ANZCA Fellows have had three major concerns about the surveys they received through the College: frequency, poor quality; and third, surveys were sent to Fellows and Trainees to address Fellows’ concerns. Currently, if a Fellow or a Trainee approaches the College to distribute a survey they are usually referred to the Trials Group Coordinator. The coordinator arranges for two members of the Trials Group Executive to review the survey and provide feedback on ways to possibly improve the survey, including appropriate target groups. The Trials Group Coordinator ensures that at least one Human Research Ethics Committee has approved each research survey distributed by the College.

The Trials Group and surveys

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Assisted by the College Information Technology Department, surveys are sent to random samples of 500 Fellows. We believe that a random sample of 500 Fellows is large enough to the represent the College Fellowship, and 250 to represent a Special Interest Group (SIG). We aim to have a balance between scientific validity and avoiding sending Fellows and Trainees excessive numbers of surveys. Limiting the number of individuals surveyed also reduces costs to researchers. Increasingly, the approach is to send emails with links to surveys websites that allow surveys to be filled in online and anonymously. For the privacy of Fellows and Trainees we do not give survey researchers the names or details of potential respondents.

What we try to avoid

There are a few things the Trials Group tries to avoid. First, unless there are strong scientific reasons, we do not send surveys to the entire Fellowship. Some researchers are very keen to compare regions such as between states for reasons that are unclear. Second, to reduce survey fatigue we will send a primary survey and one reminder. While all researchers would like a 100% response rate, a 60% response rate is quite reasonable. We think that more than one reminder to Fellows and Trainees is unreasonable. Third, because of limited resources, unless the survey is part of Trials Group sponsored research, collating and analyzing surveys is up to the researchers.

What is required?

For a Trainee or Fellow to do survey research through ANZCA, they should complete the “Application to Access the ANZCA database”; available at http://www.anzca.edu.au/resources/research/anzca-trials-group/fellows-and-trainees/fellow-and-trainee-surveys.html.

Other required information includes: 1. the research protocol, 2. the actual survey as a Word document, and 3. a covering letter to be distributed with the email sent from the College or in the envelope that is sent through Australia Post.

If using an electronic method of distribution, the cover letter needs a working hyperlink to the survey. Finally, before a survey is sent we require ethics approval from a Human Research Ethics Committee. This is because surveys constitute human research. Trainees doing surveys for their formal project need approval from the regional Formal Project Officer. These documents are sent to the Chair of the Trials Group for final approval. Depending upon the quality of the submission, the turn-around time can be one to two weeks.

A quick word on the distribution method...

The Trials Group strongly recommends using email distribution, rather than post, for surveys. There are good reasons for this. First, electronic distribution has a better response rate, and tends to be easier for respondents to use. Second, electronic methodology is less time consuming for everybody. While the College will label envelopes and post your survey, researchers need to prepare the survey, including a return address and stamped envelope for each mail out. Third, an email distribution is free for Trainees wishing to do survey research for a Formal Project, while College Fellows are charged $250 for a sample of 500 and $250 for a smaller sample of 250 from a Special Interest Group. An Australia Post distribution fee is fully charged to a Fellow. For a Trainee formal project the College will pay for the envelopes and stamps for both mail outs, but not the return envelopes. Finally, an electronic survey through a commercial website (e.g. Survey Monkey) can be free if there are fewer than 30 questions and 100 responses. A short survey is a good survey; there are “need to know” questions that have to be asked and “nice to know” questions that can often be left out.

Some advice about email hyperlinks to surveys

Ideally, a survey should be piloted with colleagues, before deciding on a final version. Please make sure the link is working before it is sent to the Trials Group. It is surprising how many are not. Make sure the survey is working properly once it has opened up. If the first question asks participants whether or not they are eligible for participation and the answer is “No”, then the survey should be completed automatically and ready to send, rather than requesting further participation when not appropriate. “No” responses to suitability of participation could be important in the final analysis. Be clear in the cover letter about the username and password, if that is what the survey requires.

Some useful links for conducting research surveys

http://www.surveymonkey.com/
http://www.snapsurveys.com/software/
http://www.keysurvey.com/au/
http://freelinesurveys.com/
http://www.objectplanet.com/opinion/
http://www.questionpro.com/
http://www.surveymonkey.com/
http://www.esurveyspro.com/

Some useful references for conducting research surveys

More resources are available by contacting Stephanie Poustie, Research Coordinator, ANZCA Trials Group on +61 3 8517 5326 or via email: spoustie@anzca.edu.au

Stephanie Poustie, Research Coordinator, ANZCA Trials Group on +61 3 8517 5326 or via email: spoustie@anzca.edu.au

http://www.makesurvey.net/default.asp
http://www.statpac.com/

http://www.keysurvey.com/au/
http://freelinesurveys.com/
http://www.objectplanet.com/opinion/
http://www.snapsurveys.com/software/softwareinternet.shtml
http://www.questionpro.com/
http://www.surveymonkey.com/
http://www.esurveyspro.com/

Some useful links for conducting research surveys

http://www.surveymonkey.com/
http://www.snapsurveys.com/software/
http://www.keysurvey.com/au/
http://freelinesurveys.com/
http://www.objectplanet.com/opinion/
http://www.snapsurveys.com/software/softwareinternet.shtml
http://www.questionpro.com/
http://www.surveymonkey.com/
http://www.esurveyspro.com/

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http://www.makesurvey.net/default.asp
http://www.statpac.com/

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 pathophysiology 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
B. Plasma Products Response: plasma-derived and recombinant product response plan

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/hbcp

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 with those gases connected to cylinders with those gases connected to oxygen lines remains.

The Solution

All medical oxygen cylinders will be pin indexed in accordance with the recent AS4733 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 jeopardise 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 as very low, of the order of 0.4 per 10,000 cases. Using the Australian Society of 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 – 11.3). 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 12.2 compared to men under 70 (95% CI 2.182).

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

Reference:


Mathew Piercey
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 are 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 protect the clinician.

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 reports and on feedback. We hope that the majority of anaesthetists will report regularly, so that we can all learn from one another’s experience and improve patient safety.

Alan Merry, New Zealand
Martin Culwick, Queensland

The ANZCA Bulletin March 2009
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 specialty is the quality of the basic 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 ascribing 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 cohort, which achieved a remarkable 100% return rate from all NHS hospitals in the UK; however the numerator was derived from a comprehensive audit of major reported complications over a 12-month period led by a network of local reporters 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 ’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 4.2 per 100,000 cases in the worst-case scenario or 2.7 per 100,000 in the best case. The incidence of death or paraplegia was 1.8 or 0.7 per 100,000 respectively. Further, two-thirds of the injuries resolved fully.

Mining the data reveals further information. CNB includes epidurals and spinal anaesthesia as well as chronic pain situations. Perioperative epidurals were associated with a higher incidence of complications (8 and 17 out of 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 patients. Sub group comparisons must be made with caution and may not be valid.

The article and an accompanying editorial 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 individual, with 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 subsequent informed consent, is always going to be complicated and difficult where CNB is involved. We are well assisted, however, by reliable resources such as this quite awesome project from the UK and its report.

Patrick Hughes

Victoria

References


3. Available from: http://www.senecainc.co.uk/
ECRI Institute notices

The ANZCA Library subscribes to ECRI publications on Operating Room Risk Management and Health Device alerts and information. Check this space regularly for updates on the latest information produced by ECRI.

Recent notices include:

• Device alerts on various anaesthesia kits, anaesthesia units, and breathing circuits in anaesthesia.
• Executive Summary on warming cabinets. Contact the ANZCA Library for further information.

New technologies and online tools

Anesthesia case log tracking made easy

An Apple iPhone or iPad Touch user can now use an application for anesthesia case log tracking. Anaesthesia Case Logs was designed by anesthesiologists and allows the user to track case information such as patients and equipment.

Available online at: http://www.caselogs.org/index.php/iphone-app

WinkingSkull.com

WinkingSkull.com offers a free online study aid on human anatomy. Sign up today for free access to material on all areas including the upper and lower limbs, neuroanatomy, head, neck and back.

Available online at: http://www.winkingskull.com

New titles


Library update

International news and resources

A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population / NEJM Implementation of the checklist was associated with concomitant reductions in the rates of death and complications among patients at least 16 years of age who were undergoing noncardiac surgery in a diverse group of hospitals.

Available online at: http://content.nejm.org/cgi/content/full/NEJMoa081019

International Anesthesia Research Society (IARS) 2009 Annual Meeting Registrations are now open: http://www.iars.org/congress/annualmeeting.asp

FDA Alerts Public about Skin Numbing Products

The U.S. Food and Drug Administration has issued a Public Health Advisory alert about potentially serious and life-threatening side effects from the improper use of skin numbing products.

Available online at: http://www.fda.gov/aboutfda/topics/NEWS/2009/NEW03927.html

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


Available online via the ANZCA Journal list

Interventional procedure overview of ultrasound-guided regional nerve block / NICC


WHO Guidelines for Safe Surgery


General anaesthesia versus local anaesthesia for carotid surgery (GALA): a multicentre, randomised controlled trial / Lancet 2009; 372: 212-21

Conclusion: There was no definite difference between general anaesthesia and local anaesthesia for carotid surgery, with decisions to be made on an individual basis.

Available via the ANZCA Library Journal List

Cyberchondria: Studies of the Escalation of Medical Concerns in Web Search / Ryen White; Eric Horvitz

Cyberchondria encompasses symptoms of non-medically trained people using the World Wide Web to find health information and self-diagnose, thereby increasing anxiety.


Transformation of the Intensive Care Unit (TICU) Measures [Collection] / VHA Inc Care and Communication Quality Measures [Set]


Analgesia and anesthetics for the breastfeeding mother / Breastfed Med 2006 Winter;1(4):271-7 (Guideline)

Major recommendations cover:

• Analgesia and anesthetics for labour
• Postpartum analgesia
• Anaesthesia for surgery in breastfeeding mothers
• Specific agents used for anesthesia and analgesia

Available online at: http://www.guideline.gov/summary/summary.aspx/view_id=121272

Physicians and the Joint Commission – The Patient Safety Partnership

1. The role of the physician in the Joint Commission
2. Focus on patient safety – accreditation process, standards and performance measurement

3. Patient safety initiatives

4. Enhancing physician involvement in quality and safety improvement initiatives


Value-Based Anesthesia / Anesthesiology Clinics, Vol. 26, No. 4, Dec 2008

Articles include:

• Is it possible to measure and improve patient satisfaction with anesthesia?
• How much work is enough work? Results from a survey of US and Australian Anesthesiologists’ perceptions of part-time practice and part-time training

Available in hardcopy at the ANZCA Library

Notice to New Zealand Fellows and trainees

A core collection of anaesthetic textbooks is available for loan from the New Zealand College of Anaesthetists. Please check the library catalogue via the ANZCA College Library site.

Contact details for the New Zealand office are as follows:

New Zealand National Committee (ANZCA)
PO Box 2743
Wellington South
New Zealand
Phone (64) 385 8556
Fax (64) 385 3950
Email anzca@anzca.org.nz

Book donations

Thanks to Dr David Brown and the Royal Hobart Hospital Department of Anaesthetics, and Dr George Waters for recent significant book donations to the ANZCA Library.

Evidence-based practice corner

Clinical Practice Guideline Handbooks

The Library has collated a list of handbooks on developing clinical guidelines. ANZCA Library staff are always happy to assist with evidence-based practice and development of clinical guidelines.

Available online at: http://www.anzca.edu.au/resources/library/research-tools.html

Cochrane Library Training Dates for 2009

The Cochrane Collaboration/ Australian Cochrane Centre offers workshops on topics such as developing a protocol, diagnostic accuracy and analysis in capital cities around Australia.

Timetable available online at: http://www.cochrane.org.au/training/timetable.php

New databases

CareSearch is an online resource that can help clinicians find relevant evidence about palliative care and trustworthy resources

Available online at: http://www.caresearch.com.au

PROQOLID – Patient Reported Outcome and Quality of Life Instruments Database

Available online at: http://www.proqolid.org/
2009 Combined Medical Education, Simulation, Welfare and Management SIG Meeting

‘Essential Skills for the Future’

The Byron at Byron
Byron Bay, Northern NSW
9–11 October 2009

For further information please contact:
Gay Hopgood
Fellowship Affairs Coordinator
ANZCA Continuing Professional Development
Tel: +61 3 9510 6299
Fax: +61 3 9510 6786
Email: ghopgood@anzca.edu.au
Website: www.anzca.edu.au/fellows/sig/medical-education-sig

Rural Anaesthesia Recruitment Service (RARS)

RARS assists rural hospitals to fill job vacancies for specialist anaesthetists and JCCA accredited GP anaesthetists throughout rural Australia.

RARS provides work opportunities for locum and permanent positions.

RARS aims to:

• Improve the recruitment of permanent staff to rural areas, and thereby improve provision of anaesthetic services to these areas.
• Provide short-term locum relief for anaesthetists in rural areas.
• Raise awareness in the profession of the possibility of rural practice as a career choice.

For further information or to register for RARS contact:
Gay Hopgood
Continuing Professional Development
Ph: +61 3 9510 6299
Email: rars@anzca.edu.au

To view current vacancies or to register for the RARS program visit www.anzca.edu.au/fellows/sig/rural-anaesthesia-sig

The International Association for Ambulatory Surgery (IAAS) is dedicated to the global exchange of information and expansion of high quality ambulatory surgery. It acts as an advisory body for the development and maintenance of the best standards of patient care (www.iaas-med.com).

The Australian Day Surgery Council (ADSC) represents Australian day surgery to this international body.

The first international congress was held in Brussels in 1995, followed successfully by London, Venice, Geneva, Boston, Seville and Amsterdam.

This 8th Congress will be held in Brisbane, the first time the event has been hosted in the Southern Hemisphere. The local organising committee is comprised of members of the ADSC.

The theme of the Congress is ‘The Destiny of Day Surgery’ and the program has been designed by and for surgeons, anaesthetists, nurses, managers and other health professionals.

The Congress opens with the prestigious “Nicoll Lecture”, named in honour of James H. Nicoll, MR, a pioneer of modern day surgery. Nicoll first described paediatric day case surgery in 1909 and performed 8988 operations as day cases at the Royal Glasgow Hospital in Scotland. This year’s Nicoll Lecturer is Jill Solly, a past President of the British Association of Day Surgery.

With an invited faculty of over 60 international and local speakers, we will hear of the challenges, developments and initiatives in day surgery across the globe. Plenary topics cover the themes of: Ambulatory surgery in the future; Risk management in day surgery centres; Worldwide expansion of day surgery; How will medical practitioners and nurses be trained in the future and the Horizons of day surgery.

We are honoured to welcome the contribution of the Society for Ambulatory Anesthesia (SAMBA), an international body, who will conduct a satellite conference on our local and international faculty discussing ‘The challenges of bureaucracy – a global perspective’.

There will be pre-congress workshops available including a simulator session at the Queensland Health Skills Development Centre entitled “Emergencies in the Day Surgery Unit”. This world-class facility features high fidelity models in a purpose-built operating theatre. There will be small groups for “hands-on” experience.

This congress represents a unique opportunity for Australian professionals involved in day surgery to enjoy the benefits of an internationally recognised event right on our doorstep.

We invite all those interested in the future of day surgery to attend this important Congress.

Dr Tony Bergin
Scientific Convener (ANZCA Representative)
8th International Congress on Ambulatory Surgery

Important Dates:
Abstract Submission Closes: Monday 2 March 2009
Early Bird Registration Closes: Friday 1 April 2009
Online registration: www.iaascongress2009.org

The Destiny of Day Surgery
Brisbane, Queensland, Australia
3–6 July 2009

Visit www.iaascongress2009.org for
> Online registrations
> Abstract submission
> Provisional program

For more information visit www.iaascongress2009.org

March 2009
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 the October. The theme is ‘New Frontiers in Paediatric Anaesthesia’. More details about both of these conferences will be distributed in the coming months.

Tasmania

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 JFCM 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.

Joint ANZCA/ASA Committee and Presidents:
Back row from left: Dr Mark Reeves (Chair, ANZCA Tas.), Dr David Brown (Treasurer ANZCA/ASA Tas.), Dr Richard Waldron (Treasurer ANZCA), Dr Stuart Day (Chair, ASA Tas.)
Dr Stephen Beed (Director of Anaesthesia, Royal Hobart Hospital), Dr Chris Wilde (Chair, Trainees 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 Lisa Freestone (Secretary of ANZCA/ASA Tas.), Dr Andrew Mulcahy (ASA Vice-President).

South Australia / Northern Territory

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

Registrares 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.

Victoria

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.wtc.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.

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: 832 2000
Email: maggie.wong@thewomens.org.au
Queensland

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

The Part Zero Course is held annually for trainees. This year’s course convenor, 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 Bramer, Dr Anton Loewenthal, Dr Tim Wong, Dr Mark Gibbs, Dr Genevieve Goulding, Dr David Belavy, Dr Joe Power, Dr George Fang, Dr Gemma 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 Caffa at the ANZCA Queensland Office: qldevents@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, were on hand to liaise with delegates. The meeting also gave delegates the opportunity to meet and discuss issues with others facing similar circumstances.

OTSAN endeavoured to hold three ‘education meetings’ annually. The next meeting will be held in Brisbane on the weekend of July 18–19. The September venue is yet to be confirmed.

If you would like further information regarding OTSAN, please contact Dr Rajesh Brijball at rajesh_brijball@health.qld.gov.au

ANZCA/ASA Combined CME Committee of Queensland – 12th Annual Queensland Registrars Meeting

Twelve registrars presented their Formal Projects at the 12th Annual Queensland Registrars Meeting held on Saturday, February 28 at the ANZCA Queensland office. A diverse range of subjects were covered.

Dr Matthew Bryant and Dr David McCormack were announced as the winners of the Tiss Crandall Prize. Dr Crandall 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, preperpetual plaque with the title of ‘Supporting Hospital of the Tiss Crandall Prize Winner’. The plaque was presented to the Cairns Hospital this year.

Dr Diana Khursandi presented the Axxon Health Prize to Dr Sarah 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 Petra Millar and Mark Dilda, Merit Winners of 2008.

New South Wales

New South Wales Regional Committee

Australian and New Zealand College of Anaesthetists

Primary refresher course in anaesthesia

The course is full-time revision, run on a lecture/tutorial basis and is suitable for candidates presenting for their Primary Examination in the second part of 2009. The first week will cover mainly physiology topics and the second week pharmacology topics.

Date: Monday, May 4–Friday, May 8, 2009 (Physiology)

Monday, May 11–Friday, May 15, 2009 (Pharmacology)

Venue: Large Conference Room

Kerry Packer Education Centre

Royal Prince Alfred Hospital

Missenden Road

Campsendon NSW 2050

Fee: A$880.00 (incl gst) (two weeks)

A$440.00 (incl gst) (one week)

In addition, a comprehensive set of supplementary notes, lectures notes and CD will be given to each participant at the commencement of the course.

APPLICATIONS CLOSE on Friday, April 24, 2009 (if not filled before this date)

The number of participants for the course will be limited.

Late applications will be considered only if vacancies exist.

For information contact:

Miss Berta Silwi

ANZCA New South Wales Regional Committee

117 Alexander Street

Crows Nest

NSW 2065

Email: nwcourses@panzac.com.au

Telephone: (02) 9966-9085

Fax: (02) 9966-9087

New South Wales Regional Committee

Australian and New Zealand College of Anaesthetists

Introduction to anaesthesia

This full-day workshop will explore ways to take the basic knowledge of the field forward. It will aim to develop understanding of small group 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 the 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 4–15: Primary Refresher Course in Anaesthesia (Royal Prince Alfred Hospital)

October 12–23: Primary Refresher Course in Anaesthesia (Royal Prince Alfred Hospital)

Date to be advised for the Part Zero Introduction to Anaesthesia Course.

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.

Post Zero Course

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

OTSAN endeavour to hold three ‘education meetings’ annually. The next meeting in Sydney will be held in Brisbane on the weekend of July 18–19. The September venue is yet to be confirmed.

If you would like further information regarding OTSAN, please contact Dr Rajesh Brijball at rajesh_brijball@health.qld.gov.au

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.

Sponsored by Schering-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 Suzanne Bertrand, Dr Rob Edeson, Dr Linda Roberts, Dr Jodi Graham, Dr Daniel Ellyard and Dr Kevin Hartley for their participation.

WA Part Zero Course

Dr Jodi Graham with Anaesthetic Trainees during Part Zero Course.

GASACT Chair Dr Ana Licina with Part Zero Sponsor Barry Weimann from Schering-Plough.
I look forward to seeing you there.

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.

The meeting will provide an update for all doctors (Specialists and GPs) providing anaesthetics 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 resus 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, Convener

REGISTRATIONS ARE NOW OPEN!
For further information please contact Marta Dziedzicki e mdziedzicki@anzca.edu.au t +613 9510 6299 or visit www.anzca.edu.au/fellows/sig/rural-sig/2009-rural-sig-conference

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

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

- CHANGE OF VENUE NOTICE -

Please note that 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.

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, RANZCOG 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 CFD 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 anaesthesiologists 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 CFD and recertification requirements. The ANZCA CFD 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 Council of New Zealand (MCNZ) consultation: Draft statement for doctors on the subject of advertising
• Clinical Training Agency: Purchase Intensities 2009/10
• PHARMAC consultation document: “Relevant Practitioner” Pharmaceutical Schedule definition
• PHARMAC: Request for nominations for clinical advisors on volatile Anaesthetics
• MH Report on the HPCA Act Review
• MCNZ consultation document: The proposed use of practice visits (periodic assessment of performance) as part of CFD
• 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
• NQIP 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.
It is my pleasure to inform you that registration for the 2009 JFICM ASM is now open. Many of you will have received a registration brochure in the post. Registration forms can also be found on the meeting website www.anzca.edu.au/jficm/asm we encourage you to register early to take advantage of the early bird discount.

The theme of the meeting is Energy Crises Large and Small. The scientific program will provide Intensive Care Specialists and Trainees with a comprehensive review of aspects of metabolism, hormonal control mechanisms and feeding including intermediary metabolism, the impact of infection on these processes and altered drug kinetics.

There are a number of outstanding international and local speakers on the program, including:

- Prof Djillali Annane (Critical Care and Metabolic/Endocrine Responses) France
- Prof Frank Brunhhorst (Critical Care and Metabolic/Endocrine Responses) Germany
- Prof Marin Kollef (Critical Care and Infection) USA
- Prof David Paterson (Infectious diseases) Australia
- Prof Michael Roberts (Drug Metabolism) Australia
- Prof John Turnidge (Infectious diseases) Australia
- Prof Duncan Topliss (Endocrine Responses in Critical Illness) Australia

The social program will include a welcome reception on Friday evening and a conference dinner to be held on the Saturday evening at the magnificent Hillstone St Lucia. The conference dinner will host the JFICM Fellowship Admission Ceremony, awards and an oration to be delivered by Carole Foot.

I look forward to welcoming you to Brisbane in June.

Assoc Prof Rob Boots
Convenor, 2009 JFICM ASM
The ANZCA Bulletin

The ANZCA Bulletin March 2009

JOINT FACULTY OF INTENSIVE CARE MEDICINE

Message

Dean’s Message

It is with great pleasure that I report on the progress made towards the establishment of the College of Intensive Care Medicine of Australia and New Zealand (CICM). What follows will, I believe, show that the Board and staff of JFICM have taken very seriously the mandate of the Joint Faculty to establish CICM within a reasonable timeframe and in a responsible way. Before reporting on progress, it needs to be clearly stated that the progress made so far has only been possible with the great goodwill and support of both ANZCA and the RACP.

Progress

As previously reported, the CICM has been incorporated as a body limited by guarantee, with a robust constitution, which will serve it well in the future. On 28 February the current JFICM Board was appointed as the Interim Board of CICM. This will allow both Boards to operate in parallel, with gradual transfer of functions from the JFICM Board to the CICM Board over the coming months, so that a smooth transition is effected. The office bearers appointed as the Interim Board of CICM, which will serve it well in the future. On 28 February the current JFICM Board was appointed as the Interim Board of CICM. This will allow both Boards to operate in parallel, with gradual transfer of functions from the JFICM Board to the CICM Board over the coming months, so that a smooth transition is effected. The office bearers appointed as the Interim Board of CICM, which will serve it well in the future. On 28 February the current JFICM Board was appointed as the Interim Board of CICM. 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INTENSIVE CARE APPEAL 2009
14TH TO 27TH APRIL

You can support the Appeal by:

- Selling merchandise - this year there will be pens only with new colours (purple and orange) at $3 per item. Wristbands and key tags can be available upon request.
- Being available for media interviews – please let us know if you are interested by emailing hayley@intensivecareappeal.com
- Holding celebrations on Intensive Care Day - make sure you take photos!
- Providing patient case studies
- Letting your hospital’s PR department know about the Appeal

Remember we are your charity and we need your help in making it possible to fund ICU research into the future.

For further information or to register interest visit www.intensivecareappeal.com or e: info@intensivecareappeal.com or p: 03 9340 3444

We need your help to make this our most successful Appeal yet!

The ANZCA Bulletin
72
March 2009

ANZCA SUPPORT THE APPEAL BY SETTING YOUR HOSPITAL’S PR DEPARTMENT KNOW.

Providing patient case studies.

Commissioning a children’s unit.

Van Heerden, took the chair. The first item of business was for the current Board of JFICM to be installed as the inaugural Board of the College.

OFFICE BEARERS

The constitution of the college calls for three office bearer positions, to be elected by secret ballot each year. Nominations were called, and each position was elected unopposed. The foundation office bearers are:

President
Professor Vernon van Heerden

Vice-President
Professor John Myburgh

Treasurer
Professor Ilala Venkatesh

INFORMATION OF THE NEW BODY

Although the new college will not take over the functions of the Joint Faculty until the end of the year, it exists as a corporate entity. The constitution has been ratified by the Directors (who at this stage are the only members), the college is registered with ASIC and has an ACN (and is in the process of registering for an ABN and a tax file number).

NOTIFICATION OF REGULATORY AUTHORITIES

The Australian Medical Council have been informed of the formation of the new college and the intention to transfer the existing JFICM training program to the college at the end of the year. It is likely that the AMC will wish to undertake a full accreditation of the new college about 12 months after the changeover. The Medical Council of New Zealand and Medicare have also been informed of these developments.

Suggestion of the New College

As JFICM is legally and functionally a part of ANZCA, there is a lot of preparatory work to be done to establish the new college as an independent business. Many of the administrative tasks are underway, with work currently in train to set up the business structure (for example, open bank accounts, set up finance and IT systems, find an appropriate location, etc.). A committee consisting of the ANZCA President and Vice President, along with the JFICM Dean and Vice Dean, is meeting regularly to consider some of the more complex issues, such as transfer of employment agreements to the new college and the intellectual property ramifications of the JFICM Documents going to the new college.

FREQUENCY FELLOWSHIP

The Board of the College considered a proposal from the JFICM Censor on eligibility to become a Foundation Fellow of the new college, specifically whether there would be any opportunity for anyone who is not currently a JFICM Fellow to apply for Foundation Fellowship. This will be further debated and a decision made at the next CRM Board meeting. It is anticipated that a call for applications for Foundation Fellowship will go out in July.

FINANCIAL

The Board discussed the necessity for the new college to be fully independent financially from the start of 2010. Currently JFICM meets its own operational expenditure from revenue from Fellows subscriptions, training and exam fees. However, in order to provide a buffer in case of difficulties with cash flow and to establish an asset base for the college to consider the purchase of a building at some stage, further financial resources will be necessary. The Board considered options for raising some capital, including possibly making a call on Fellows for a subscription in advance or charging an entry fee for Foundation Fellowship.

Coat of Arms

A number of possible design features have been suggested for the coat of arms of the new college. The Australian Heraldry Society has been consulted about the most suitable design. A number of possibilities were presented to the Board, these will be further developed and presented to the Fellowship for further input, including ideas for a motto.

Governing and Risk Management

The ANZCA solicitor, Mr Michael Gorton, delivered a short seminar on the role of the Board in ensuring good corporate governance of the new college and their fiduciary and other responsibilities. The Board have begun the process of developing a risk management plan for the new college and will oversee the establishment of financial and management reporting and auditing processes.

JOINT FACULTY OF INTENSIVE CARE MEDICINE

News

The first meeting of the Board of Directors of the new College of Intensive Care Medicine took place at ANZCA House on Friday, February 27. The JFICM Dean, Professor van Heerden, took the chair. The first item of business was for the current Board of JFICM to be installed as the inaugural Board of the College.

Office Bearers

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Incorporation of the New Body

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Notification of Regulatory Authorities

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Separation from ANZCA

As JFICM is legally and functionally a part of ANZCA, there is a lot of preparatory work to be done to establish the new college as an independent business. Many of the administrative tasks are underway, with work currently in train to set up the business structure (for example, open bank accounts, set up finance and IT systems, find an appropriate location, etc.). A
The ANZCA Bulletin

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, by Nature. The fires in Victoria have been devastating and the loss of lives and homes have also created widespread heartache. Attending the College in Victoria during February, one could tell by 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 Hawai’i 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.

As part of the meeting there was a Pacific Rim dinner attended by Roger and myself, several other FPM Fellows and members of the AAPM 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 specialty of Pain Medicine in our countries. In mainland China, Pain Medicine is now recognized 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 thank each and every one of you. In particular, Roger Goucke and Milton Cohen who have decided after 10 years on the Board that they do retire to allow 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 continue 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 Balfour from Wellington, 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 aim to involve our parent colleges more. I’m hoping that Ray and Guy, with input from Carolyn Arnold (who was recent elect to the Board), can work with the RACP to raise our profile and to encourage its younger Fellows to get involved with the Board.

Leigh Atkinson has been working diligently with the Royal Australasian College of Surgeons (RACS) in mainland China, and with the RACP to raise our profile and to encourage its younger Fellows to get involved with the Board. Our specialty in Australia. We are now working on the same process for New Zealand.

Applications from many people for Fellowship either by election or through the training program. Two years ago, we added both the Royal College of General Practitioners and the Royal New Zealand College of General Practitioners to specialty groups to which our Fellows can apply to 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 enquirers from other specialty groups and our regulations state that people who have an Australian 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 Australian 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 an Australian specialist qualification, to apply for Fellowship without further training. After having viewed the information provided by the candidate, 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, whether or not they meet our requirements for Fellowship, to apply for Fellowship without further training. Applicants will be considered through the Election to Fellowship application process.
The ANZCA Bulletin

News

Continued

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 1987. The Orton Medal is the highest award in the College/Faculty honouring trainees in acute, chronic and cancer pain settings will create stimulating and learning environments for clinicians faced with complex pain cases in all settings. A preliminary program will be circulated shortly, however we encourage you to note the date in your diary.

Dr Carolyn Arnold

Convenor

Spring Meeting in Melbourne

Planes are underway for the Faculty’s 2009 Spring Meeting in Melbourne. The theme will be ‘Dueling 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: m.dziedzicki@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 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 July which would allow Fellows and trainees to meet in an informal setting and discuss FPM issues and understand the role of the committee.

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, FA F R M R A C P , Victoria

Rupert Leigh ATKINSON, FR ACS, Queensland

Penelope Anne BRISCOE, FANZCA, South Australia

Christopher HAYES, FANZCA, New South Wales

David JONES, FANZCA, New Zealand

Brendan Joseph MOORE, FANZCA, Queensland

Frank James NEW, FRANZCP, Queensland

Edward Archibald SHIPTON, FANZCA, New Zealand

Guy Michael BASHFORD, FAFRM RACP, New South Wales

Raymond GARRICK, RACP, New South Wales

Re-elected unopposed

**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.

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 Neurological 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 Australian 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

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 1.13 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

Liaisons with Colleges

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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, satisfy In-Training Assessments, examination and Case Report...
Alternative Pathway
Further to earlier advice that the Board was exploring re-establishment of the Alternative Pathway for applicants to 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 3.2 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 Ornion 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 Rogduk – 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 concern about confusing the public. It was agreed that the Faculty should be proactive and notify registration bodies in Australia and New Zealand that FPFPANZCA 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 progressed 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 MBF Foundation, will now proceed in 2010, however a date and venue have yet to be confirmed. Involvement of physicians and nurses and the Faculty National 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 Inukandji 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.

2010 Spring 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, Melbourne, and subsequently in 1941 attended the University of Melbourne. He is well-remembered by fellow medical students as an engaging, amiable, and convivial companion.

He graduated as MBBS in 1944 and forthwith elected to serve 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 secondment from the RAN to the Hospital. He continued medical studies at The Alfred Hospital, in which he maintained a deep interest until his retirement.

In 1949 he returned to Melbourne and was appointed as a demonstrator in anatomy as a senior staff specialist until his formal retirement. Russell Cole was an inveterate traveller. In 1962, he decided to change direction. He ceased private anaesthetic practice, having had a long interest in the anatomical 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 surgical anaesthetic medical assistant at the Peter MacCallum Cancer Hospital with duties that included supervision of the Consultant Pain Clinic, 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 to 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 visiting 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 eye surgery on indigenous patients in the Northern Territory, Australia.

Russell Cole’s committee activities included membership in 1966 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 see 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 of skill. Although always courteous and accommodating and easy to communicate with, he did not compromise on what was happening in other countries. He was a great traveller and intensely interested in the lives of his patients.

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In 1965, Russell Cole was appointed Director of Anaesthetics at the Royal Melbourne Hospital, succeeding to 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 visiting 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 eye surgery on indigenous patients in the Northern Territory, Australia.

Russell Cole’s committee activities included membership in 1966 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 see 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 of skill. Although always courteous and accommodating and easy to communicate with, he did not compromise on what was happening in other countries. He was a great traveller and intensely interested in the lives of his patients.

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.

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 also(Type)

Dr Russell Geoffrey Cole 1920–2008

Dr Nalin Rohitha Wijeyesekera 1943–2008

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.

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Dr Nalin (Wijey) Wijeyesekera was born in Colombo, Sri Lanka (then Ceylon) in 1943. He was the fourth son of Niconomus Wijeyesekera, a prominent paediatric surgeon and specialist. Sadly, his much loved father died when he was 11 years old. Niconomus Wijeyesekera was keen that his sons become doctors also and this paternal wish influenced the young Wijey. He studied medicine in the Faculty of Medicine, University of Ceylon (Colombo) from 1963 to 1968, graduating MB.BS. in 1969. He began his anaesthesia training in Colombo and passed the London primary FFARCS. In 1971, he passed the ECFMG and in that same year became aware that the UK was to change its immigration laws meaning that subjects of former British colonies would no longer have entry rights. Wijey wished to continue his anaesthesia training in the UK so at some personal cost immediately left Ceylon for London and obtained full registration with the GMC in 1972. The desire to further his training in the UK and the pending immigration law changes meant that his newly-formed family was separated for a while. His wife, Deepthi, was not to join him in London until 1973. His third and youngest year-old daughter, Shamila, joined them in 1975. His first anaesthetic job in the UK was at the Royal London Hospital. Wijey obtained his Final FFARCS in 1978. In 1980, following a brief stint in the USA, Wijey was appointed as a consultant anaesthetist in Wellington Hospital, New Zealand. He was awarded FFARCS in 1984 and FRCA in 1992. He carried on in anaesthesia practice in Wellington until 2008.

Wijey’s special interest was neuroanaesthesia and he formed a close partnership with prominent Wellington neurosurgeon Balakrishnan that lasted for many years. Wijey not only performed complex neurosurgery, especially surgery in sitting position, made all the surgeons feel very comfortable working with him. His reputation and techniques for neuroanaesthesia in the sitting position were widely recognised in other neurosurgical units in New Zealand.
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 residential work 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 FRACR 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 29 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. He continued on the sessional staff at the Royal Children’s Hospital for 29 years, even after he changed course in middle and went into the church.

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 1979 on the way to Canberra for the third Asian Australasian Congress in a VW beetle we had two windscreen 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 Anaesthetists 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 Jerilderee 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, Andrew, and Brian. 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

Following the normal review process by Council, the following Professional Document has recently been withdrawn:

PSh.8 – Statement on Clinical Principles for Procedural Sedation

Australian and New Zealand College of Anaesthetists
ABN 82 055 042 852

Professional documents

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

TE1 (2008) Recommendations for Hospitals Seeking College Approval for Vocational Training in Anaesthesia
TE2 (2006) Policy on Vocational Training Modules and Module Supervision (interim review)
TE4 (2005) Policy on Duties of Regional Education Officers in Anaesthesia
TE5 (2005) Policy for Supervisors of Training in Anaesthesia
TE7 (2005) Guidelines for Secretarial and Support Services to Departments of Anaesthesia
TER (2005) Guidelines for the Learning Portfolio for Trainees in Anaesthesia
TE10 (2003) Recommendations for Vocational Training Programs
TE13 (2005) Guidelines for the Provisional Fellowship Program
TE14 (2007) Policy for the In-Training Assessment of Trainees in Anaesthesia
TE16 (2005) Guidelines for Assisting Trainees with Difficulties
TE17 (2006) Policy on Examination Candidates Suffering from Illness, Accident or Disability

T1 (2008) Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations (interim review)

T3 (2008) Minimum Safety Requirements for Anaesthetic Machines for Clinical Practice
PS1 (2002) Recommendations on Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia
PS2 (2006) Statement on Credentialling and Defining the Scope of Clinical Practice in Anaesthesia
PS3 (2003) Guidelines for the Management of Major Regional Analgesia
PS7 (2008) Recommendations on the Pre-Anaesthesia Consultation
PS8 (2008) Guidelines on the Assistant for the Anaesthetist
PS9 (2008) Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical or Surgical Procedures
Australian and New Zealand College of Anaesthetists
and
Joint Faculty of Intensive Care Medicine

Professional documents

IC-2 (2005)  Intensive Care Specialist Practice in Hospitals
IC-6 (2009)  Secretarial Services to Intensive Care Units
IC-7 (2006)  Quality Assurance
IC-8 (2006)  Statement on the Ethical Practice of Intensive Care Medicine

February 2009

Australian and New Zealand College of Anaesthetists
and
Faculty of Pain Medicine

Professional documents

PM2 (2005)  Guidelines for Units Offering Training in Multidisciplinary Pain Medicine
PM3 (2002)  Lumbar Epidural Administration of Corticosteroids
PM4 (2005)  Guidelines for Patient Assessment and Implantation of Intrathecal Catheters, Ports and Pumps for Intrathecal Therapy
PM6 (2007)  Guidelines for Longterm Intrathecal Infusions (Analgesics/Adjuvants/Antispasmodics)
PM8 (2004)  Statement relating to the Relief of Pain and Suffering and End of Life Decisions
PM10 (2003)  Guidelines for the Management of Major Regional Anaesthesia

February 2009
Future Meetings
Australia & New Zealand
2009

29 April
Melbourne VIC
Continuing Medical Education Meeting
Theme: Hot Air – Full Steam Ahead!
Venue: ANZCA House, Melbourne, VIC
Contact: Daphne Erler – VRC Coordinator
Tel: +61 3 9510 6299
Fax: +61 3 9510 6786
Email: vrc@anzca.edu.au

29 April–1 May
Port Douglas QLD
New Fellows' Conference 2009
Theme: Keeping Doctors Well
Venue: Thala Beach Resort, Port Douglas QLD
Contact: Kate Briggs – ASM Coordinator ANZCA
Tel: +61 3 9510 6299
Fax: +61 3 9510 6786
Email: kbriggs@anzca.edu.au

1 May
Cairns QLD
FFP Refresher Course Day and Faculty Dinner
Theme: Unravelling the Chaos of Pain
Venue: Cairns Convention Centre
Contact: Faculty of Pain Medicine Office
Tel: +61 3 8517 5337
Email: painmed@anzca.edu.au

2–6 May
Cairns QLD
2009 ANZCA Annual Scientific Meeting
Theme: Branching Out
Venue: Cairns Convention Centre
Contact: ANZCA ASM Secretariat, ICMS Australasia, GPO Box 3270, Sydney NSW
Tel: +61 2 9254 3900
Fax: +61 2 9251 3552
Email: natalia@icmsaustralasia.com.au

12–14 June
Brisbane QLD
2009 FPM ASM
Theme: Energy Crises Large and Small
Venue: Brisbane Convention and Exhibition Centre
Contact: Kate Briggs, ASM Coordinator ANZCA
Tel: +61 3 9510 6299
Fax: +61 3 9510 6786
Email: kbriggs@anzca.edu.au

13 June
Perth WA
WA Winter Scientific Meeting
Theme: Perth Convention and Entertainment Centre
Contact: Sandra Box, WA Regional Coordinator, ANZCA
Tel: +61 6 9386 2077
Fax: +61 6 9386 2066
Email: sbx@anzca.edu.au

3–7 June
Brisbane QLD
8th International Congress on Ambulatory Surgery
Theme: The Destiny of Day Surgery
Venue: Brisbane Convention & Exhibition Centre
Contact: Conferences & Events Management, Royal Australasian College of Surgeons, College of Surgeons' Gardens, Spring Street, Melbourne VIC 3000
Tel: +61 3 9349 1373
Fax: +61 3 9376 7031
Email: iac@surgeons.org
Website: www.ianzcongress2009.org

22 August
Brisbane QLD
31st Annual ANZCA/ASA Combined CME Committee of Queensland Meeting
Venue: Queensland Turf Club
Theme: The Duffers – Occasional Forays into Anaesthesia for Obstetrics, Paediatrics and Trauma
Contact: Linda Cuffe, QFRC Event Coordinator, ANZCA
Tel: +61 7 3846 1233
Fax: +61 7 3844 0249
Email: qfedevents@anzca.edu.au

5–8 September
Darwin NT
26th National Scientific Congress of the Australian Society of Anaesthetists
Venue: Darwin Convention Centre
Contact: SAPMEA Meetings Management
Tel: +61 8 8924 6008
Fax: +61 8 8924 6000
Email: asa2009@iapmea.anx.au
Website: www.asa2009.com

9–11 October
Brisbane QLD
NSW Anaesthetic Continuing Education Meeting
Venue: Hilton Sydney Hotel
Contact: Anna Kouprianova, NSW Regional Events Co-ordinator
117 Alexander Street, Crosses Nest NSW 2065
Tel: +61 2 9666 9085
Fax: +61 2 9666 9087
Email: nswevents@anzca.edu.au

25 October
Melbourne VIC
50th Annual ASA/ANZCA Combined CME Meeting
Theme: Anaesthesia Right Now! – A Clinical Update
Venue: Sofitel Melbourne, VIC
Contact: Daphne Erler – VRC Coordinator
Tel: +61 3 9510 6299
Fax: +61 3 9510 6786
Email: vrc@anzca.edu.au

4–7 October
Noosa QLD
10th Biennial Conference of The Cardiothoracic, Vascular And Perfusion Special Interest Group
Venue: Sheraton Noosa, QLD
Contact: Kate Briggs, SIGs Co-ordinator ANZCA
Tel: +61 3 9510 6299
Email: kbriggs@anzca.edu.au

4–7 November
Rotorua NZ
New Zealand Anaesthesia ASM 2009
Theme: How meets Why – Clinical Practice and the Science Behind it
Venue: Christchurch, New Zealand
Contact: Ms Rachel Cook, Conference Innovators, PO Box 13994, 96 Gloucester Street, Christchurch 8011
Tel: +61 3 379 0490
Fax: +61 3 379 0480
Email: rachel@conference.co.nz

7–9 November
Darwin NT
2010 ANZCA ASM
Theme: How to measure – Clinical Practice and the Science Behind it
Venue: Darwin, Northern Territory
Contact: Ms Rachel Cook, Conference Innovators, PO Box 13994, 96 Gloucester Street, Christchurch 8011
Tel: +61 3 379 0490
Fax: +61 3 379 0480
Email: rachel@conference.co.nz

14–15 November
Wollongong VIC
NSW Anaesthetic Continuing Education Meeting
Venue: Novotel Northbeach, Wollongong
Contact: Anna Kouprianova, NSW Events Co-ordinator, ANZCA
117 Alexander Street, Crosses Nest NSW 2065
Tel: +61 2 9666 9085
Fax: +61 2 9666 9087
Email: akouprianova@anzca.edu.au

20 November
Brisbane QLD
Australasian Symposium on Ultrasound And Regional Anaesthesia (ASURA) 2009
Venue: Mater Mothers’ Hospital, Brisbane, QLD
Contact: Cassandra Hargreaves, ASA Events Manager
Tel: +61 415 937 525
Email: chargreaves@feds.asa.org.au
Website: http://www.asura2009.org.au

30 October–1 November
Canberra ACT
SPANZA National Meeting 2009
Theme: Ventilation of Neonates/Prems in the Operating Theatre/Update on Pain Management/Ethical Matters in Paediatric Anaesthesia
Venue: Hyatt Hotel Canberra
Contact: Stephen Brazenor, Regional Chair
Email: sbrazenor@dodo.com.au

2010

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2010

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## Future Meetings
### Overseas 2009

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Event Name</th>
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<tbody>
<tr>
<td><strong>15–17 May</strong></td>
<td><strong>California, USA</strong></td>
<td>California Society of Anesthesiologists 2009 Annual Meeting</td>
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<td></td>
<td><strong>Venue:</strong> Hyatt Regency Monterey</td>
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<td></td>
<td></td>
<td><strong>Contact:</strong> Conference Secretariat</td>
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<td><strong>20–22 May</strong></td>
<td><strong>Jersey, UK</strong></td>
<td>Obstetric Anaesthesia 2009</td>
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<td><strong>Venue:</strong> Jersey, UK</td>
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<td><strong>Contact:</strong> Obstetric Anaesthetists’ Association</td>
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<td><strong>PO Box 3219, Barnes, London SW13 9XR, UK</strong></td>
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<td><strong>Website:</strong> <a href="http://www.oaa-anaes.ac.uk">www.oaa-anaes.ac.uk</a></td>
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<td><strong>7–11 June</strong></td>
<td><strong>Acapulco, Mexico</strong></td>
<td>8th International Symposium on Pediatric Pain (ISPP09)</td>
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<td><strong>Theme:</strong> Sharing Knowledge with All Cultures</td>
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<td><strong>Venue:</strong> Acapulco, Mexico</td>
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<td><strong>6 September</strong></td>
<td><strong>Milan, Italy</strong></td>
<td>Euroanaesthesia 2009</td>
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<td><strong>Venue:</strong> Milan, Italy</td>
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<td><strong>12–17 September</strong></td>
<td><strong>Kenya, Africa</strong></td>
<td>4th AAAC Kenya 2009</td>
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<td></td>
<td><strong>Theme:</strong> Anaesthesia, Intensive Care and Pain Management in Africa – Present and Future</td>
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<td><strong>Venue:</strong> Kenya, Africa – The Kenyatta International Conference Center – Congress Venue</td>
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<td><strong>Contact:</strong> Dr P Okutoyi – Executive Treasurer</td>
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<tr>
<td><strong>21–24 September</strong></td>
<td><strong>Lisbon, Portugal</strong></td>
<td>21st Annual Congress European Society Of Intensive Care Medicine</td>
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<td><strong>Venue:</strong> Lisbon, Portugal</td>
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<td><strong>Contact:</strong> Estelle Flament</td>
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<td><strong>16 October</strong></td>
<td><strong>Illinois, USA</strong></td>
<td>American Society of Critical Care Anesthesiologists 22nd Annual Meeting</td>
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<td><strong>Venue:</strong> ASCCA, 520 N. Northwest Hwy, Park Ridge, IL 60068-2573, USA</td>
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<td><strong>Contact:</strong> ASCCA</td>
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<td><strong>17–21 October</strong></td>
<td><strong>New Orleans, USA</strong></td>
<td>2009 American Society of Anesthesiologists Annual Meeting</td>
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<td><strong>Venue:</strong> New Orleans, USA</td>
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<td><strong>Contact:</strong> IASA, 520 N. Northwest Highway, Park Ridge IL 60068-2573, USA</td>
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<tr>
<td><strong>26–30 October</strong></td>
<td><strong>Hawaii, USA</strong></td>
<td>California Society Of Anesthesiologists Fall Hawaiian Seminar 2009</td>
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<td><strong>Venue:</strong> Kauai, Hawaii</td>
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<td><strong>Contact:</strong> Rosie Alegria</td>
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2nd International Symposium on Extracorporeal Support in Critical Care

Park Hyatt Hotel
Melbourne, Australia
24th-25th July 2009

Themes:
- Mechanical Circulatory Support
- ECMO
- Advanced Mechanical Ventilation
- Problems and Barriers to Extracorporeal Support
- Anticoagulation management

Keynote Speakers

Dr. Robert Bartlett
UMMC, USA

Dr. Bart Meyns
Leuven, Belgium

For further information contact;
Janine Dyer (J.Dyer@alfred.org.au)
Alfred Intensive Care
L3 East Block,
Commercial Rd,
Melbourne Vic, 3004

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FAX:+613 9076 3780
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The Cairns ASM shows you the way to create a myriad of opportunities while advancing your career

The Organising Committee invites you to submit an expression of interest for the 2009 Annual Scientific Meeting of the Australian and New Zealand College of Anaesthetists and its Faculties of Intensive Care Medicine and Pain Medicine. Register your interest at www.anzca2009.asm.com

ASM 2009 Invited Speakers:
- Dr Andrew Lumb, St James’s University Hospital, Leeds, UK
- Dr Andrew Rice, Chelsea and Westminster Hospital, London, UK
- A/Prof Matthew Chan, Prince of Wales Hospital, Hong Kong
- Prof Dan Raemer, Boston Center for Medical Simulation, Massachusetts, USA
- Prof Joe Brimacombe, Cairns Base Hospital, Cairns, Australia

Put the Cairns 2009 ASM into your diary now