

bulletin



AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS
JOINT FACULTY OF INTENSIVE CARE MEDICINE FACULTY OF PAIN MEDICINE

VOL 14 NO 1

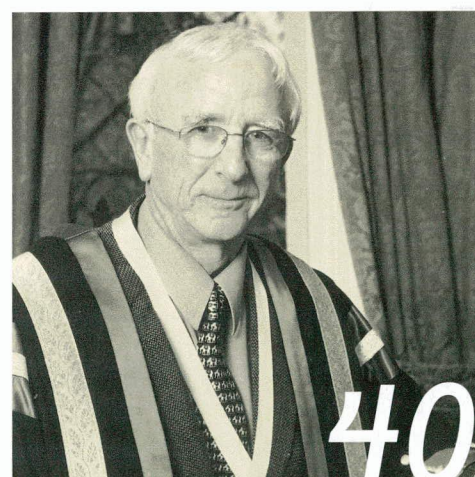
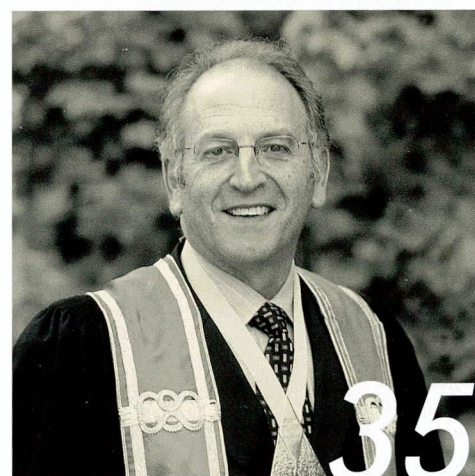
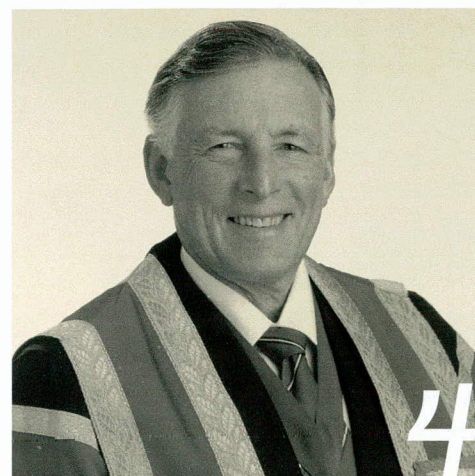
MARCH
05

- ***ANZCA Taskforces***
- ***JFICM ASM 2005, Sydney
Neurointensive Care: The Road Ahead***
- ***FPM Trainee Awarded NICS Fellowship***



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Editorial

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

Committee

- Mrs Joan Sheales, Editor
- Professor Michael Cousins
- Associate Professor Kate Leslie
- Dr Mike Martyn
- Professor Garry Phillips
- Mr Eddie Dean

The Bulletin

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

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President's Message

Fellows Contributions to the ANZCA Foundation

As I mentioned in my last President's Message, good news stories from the success of our Fellows in research and development is currently the best way to promote the image of our specialty. This is why the ANZCA Foundation is so important to all Fellows, not just those involved in research.

The initial response of Fellows to the call for donations to the Foundation has been good, however there are many who have not yet responded at all. On page 6, you will see the donations "thermometer" and it is not hard to see that we are not yet at "body temperature"!

So once again, I ask all Fellows to remember that supporting the ANZCA Foundation will play a major role in helping to promote the image of our specialty.

"...supporting the ANZCA Foundation will play a major role in helping to promote the image of our specialty."

Ongoing Challenges to ANZCA

This continues to be an extremely challenging time for all Medical Colleges, including ANZCA. In addition to the need to comply much more closely with the Corporations Act via the Australian Securities and Investment Commission (ASIC) and the Australian Competition and Consumer Commission (ACCC), ANZCA has also recently been heavily involved with ongoing discussions with the Federal Government concerning the Overseas Trained Specialists/Area of Need Program and with the Australian Medical Council (AMC) regarding training, examinations and specialist recognition.

There is an increasing interest of State Governments and the Federal Government in

our training programs, with a desire to have a much greater involvement. This will require very careful management in order to preserve equality and independence. Most recently the Council of Australian Government (COAG) has commissioned the Productivity Commission to undertake a study of health professional workforce issues, including training and education. This is a very wide ranging study which has already commenced with the pharmaceutical area.

ANZCA has responded in an effective manner to these bodies except COAG and has received positive feedback. Fellows will appreciate that this has entailed an order of magnitude increase in work for the College and also places the College under much greater scrutiny than ever before. This is one reason why ANZCA needs the participation of a much larger number of Fellows and needs to strengthen and streamline the governance of the College.

Finally, Council is currently examining the need for a completely new strategy for our interface with Government and the general public. It is quite clear now that we will need to take a proactive and continuous approach to this area, including our image.

Major Changes to ANZCA Governance

On the 10th February 2005, ANZCA Council and key administrative staff were involved in a Strategic Planning Day, facilitated by former Chairman of ASIC, Mr Henry Bosch AO.

Some major changes to ANZCA governance were developed during this day and then passed by ANZCA Council on 11th February:

1. A major reduction in the size of the Executive to comprise the President, Vice President, Director of Professional Affairs and CEO.
2. A reduction in the decision making role of the Executive, to that of conducting essential business between Council Meetings.
3. An increase in the number of Council Meetings per annum to at least six per year. This will enable Council to take on increased responsibilities, previously vested in the Executive, and to have adequate time to meet all of the requirements of a company Board that were previously difficult to address because of the demands of ANZCA specific business. Such activities include: regular review of a Strategic Plan; review of Performance Indicators and Performance Arrangements; review of College Risk Management process; review of Organisation Structure; review of Accounting Policies; other ongoing review of Council Governance.
4. Approval of a Council Charter which provides a detailed description of the Role and Responsibilities of Council, delegations, composition of the Council and guidelines for meetings of Council.
5. A Council Protocol which gives a detailed statement of what is expected of individual Councillors, acting as directors of a Board. All Councillors will be required to sign this Protocol prior to taking Office. There are a number of appendices to the Protocol which include: Induction of New Council Members; Councillor Selection Criteria; a Council Handbook; Councillors' Benefits; President's Responsibilities and Authorities; Role and Responsibilities of the College Council Secretary.
6. The Executive Committee Charter which clearly defines the revised role of the Executive.
7. Finance, Audit and Risk Management Committee Charter.
8. Role and Responsibilities of the CEO.
9. Role and Responsibilities of the DPA.



"I am delighted by the depth and strength of the ninety individuals who have agreed to participate in this important work..."

All of these new governance measures were unanimously passed by Council and it is the view of Council that they represent a major step forward in the operations of our College.

The new arrangements for Council will come into action from June 2005 onwards.

The second Strategic Planning Day was held on 17th March 2005 and dealt with details of implementation of changes in governance, particularly the need to strengthen administrative resources around major areas of College activity and strengthen reporting mechanisms to Council.

On the 2nd June 2005, Mr Bosch will facilitate a Training Day for Councillors on "Responsibilities of Board Directors". This will allow the inclusion of any newly elected Councillor and will be an ongoing process for all subsequent Councillors.

ANZCA Taskforces

The members of all nine ANZCA Taskforces have now been appointed and the initial meeting of all Taskforces by teleconference has already occurred. At these meetings, individual Taskforce members outlined their areas of expertise in order for the Taskforce to become aware of the range of expertise available to it. Also key resource documents were identified and circulated to all Taskforce members. Terms of Reference were refined and nominations for the Chairperson were provided to me from whom I selected a Chair (See Taskforces on pages 8-10).

eCommunity websites have been set up for all Taskforces and all members of the Taskforces will have access to all of the information on the nine Taskforce websites in order to facilitate cross-fertilisation of information.

Face-to-face meetings of the individual Taskforces are now being arranged.

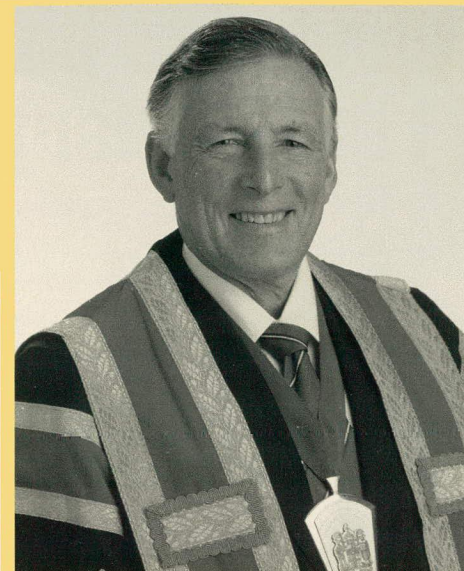
The Taskforces have been given a timeline of reporting by Monday 19th September 2005 so that Recommendations can be considered by the October 2005 Council.

I am delighted by the depth and strength of the ninety individuals who have agreed to participate in this important work, which will have major implications for the future of ANZCA. It has been extremely encouraging to learn of the willingness of such accomplished individuals to contribute at a time when all medical Colleges desperately need to harness more resources to meet the challenges that they face. I have tried very hard to identify young Fellows and individuals who have not previously contributed to the work of ANZCA and this is certainly reflected in the Taskforce composition.

Honours for ANZCA Fellows

I would particularly like to express my pleasure at the award of the following Honours to ANZCA Fellows:

- Professor Garry D Phillips, Director of Professional Affairs – Member of the Order of Australia (AM)
- Dr Jack H Havill, Dean of Joint Faculty of Intensive Care Medicine – Officer of the New Zealand Order of Merit (ONZM)
- Associate Professor Victor I Callanan, Member of ANZCA Taskforce on Perioperative Medicine – Member of the Order of Australia (AM)
- Dr George M Boffa – Medal in the Order of Australia (OAM)



It is good to see recognition of these senior Fellows of our College who have made such major and sustained contributions, far above the call of duty.

Michael J Cousins
President



ANZCA Taskforces

Integrated Approach to Quality And Safety

Membership

Dr. Patricia Mackay, FANZCA, <i>Chair</i>	VIC
Dr. Christine Jorm, FANZCA, <i>Deputy Chair</i>	NSW
Dr. Michael Bujor, FANZCA	VIC
Dr. Martin Culwick, FANZCA	QLD
Dr. Genevieve Goulding, FANZCA	QLD
Dr. John Morris, FANZCA	VIC
Professor William Runciman, FANZCA, FJFICM	SA
Dr. Leonie Watterson, FANZCA	NSW
Assoc. Prof. Jenny Weller, FANZCA	NZ
Dr. Su-Jen Yap, FANZCA	NSW

Terms of Reference

1. To determine what strategies/methodologies including those for implementation, are needed by our *speciality* over the next 5-10 years: to foster excellence; to permit a comprehensive integrated, intramural and extramural approach to quality and safety; to include a patient focus and public/government interface with ANZCA.
2. To take a very broad approach to *evaluation* of quality and safety measures, prior to identifying targeted approaches of relevance to ANZCA.
3. To examine the role that ANZCA could play in fostering or directly managing quality and safety strategies/methodologies: e.g. development of EBM clinical practice guidelines; e.g. other methods/tools which can be extended across healthcare and other spheres of activity.
4. The Task Force to provide specific recommendations, including a strategic plan, for consideration of action by ANZCA Council within 6 months of commencing work

Name of the Specialty

Membership

Professor Guy Ludbrook, FANZCA, <i>Chair</i>	SA
Dr. Jim Bradley, FANZCA, FFPMANZCA	QLD
Dr. Mark Bukofzer, FANZCA	NZ
Dr. Jeremy Foate, FANZCA	NZ
Dr. Patrick Hughes, FANZCA	VIC
Dr. Kok Khor, FANZCA, FFPMANZCA	NSW
Dr. Michelle. Mulligan, FANZCA	ACT
Dr. Elizabeth Pemberton, FANZCA	VIC
Prof. Stephan Schug, FANZCA, FFPMANZCA	WA
Dr. Peter Van Heerden, FANZCA, FJFICM	WA

Terms of Reference

1. To examine the current and likely future scope of professional activities of Anaesthetists, including: anaesthesia; resuscitation; perioperative medicine; pain medicine; palliative medicine; intensive care medicine; hyperbaric medicine; emergency medical retrieval; military medicine; research and innovation; education.
2. To evaluate the appropriateness of the current name ANZCA "College of Anaesthetists" in view of (1) and public perceptions of the specialty.
3. To examine approaches being taken to (1) and (2) by similar organisations to ANZCA in Europe, the USA and elsewhere, as well as nomenclature used in leading scientific journals and major clinical departments internationally.
4. The Task Force to provide specific recommendations for consideration of action by ANZCA Council, within 6 months of commencing work.

Non Medical Members of the Anaesthesia Care Team

Membership

Dr. Philip Ragg, FANZCA, <i>Chair</i>	VIC
Dr. Suzanne Bertrand, FANZCA	WA
Dr. Mark Bukofzer, FANZCA	NZ
Dr. Peter Cooke, FANZCA	NZ
Dr. Robyn Gillies, FANZCA	VIC
Dr. Emma Halliday, FANZCA	NSW
Assoc. Prof. Greg Knoblanche, FANZCA	NSW
Dr. Vaughan Laurenson, FANZCA	NZ
Dr. John Monagle, FANZCA	VIC
Dr. Fariborz Moradi, FANZCA	ACT

Terms of Reference

1. To review the current status of demand versus supply of specialist anaesthetist manpower in Australia and New Zealand and likely changes over the next 5-10 years.
2. In the light of (1), to examine the strengths and weaknesses of various models of non-medical members of the anaesthesia care team, in order to safely and effectively meet the demand for anaesthesia care over the next 5-15 years.
3. In examining different models of the anaesthesia care team, evaluate needs for education, training, certification and administration as well as the most appropriate role for ANZCA.
4. The Task Force to provide specific recommendations for consideration of action by ANZCA Council, within 6 months of commencing work.



Data

Membership

Dr. Michele Joseph, FANZCA, <i>Chair</i>	VIC
Dr. Bernard Creati, FANZCA	VIC
Dr. Brendan Flanagan, FANZCA	VIC
Dr. Michal Kluger, FANZCA	NZ
Professor Alan Merry, FANZCA, FFPANZCA	NZ
Dr. Richard Morris, FANZCA	NSW
Dr. John Williamson, FANZCA	SA

Terms of Reference

1. To determine what type/scope of data our specialty requires over the next 5-10 years, to evaluate outcome in order to develop interventional/ corrective strategies.
2. What methodological options would be required to achieve aim (1). A Broad system approach should be considered, with optimal input from other industries.
3. What hardware/software/liveware systems would be required to support the methodology and what support personnel at ANZCA and at the periphery are needed
4. The Core Group to provide specific recommendations for action to ASA / ANZCA / NZSA within 6 months of commencing work by the Core Group

Perioperative Medicine

Membership

Dr. Su-Jen Yap, FANZCA, <i>Chair</i>	NSW
Dr. Ross Kerridge, FANZCA, <i>Deputy Chair</i>	NSW
Dr. Vanessa Beavis, FANZCA	NZ
Assoc. Prof. Vic Callanan, AM FANZCA, FJFICM,	QLD
Dr. Mark Colson, FANZCA	VIC
Dr. Richard Horton, FANZCA	VIC
Dr. Ross Macpherson, FANZCA	NSW
Dr. William Shearer, FANZCA	VIC
Dr. Roger Traill, FANZCA	NSW
Dr. Daryl Williams, FANZCA	VIC

Terms of Reference

1. To examine the current and future development of Perioperative Medicine and the likely role of anaesthetists over the next 5-10 years including: pre and post-operative management; acute pain management; intensive care.
2. In the light of (1), evaluate approaches being taken, by professional anaesthesia bodies and hospital departments internationally, to perioperative medicine, including nomenclature.
3. To consider implications of (1) and (2) for ANZCA including research, education, training, assessment, resource allocation and inter-relationship with other health care professionals and possible inclusion of perioperative medicine or other terminology in the name of the specialty.
4. The Task Force to provide specific recommendations for consideration of action by ANZCA Council, within 6 months of commencing work.

Private Practitioner Involvement in ANZCA

Membership

Dr. Michelle Mulligan, FANZCA, <i>Chair</i>	ACT
Dr. Antonio Grossi, FANZCA	VIC
Dr. Richard Grutzner, FANZCA	VIC
Dr. Anton Loewenthal, FANZCA	QLD
Dr. Paul Rodoreda, FANZCA	WA
Dr. Steve Schumacher, FANZCA	NSW
Dr. Rodney Taylor, FANZCA	VIC
Dr. Richard Waldron, FANZCA	TAS
Dr. Ruth Wall, FANZCA	NZ

Terms of Reference

1. To evaluate current status of involvement, of private practice based specialist anaesthetists in ANZCA with regard to education, training, examinations and other ANZCA activities and committees, as well as Regional Committees and Council. To suggest strategies to increase involvement and profile.
2. To determine the level of satisfaction or otherwise of private practitioners with the range of professional support that ANZCA provides to Fellows, e.g. education, research, MOPS, professional documents, public perception etc.
3. To examine the current and likely future response of private practitioners to Government plans to expand specialist training into the private sector including: attitudes and possible changes in practice of specialists; hospital responses; resources; costs of trainee salaries; medical indemnity; training programs for new Supervisors of Training; trainee and public expectations.
4. The Task Force to provide specific recommendations for consideration of action by ANZCA Council, within 6 months of commencing work.



Professionalism

Membership

Dr. Terry Little FANZCA, FFPMANZCA, <i>Chair</i>	VIC
Dr. Ian Banks, FANZCA	SA
Dr. Winifred Burnett, FANZCA	VIC
Dr. Jennifer Carden, FANZCA	VIC
Dr. Ross Freebairn, FANZCA, FJFICM	NZ
Professor John Gibbs, FANZCA	QLD
Dr. Dennis Hayward, FANZCA	WA
Dr. Steven Katz, FANZCA	NSW
Dr. Tom Watson, FANZCA	NZ
Dr. Leonie Watterson, FANZCA	NSW

Terms of Reference

1. To develop a Code of Professional Conduct for ANZCA Fellows and Trainees and examine existing Codes for other specialities in Australia/New Zealand and overseas
2. To examine the current status of Professionalism among ANZCA Fellows and Trainees with respect to: standards of patient care; professional standards; professional relationships with ANZCA, colleagues, patients and the community, and medical industry. Recommend strategies for improvement
3. To identify any current activities that are unprofessional, or perceived in the public arena as unprofessional, or bordering on unprofessional, and recommend measures to address such activities
4. The Task Force to provide specific recommendations for consideration of action by ANZCA Council, within 6 months of commencing work.

Relationship of Regional/National Committees to ANZCA

Membership

Dr. Matthew Crawford, FANZCA, FJFICM, FFPMANZCA, <i>Chair</i>	NSW
Dr. Michael Jones, FANZCA, <i>Deputy Chair</i>	NSW
Dr. Peter Cooke, FANZCA	NZ
Dr. Margie Cowling, FANZCA	SA
Dr. Simon Maclaurin, FANZCA	WA
Dr. Peter McCall, FANZCA	VIC
Dr. Frank Moloney, FANZCA	NSW
Dr. Clifford Peady, FANZCA	NSW
Dr. Brian Spain, FANZCA	NT
To be appointed	QLD

Terms of Reference

1. To review the current strengths and weaknesses of relationships of Regional/National Committees to ANZCA Council. To suggest strategies to strengthen relationships.
2. To consult with ANZCA Fellows in each region to determine their satisfaction or otherwise with communication to and from ANZCA; after identifying key issues, to assist ANZCA Council in developing an appropriate survey of Fellows. To suggest strategies to improve relationships.
3. To examine different models of interaction of Regional/National Committees with ANZCA Council that could increase the effectiveness of ANZCA's whole range of educational, training, examining, professional and other activities in Australia and New Zealand.
4. The Task Force to provide specific recommendations for consideration of action by ANZCA Council, within 6 months of commencing work.

Younger Fellows and ANZCA

Membership

Dr. Andrew Patrick, FANZCA, <i>Chair</i>	VIC
Dr. Michael Fanshawe, FANZCA	QLD
Dr. Andrew Gardner, FANZCA	WA
Dr. Colin King, FANZCA	NZ
Dr. Carmel McInerney, FANZCA	ACT
Dr. Annabel Orr (Trainee Representative)	VIC
Dr. Michael Rose, FANZCA	NSW
Dr. Jamie Smart, FANZCA	VIC
Dr. Geoffrey Tweeddale, FANZCA	NSW
Dr. Michael Veltman, FANZCA	WA
Dr. Kathryn Wearne, FANZCA	TAS

Terms of Reference

1. To evaluate the current status of involvement, of Younger Fellows in ANZCA with respect to: education, training, examinations and other ANZCA activities and committees. To suggest strategies for improvement.
2. To determine the level of satisfaction or otherwise, of Younger Fellows with professional support that ANZCA currently provides, e.g. education, research, MOPS, professional standards/documents, public perceptions etc.
3. To obtain Younger Fellows views on the key challenges that face ANZCA over the next 5-10 years and the ways in which Younger Fellows wish to be involved in such challenges – particularly with respect to ANZCA.
4. The Task Force to provide specific recommendations for consideration of action by ANZCA Council, within 6 months of commencing work.



Law Report

Area of Need - Quality or Quantity



Michael Gorton
AM LLB, BComm FRACS (Hon)
FANZCA (Hon)
College Honorary Solicitor
Partner - Russell Kennedy
Solicitors

As part of the response to the perceived shortage of general practitioners and medical specialists, the Australian Government and its agencies have developed programs to fast track the admission of overseas trained doctors into Australia in Areas of Need - particularly rural and regional Australia.

In itself, such a program would assist in workforce balance and ensuring an adequate supply of practitioners across the country, to fill perceived workforce gaps and to provide diversity in the profession.

In addition, government should also be providing additional resources for the training of medical graduates and ensuring that future workforce requirements are met locally.

However, recent speculation and concern suggest that Medical Colleges, and even Medical Boards, are under increasing pressure to maintain the

unsuitable, inexperienced or underqualified practitioners. Assessors should not be tempted to lower standards simply because practitioners may be sent to Areas of Need or smaller rural communities. Standards are standards, whether rural or metropolitan. Approved practitioners will certainly end up in metropolitan areas in any event. Indeed, in most cases one would expect that practice in rural communities may require higher standards and present greater difficulties than some of the more well resourced and well supervised metropolitan positions.

The Medical Boards also have a role to play in ensuring registration only of appropriately qualified candidates. Assessment of experience, skills, training and education must be accompanied by English language competence.

There must also be, as part of the process, a program to ensure that candidates become familiar with the processes and systems for the

to achieve fellowship of the Medical Colleges, once assessed as meeting Australian standards. No doubt the ACCC, as well as other government agencies, will ask for an explanation as to the difference between an overseas trained doctor assessed as "competent" but who does not meet the Australian requirements for Fellowship. Is there a difference? How is the difference assessed? If a specialist is assessed as competent to practice in Australia, how can they be denied Fellowship of the appropriate Specialist College?

In a system of this nature it will also be important to ensure that there is some continuing supervision or follow up to ensure that the original assessment (if positive) was correct. Overseas trained doctors admitted to Areas of Need will require greater supervision, support and mentoring in order to properly establish themselves within the Australian medical system. There will still be parts of the Australian medical system with which they are not familiar and where they will need guidance. It is not clear that the current program for admission of overseas trained doctors adequately addresses these issues. Clearly Government resources are necessary.

It is clear that the Medical Boards are alert to these issues. Andrew Dix, the Registrar of the NSW Medical Board has noted:

"Recent press coverage suggested standards are being compromised by the pressure to register overseas trained doctors to meet workforce shortages. There is no doubt that this pressure exists, but steps being taken by all Medical Boards to develop uniformity of process and standards means the proper balance can be struck, and that communities can get the medical services they require without compromising the quality of those services".

"Recent press coverage suggested standards are being compromised by the pressure to register overseas trained doctors to meet workforce shortages."

flow of numbers of overseas trained doctors to meet Area of Need requirements. The concern is that quantity may be pursued at the expense of quality.

A key role of the Medical Colleges is to ensure that standards are met by all professionals. The Colleges establish the standards for training and education, as well as the standards for practice, ethics and continuing professional development. It is therefore important that any involvement by the Medical Colleges in the Area of Need program recognise the primacy of standards and quality, and that processes do not compromise quality at the expense of quantity.

Indeed, Medical Colleges expose themselves to a risk of liability if they approve or endorse

practice of medicine in general practice in Australia and in Australian hospitals.

There is and will continue to be enormous political pressure to admit more overseas trained doctors to deal with immediate shortages. Already Medical Colleges have been asked by the Australian Medical Council to "fast track" candidates with recognised overseas qualifications.

Such fast track recognition should not automatically override the continuing need to assess a candidate on an individual basis to ensure appropriate competence.

Medical Colleges should also be aware of the inevitable pressure to allow specialist candidates



Obituary

Professor Tan Sri G. B. Ong, OBE, DSc, MS, MD, FRCS, FACS, FRACS.

The death of Professor G. B. Ong on 10th January, 2004 following a long illness will be noted with deep regret by Fellows of the College who knew him during the early involvement of the Faculty of Anaesthetists (and later the College of Anaesthetists) in the development of anaesthesia in Hong Kong.

He had an international reputation as a master surgeon, displaying meticulous technique, great dexterity and unusual speed and precision. The volume of his work was equally impressive.

Professor Ong was a graduate of the Faculty of Medicine, The University of Hong Kong, and the first graduate of that University to be appointed to a Medical Chair in the University. It is noteworthy that when he was a house officer to Dr John Gray, acting head and Professor in the Department of Surgery, one of his patients presented for lobectomy. When tracheal intubation proved impossible, the operation was done under "high unilateral spinal block." The resulting autonomic paralysis led to profound hypotension, and G. B. Ong spent the next 24 hours resuscitating the patient. In the absence of today's greater understanding and advanced monitoring equipment this was a remarkable achievement, and he could have been identified as Hong Kong's first contributor to the specialty of Critical Care. An intriguing anecdote about Professor Ong's surgical skill relates to a visit by Sir Robert Macintosh from Oxford. Sir Robert, the first Professor of Anaesthetics in the UK and doyen of anaesthetists, was to demonstrate the use of equipment devised under his direction: the Mitchell needle, the EMO inhaler and the Oxford bellows, but expressed a wish to see Professor Ong operating. The procedure was a thoracotomy for division of a patent ductus arteriosus on a 7 year old girl. As the operation had not started, Sir Robert went to the anaesthetic room nearby to prepare his equipment for the demonstration. On returning about 12 minutes later Professor Ong was attending to the skin incision. "Good," said Sir Robert, "I see you are just starting." "So sorry," said G. B., "we are just closing the skin!"

In 1968 the Australasian Faculty of Anaesthetists became involved in providing examinations – and later standards of training – in the South East Asian region. At Dr Lefty Lett's request examiners visited Hong Kong (as well as Singapore and Malaysia which initiated the proposal,) and Professor Ong was appointed examiner in Anatomy. His attainments in anatomy were no less than those in surgery. He also provided facilities in his department at Queen Mary Hospital for the conduct of the examinations, and also for the later pre-examination courses of lectures. Although anatomy was subsequently deleted from the Primary Examination, he continued to lend his considerable authority to the efforts of the anaesthetists to upgrade the standards and facilities for anaesthesia in Hong Kong, with Dr Lett's equally effective and vigorous contributions.

Professor Ong also contributed most generously to the hospitality extended to the visiting examiners, ensuring that their visit was as enjoyable as it was influential in advancing the cause of the specialty. In discussions with Maurice Sando (Chairman of the Primary Examination) and Noel Cass (then Dean of the Faculty) he was keen to promote a South East Asian College of Anaesthesia, but logistical problems proved insurmountable in achieving this goal.

Dr Lett's remarkable contributions to Professor Ong's surgical work and to the specialty were continually emphasised by Professor Ong. Their working relationship is perhaps epitomised by Ong's comment that "Dr Lett is the politest man in the world!" There must have been times when circumstances in the operating theatre produced great strain, and Ong was not always an easy taskmaster. Certainly Lett must have acted to smooth the waters, and indeed Ong was a pleasure to see at work because of his remarkable surgical skills. An example of this was the operation for cancer of the oesophagus, a very common disease in the Chinese. Ong excised the lesion and brought a loop of small bowel through the mediastinum up to the lower pharynx where it was anastomosed at a level visible though the mouth. On one visit he



demonstrated the operative result to the visiting examiners, using a simple tongue depressor to reveal the suture line. He was also well ahead of his time in using endoscopic surgery, and demonstrated its use in staging intra-abdominal malignancy when the usual procedure was a formal laparotomy. The visitors could only conclude that working with him must have been both exciting and rewarding. Other surgical visitors would be heard commenting to Dr Lett their admiration and appreciation of the surgeon's talents.

It is a great pleasure to be able to acknowledge the contributions to our specialty made by this exceptional surgeon. Perhaps no greater evidence for his support can be given that the fact that he was a founding member of the Society of Anaesthetists of Hong Kong when this was initiated by Ozorio and Lett in 1959 and continued to attend its meetings whenever he could.

Z. Lett, MD, FANZCA, FHKCA, FHKAcMed, FRCA, FFARCSI, DA (RCP&S.)

Noel Cass, FANZCA, FRCA.

Postscript by Noel Cass: *The references to Dr Lett in this Obituary were added by me over Dr Lett's protest! I felt this example of great team work and its contribution to the development of anaesthetics as a specialty in Hong Kong should be acknowledged in this way.*



Obituary

Simon Woodside Macdonald – Vic

6 February 1932 – 24 January 2005

FFARACS - 23 February 1968, FANZCA – 2 March 1992

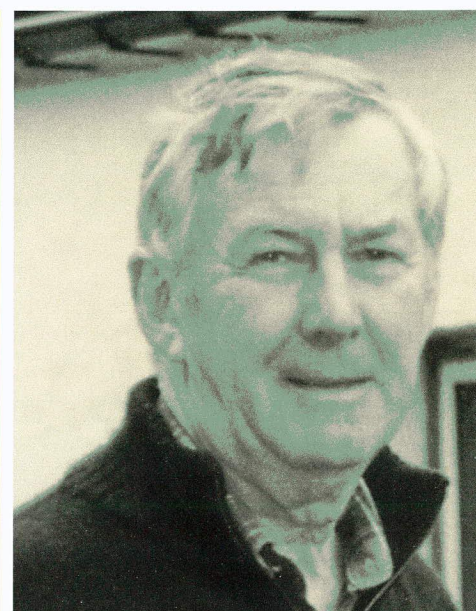
Simon was born in Narrandera into a family that had been farming in Australia for more than 70 years. He was the second youngest of six children. To eliminate confusion with his father, also named Simon, he was known as 'Bill' at home. It was at the kitchen table his formal education began by correspondence supervised by his mother, Margaret. At secondary level he attended Geelong College and being disinclined to take up farming he moved into Ormond College to study medicine at Melbourne University, graduating in 1957. After residency at Geelong Hospital and early training at RCH and RMH he travelled to UK where he served as anaesthetic registrar the at Marsden and St Thomas'. There he obtained his DA and, on return to Australia, his FFARACS by examination in 1967.

Simon practised in private and as a Visiting Medical Officer at Queen Victoria Memorial Hospital for many years until it relocated to Monash. His techniques were simple, believing the less complicated things were safest. As with everything he did he was absolutely methodical and yet he kept up to date and made changes if he was convinced there was a better way. Surgical colleagues appreciated his coolness in crisis situations and recovery staff were impressed with the condition of his patients at the end of procedures. Simon valued the help of skilled nurses in the operating room. They respected his standards and responded to his interest in them and their lives. He was a tall, retiring, cultured man and patients often expressed to their surgeon how relaxed and confident Simon made them feel.

Above all Simon was a family man. His union with Alison Hart in London in July 1964 began a close sharing of interests and activities over more than forty years. His wife, his three children Louise, Hugh and Ewen and latterly his grandchildren were the centre of his world. Louise describes her father's defining quality as his capacity to love. He felt the joys and pains of those he loved intensely. The sadness of the loss of his youngest son Ewen from a complication of

elective surgery eight years ago was acute as also the pain of watching Hugh and his wife Francoise experience the loss of baby Anouk. This was only countered by the joy of being Grandpa to their other children Ines and Tristan. Even in the last weeks of his illness with failing energy and increasing disablement Alison did not hear him complain.

Being an avid reader he was knowledgeable about a large variety of things. He encouraged Alison's creative talents and was keenly interested in whatever path his children took. Friends knew him as a delightful, elegant, attentive but unassuming host. He was an excellent and adventurous cook. Gardening was one of his passions especially cultivating irises and tree peonies. He enjoyed the thrill of the



"His techniques were simple, believing the less complicated things were safest. As with everything he did he was absolutely methodical and yet he kept up to date and made changes if he was convinced there was a better way."

search as a collector of textiles, especially carpets, glass, prints and exotic items such as Afghani camel bells and Burmese imperial weights (also know as opium weights). His children were astonished by his ability to see detail in the world around him – a skill learnt as a child on the farm – a bird in the bush, shells on the beach and even 'missing car keys'. Simon did not have a loud laugh but he had a keen sense of humour. Smiling eyes often gave the clue to the point of an astute whimsical comment.

Although Simon is missed by his family, friends and colleagues, all express very positive memories and gratitude for having known and been know by him, a true gentleman.

Arthur Woods

Deaths

Council noted with regret the death of the following Fellows:

Dr Kathleen Isabel Cole (WA)
– FFARACS 1978, FANZCA 1992

Dr Simon Woodside Macdonald (Vic)
– FFARACS 1968, FANZCA 1962

Dr Francis William (Bobby) Roberts (Tas)
– FFARACS 1964, FANZCA 1992.



Report

Highlights from the Council Meeting

February 2005

Election of President Elect

Professor Michael Cousins was re-elected President to continue his Presidency after the Annual General Meeting in May.

Internal Affairs

Taskforces

Nine Taskforces have been established of which five have already met by teleconference. The Taskforces have a broadly based membership of highly motivated individuals. A time frame of six months has been established for these initial Taskforces to report back. Topics include: Data; Integrated Approach to Quality and Safety; Name of the Specialty; Non-Medical Members of the Anaesthesia Care Team; Perioperative Medicine; Private Practitioner Involvement in ANZCA; Professionalism; Relationship of Regional/National Committees to ANZCA; Younger Fellows and ANZCA.

ANZCA Electronic Agenda and Document Access

With the success of the Electronic Agendas for Executive and Council, it has been agreed that the Electronic Agenda system be adopted and rolled out for other College Committees.

Additional PCs will be purchased and stored in the College to provide a PC for Committee Participants. Any Fellow wishing to bring their personal PC is welcome. However such PC may require some updating by the IT Department in order to participate.

Currently a wireless connection is available in both the ANZCA House Council Room and the Ulimaroa Board Room.

Website Redevelopment

The College website is being redeveloped and will be hosted internally at ANZCA via M Broadband.

Consumer Representative to College Committees

The College is seeking a Community Representative on the General Examination

Committee and the Hospital Accreditation Committee. Currently there is consumer representation on the Education and Training Committee and the Overseas Trained Specialists Interviewing Panel.

Council Strategic Planning Day

Council approved a Charter and a Protocol for Council Meetings at the first of its two Strategic Planning Days for 2005. A second day was held on the 17th of March to expand these initiatives, and a training day arranged for Councillors in June on their Role and Responsibilities.

Commencing in June, it is proposed that Council will meet at least six times per year for a single day meeting.

A revised Executive Committee will meet in the months when Council does not meet.

Affinity Health

Affinity Health (formerly Mayne Health) will continue its commitment in 2005 to providing a Rural Specialist Establishment Grant of \$55,000. The grant will also be available for the establishment of a specialist practice in a designated rural area.

Joint Faculty of Intensive Care Medicine

Council has agreed to provide funding for a JFICM Visitor to the independent JFICM Annual Scientific Meeting and the College ASM on the basis of 50% of the cost from the Foundation and 50% to be borne by the Meeting, on the principle that the contribution of the Intensive Care Visitor be spread throughout the ASM program.

Education and Training

Supervisors of Training Workshop

The topic for the 2005 ASM SoT Workshop will be the ITA with emphasis on issues arising from the survey of trainees and Supervisors of Training.

Clinical Teachers' Course

1. The College will deliver the Clinical Teachers' Course as part of the Supervisors of Training and Module Supervisors training.
2. The CTC Modules will be delivered singly regionally, to a maximum of twelve participants by at least two instructors.
3. The Regional Education Officer will convene a short meeting with the Supervisors of Training and Module Supervisors at the end of the meeting, to deal with any other matters relevant to trainees and training.
4. ANZCA will open the Clinical Teaching Course to other Fellows and senior trainees interested in training and education after the needs of the Supervisors of Training and Module Supervisors have been met.
5. The two modules; Small Group Learning and Dealing with Trainees with Difficulties, continue to be developed and will be piloted at the April South Australian CME Meeting and the March Queensland Supervisors of Training Meeting, respectively.
6. Further modules will be developed at a later date.
7. With regard to course delivery, one module will be delivered in each region/country each year.

Education Materials for Trainees

Council has established a sub-committee consisting of Drs Leona Wilson, Kerry Brandis and Russell Jones to progress the development of educational materials for use in distance learning.

Supervisors of Training Access to ANZCA Website

All Supervisors of Training, whether FANZCA or otherwise, will be given access to the restricted part of the ANZCA website as well as the public areas.

Examinations

Council has accepted a recommendation from the Examination Committees to provide text books to ANZCA Examiners during their term of appointment to assist them in Examination preparation and marking.



On appointment to the Panel of Examiners and following attendance at the new Examiners Workshop, new Examiners may request texts to the value of \$1,000 from the relevant reading list of recommended texts.

Current Examiners (those who commenced examining prior to February 2005) may request the College to purchase texts to the value of \$700 from the relevant list of recommended texts in 2005.

On reappointment every three years, Examiners may request the College to purchase texts to the value of \$300 from the relevant list of recommended texts. The books remain the property of the College.

If any of the books on the recommended lists are available online, an online version will be purchased by the ANZCA Library for accession by the Examiners.

Feedback to Candidates – Training of Interviewers

The College is continuing to implement guidelines and training of interviewers for the provision of feedback to Examination Candidates. Currently this feedback is carried out by the Chair and the Deputy Chair of the Final Examination. It is anticipated that this process will also allow for the provision of more specific feedback to unsuccessful OTS Performance Assessment Candidates.

Tenure of Appointment

Regulation 4.6 has been amended to read: "The Tenure of Appointment of an Examiner shall be three years and shall date from 1 January following the appointment. An Examiner will be eligible for reappointment for three further three-year terms and such reappointments shall be made at the October Council Meeting.

Professional Affairs

The following Professional Documents were accepted and are published in this Bulletin:

TE7 - Recommendations on Secretarial and Support Services to Departments of Anaesthesia

TE9 - Guidelines on Quality Assurance in Anaesthesia

PS28 - Policy on Infection Control in Anaesthesia

Australian Day Surgery Council

The Charter and membership of the Australian Day Surgery Council was reviewed following the demise of the Australian Association of Surgeons. The remaining members are ANZCA, the Australian Society of Anaesthetists and the Royal Australasian College of Surgeons, who have all accepted a revised Charter for the Council. The anaesthesia representatives on the Council are; Dr Colleen Kane (ANZCA), Dr Elliott Rubinstein (ASA) and Dr David Kinchington (ANZCA/ASA).

Perfusion Services

The President has forwarded a copy of Professional Document PS27 – Guidelines for Fellows who Practice Major Extracorporeal Perfusion, to all teaching and Australian private hospitals, highlighting the educational requirements for such practice.

Hospital Accreditation

Criteria for Approval of Duration of Training

Council accepted the following Criteria:

1. The maximum duration at any one hospital in clinical anaesthesia be one, two or three years.
2. Up to one year extra to the maximum duration in clinical anaesthesia can be spent at a hospital in attachments other than clinical anaesthesia such as Intensive Care Medicine. (Reg 15.4.6.2) and other disciplines as listed in Regulation 15.4.6.3, namely clinical medicine, emergency medicine, pain medicine, other disciplines related to anaesthesia and a formal research program.
3. The criteria for one year approval will be that there is an appropriate department of anaesthesia, quality assurance and educational program, and that the hospital meets the Colleges' standards as expressed in College Policy Documents and Regulations. There should be adequate experience for the trainee to complete

module one and at least one other module if it is a general hospital; if the hospital is a specialist hospital, such as a paediatric hospital, then it must provide adequate clinical experience to allow completion of a clinical module.

4. The criteria for two years approval should be:
 - all of the criteria for "one year",
 - the clinical experience to complete modules 1 and 2, and at least two other modules requiring clinical experience.
5. The criteria for three years approval be:
 - all of the criteria for "one year" and,
 - the clinical experience to complete most or all of the modules, (ie. at least seven of the nine requiring clinical experience),
 - experience adequate to complete the formal project
 - access to good examination preparation courses

Research – Clinical Trials Group Pilot Grants

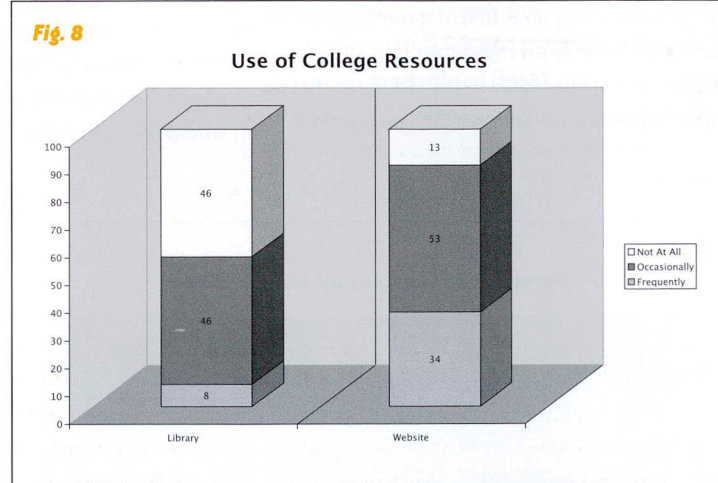
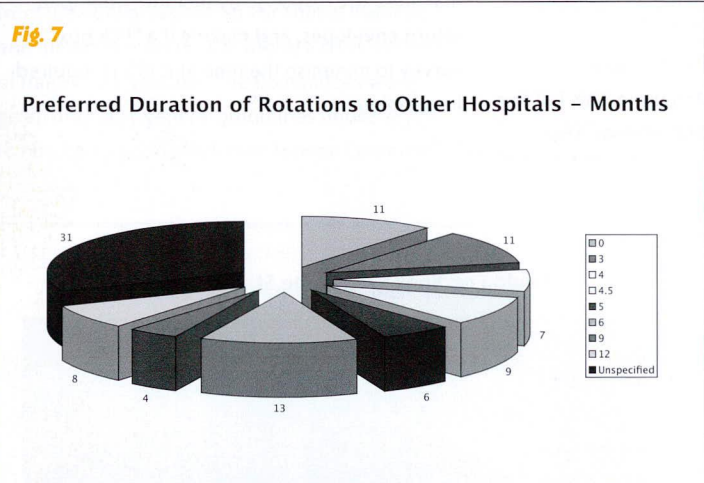
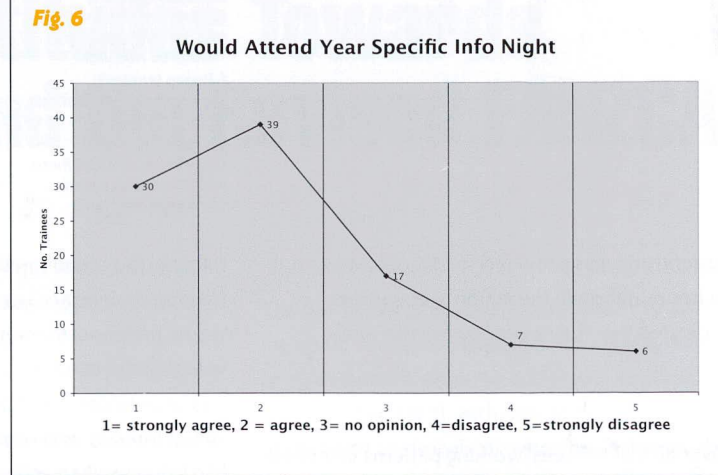
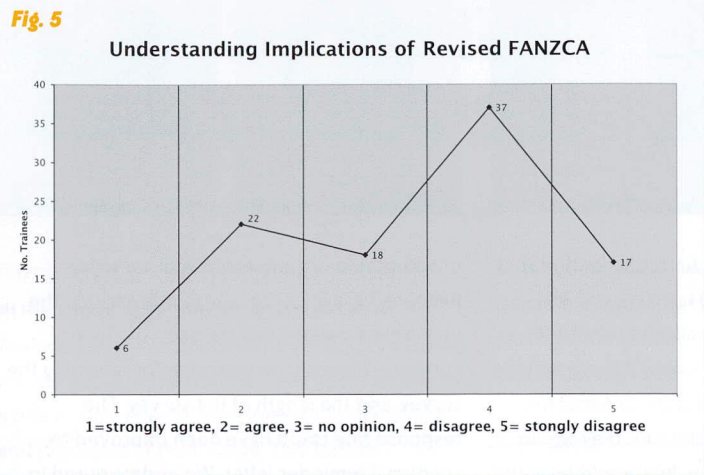
Council has agreed to make available \$25,000 in February 2005 from the Research Grant allocation for 2006, to fund a fast track Small Grants Program administered by the CTG Executive.

A deduction will be made from the allocation for 2006 to account for this amount plus interest which would have been allocated, had the \$25,000 remained in fund.

Resignation From College Executive

Associate Professor Tony Weeks has resigned from the Executive Committee and hence from his position as Assessor.

Dr Lindy Roberts will be Acting Assessor until after the Annual General Meeting in May.



anaesthetic training is undertaken in the regions under the auspices of the Australian and New Zealand College of Anaesthetists. It appears that despite efforts undertaken by the College, it is still not well understood by the trainee community, and that informal education evenings would be well received.

The majority of trainees are able to attend educational courses and seminars, most of which are run by the College, with almost half being able to take study leave to attend these events. An information session where different hospitals outline the training and experience available for their provisional fellows would probably be very well received, and allow trainees to evaluate better the experience they are likely to obtain in their final year of training.

A proportion of trainees expressed a preference to rotate away from their training hospital in their 4th year of training, and with the implementation of the Revised FANZCA this may in fact become necessary in order to obtain the requisite experience in various modules. Trainees would

prefer to know where they will rotate to when they commence their training – something that logistically may be quite difficult.

As the significant resources of the College library and website seem to be very under-utilised, it may be worth considering making trainees aware of these at the commencement of their training and perhaps reminding them at regular intervals.

Conclusion

This survey, although receiving only a 52% response rate, gave a valuable insight into the concerns and needs of the trainees that may be able to be addressed with minimal cost or effort. It is something that the authors believe would be worth repeating perhaps on an annual basis, possibly with some input from other groups such as Supervisors of Training, the Education and Training Committee, and the various Regional Committees regarding the questions that should be asked. A follow-up letter could be used to improve the response rate, and it could be extended to include trainees from all regions – not just Victoria.

The results of the survey have helped to give the Trainee Committee a more structured framework within which to work, and guide our efforts as we try to create a stronger link between the trainees and the College administration.

1 Increasing response to a postal survey of sedentary patients – a randomised controlled trial. Harrison RA, Cock D. *BMC Health Services Research* 2004, 4:31
2 Spicker P, Hock J, Answers to Previous Questions. *J Helath Serv Res Policy* 2004 9:127

Errata

In the previous *Bulletin*, November 2004, Vol 13 No 4, Page 6 under *Honours and Appointments*, **Dr David A Scott** was appointed Associate Professor, Department of Surgery, University of Melbourne at St. Vincent's Hospital (not Dr David M Scott as published).

We apologise for this error.



Education Report

Clinical Teaching Course



Russell W. Jones
Director of Education, ANZCA

Due to increasing interest amongst Fellows for educational training, ANZCA is introducing a Clinical Teaching Course. The course covers material appropriate to anaesthesia, intensive care and pain medicine. The purpose of the course is to provide Supervisors of Training, Module Supervisors and other Fellows who have an interest in teaching with the opportunity to receive formal training.

- *Assessment in the workplace.* Includes an overview of assessment issues, explanation of assessment characteristics and terminology, approaches for assessing knowledge, skills and attitudes, performance assessment and trainees self-assessment.
- *How to teach effectively in small groups.* Teaches participants how to apply the

workshops have been run in New South Wales, New Zealand, Queensland, Victoria and Western Australia. It is intended that each unit will be made available to Fellows within each region/country on a regular basis. Anyone who would like the College to hold a specific unit in their region or country is encouraged to forward a request to the College via their Regional or National Education Officer.

“The workshops incorporate a variety of teaching techniques such as small group activities, round table discussions, interactive didactics, role-plays and video presentations.”

The course was designed to meet the needs of Fellows identified in a needs analysis conducted by the Education Unit. The needs analysis found there existed widespread desire for a course to address teaching and other aspects of education. Moreover, the needs analysis revealed that (1) the course should be unit based allowing Fellows to choose those units with content of most relevance to them; (2) each unit should consist of a workshop with pre-and post-workshop activities; (3) completion of each unit would require a total of 10 hours of work for all activities (ie, the workshop plus pre and post activities); and (4) completion of several units would result in an acknowledgement by the College.

Four units have been developed in response to the topics most frequently requested by Fellows. They are:

- *Assisting the trainee with difficulties.* This unit includes an overview of the types of problems encountered by trainees, different approaches required for different problems, relevant College policies and procedures, how In-Training Assessment may be used to define, remediate and prevent problems, and provides an opportunity to practise skills for providing feedback to trainees.

principles of group learning to small group teaching, employ principles of group dynamics, create a plan for teaching trainees in a small group setting, conduct a small group session, and evaluate the small group learning process with a view to improvement.

- *Teaching in the operating theatre.* Covers the features of a good clinical teacher, how to improve clinical teaching, the Learning Cycle, learning objectives, teaching strategy, learning theory, the one-minute preceptor, and practises participants in teaching a practical skill.

The workshops incorporate a variety of teaching techniques such as small group activities, round table discussions, interactive didactics, role-plays and video presentations. This ensures that the educational objectives comprising each unit are taught using an appropriate method.

Furthermore it caters for the different learning preferences of workshop participants. The number of workshop participants is typically limited to 12 in order to facilitate high quality interaction between instructors and participants.

The course was piloted in March last year and has been met with substantial enthusiasm among both participants and instructors. Thus far

Appointments

Congratulations were extended to:

Dr Jennifer Weller (NZ) – Associate Professor, Director of Faculty Education Unit, Faculty of Medicine and Health Sciences, University of Auckland

Professor Paul S Myles (Vic) – Professor, Departments of Anaesthesia, and Epidemiology and Preventive Medicine, Monash University at the Alfred Hospital

Dr Leona Wilson (NZ) – Appointed to the Health Practitioners Disciplinary Tribunal

Admission to Fellowship by Examination

Fellows Admitted December 2004

Brendon John BIGWOOD	NZ
Tod Richard EGGLETON	NSW
Kevin Nigel ELKS	NZ
Kevin Charles ELLIOTT	NZ
Thomas Charles Edward GALE	VIC
Bruce Richard HAMMONDS	NZ
Anthony John HULL	VIC
Eugenie KAYAK	VIC
LIM Boon Kian	HK
Geoffrey Edward SILK	NSW
IAN Khong Cheong	MAL
Andrew Ching WONG	NZ

Fellows Admitted January 2005

Mark James ADAMS	NZ
Christopher Leo ASHLEY	NSW
Magid Samir BISHAY	NSW
Martin Tibor BOHM	NSW
Ian Alexander BRIGLAND	NSW
James Dat Hing CHEE	NSW
Woon Kean CHONG	SA
Elaine Marie CHRISTIANSEN	WA
Charles Maxwell CLEGG	SA
Colin Christopher CROWE	QLD
Stephen James DAVIES	ACT
Amanda Jane DAWSON	NZ
Stuart Kenneth DAY	TAS
Jonah Crispin William DEBORGHES	WA
Rebecca Louise DE SOUZA	NZ
Mark Joseph DUANE	NSW
Slmeon EATON	NZ
Caroline May FAHLY	ACT
Kenneth Robert FITZSIMMONS	QLD
Salwan FRANSI	NSW
Jonathon Paul GIBSON	NSW
Adam Clifford HARMON	QLD
Nicole Annette HEALY	QLD

Nicholas HUGHES	QLD
Matthew Walters KELSO	QLD
Mi-Jin KIM	VIC
LEE Ha Yun	HK
George Siak Kwang LIM	NSW
Phang-Chien LIM	SA
Andrew Frederic LOVEGROVE	WA
Hang Wai James LUI	NSW
Leonard Kheng Hian LUM	NSW
Justine Mary MCCARTHY	QLD
Stephanie Louise MCINNES	NSW
Joshue MCNAMARA	NSW
Brenton Clifford MILLARD	SA
Kirsten Elissa MORGAN	NSW
David George NOBLE	QLD
Andrew James OLNEY	WA
Joanne Elizabeth PAVER	NZ
Veronica Margaret PAYNE	NSW
Kate Elizabeth PENNINGTON	NSW
John POULOS	NSW
Roger Eric Stirling PYE	NSW
Lachlan Michael RATHIE	QLD
Arthur Mervyn HUDMAN	NZ
Deborah Elizabeth SIMMONS	SA
Lloyd Hay SMAIL	NSW
Vera SPIKA	NZ
Timothy STAVRAKIS	NSW
Lanie Cherie STEPHENS	ACT
Steven Paul SWANSON	WA
Andrew Francis WALLIS	TAS
Surendra YOGALINGAM	SA

Fellows Admitted February 2005

Mark Jason ALTER	VIC
Frank Frederick BUCHANAN	VIC
Simon Lloyd Mortlock BURROWS	NSW
Christie Michelle CAMERON	VIC
David James CARMAN	SA
Barbara CHIA	VIC
James Mayfield DENNIS	VIC
Ben Jon DE LUCA	VIC
Dean DIMOVSKI	VIC
Tzung Ping DING	VIC
Ruth Irene DUNCAN	QLD
Liadain Anne FREESTONE	VIC
Michael Phillip GARRETT	VIC
Andrew Roland HILL	NSW
John David HOLLOTT	NSW
Anthony Charles KEEBLE	VIC
LIM Su-Li	VIC
Graham Ralph LOWRY	SA
Shiva MALEKZADEH	VIC
Thomas William PAINTER	SA
Frances Anne PERRET	VIC
Mathew PILRCY	VIC
Kien Lap QUACH	VIC
Tomasz Jerzy RAWDANOWICZ	VIC
Michael Charles READE	VIC
Christine Lee ROWE	QLD
Martin RUSSNAK	TAS
Peter James SQUIRE	VIC
Joel Ari SYMONS	VIC
Nicole Lay Tin TAN	VIC
Priya THALAYASINGAM	WA
Beth Michele VEIVERS	QLD
Brent Randolph Daley WALDRON	NZ
Ingrid Halina WALKLEY	SA
Sue Ann WAN	NSW
Douglas Keith WHITTLE	QLD
Timothy David WRIGHT	SA

Admission to Fellowship via OTS Performance Assessment Process

OTS Fellows Admitted December 2004

Patrick Douglas EAKINS	WA
Mahzar MAHMOUD	QLD

OTS Fellows Admitted January 2005

Mohua JAIN	NZ
Frances Mary Larman PAGE	NSW
Nenna SINGH	NSW
Charlotte Mary Willasey WILSEY	NSW

OTS Fellows Admitted February 2005

Michaela Maria HAMSCHMIDT	NZ
John Alexander PRICKETT	NSW

Fellow Admitted by Election February 2005

Dr Jennifer Stedmon (WA), was elected to Fellowship under Regulation 6.3.1(b)



Series on Past Deans and Presidents

Leonard Thomas Shea

Leonard (Len) Shea was the fifth Dean of the Faculty of Anaesthetists, Royal Australasian College of Surgeons, serving in this post from 1964-1966. He followed Dr James McCulloch and was succeeded by Dr Mary Burnell.

Len Shea was born in Queensland and commenced training as a teacher at the Queensland Teachers' Training College in 1930. It was his intention to pursue a career in music, but he found that prospect an inadequate challenge. His passion for music was not lost and one of his proudest appointments was that of Honorary Carillonneur to the University of Sydney.

He returned to school and matriculated to enter Sydney University Medical School. He commenced in 1932 and graduated in 1937. In 1934-1935 he was awarded the Sydney University Busby

"It is impossible not to be impressed at the warmth and generosity with which his citation for the Faculty Medal and his obituaries were written. He had the unquestionable respect and admiration of his contemporary colleagues."

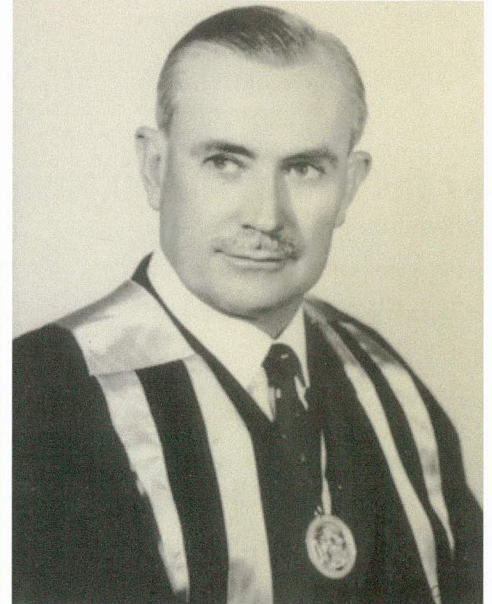
Musical Scholarship on Carillon and Organ. After several hospital jobs in Sydney he entered general practice in King's Cross in 1940.

He enlisted in the A.I.F. in 1942 and served until 1946 including two years of overseas duty and was commissioned a Major. He successfully completed the Diploma in Anaesthesia (Sydney) in 1946 and joined practice with Drs Harry Daly and Stuart Marshall in 1947. He was immediately successful in private anaesthetic practice and became much sought after as a teacher and committeeman due to his energy and clarity of thought. He held honorary anaesthetic appointments at Repatriation General Hospital, Sydney Hospital and St Vincent's Hospital which he served for 26 years.

At this time of his career he held a multitude of roles including part time Director of Anaesthetics at Prince Henry's Hospital from 1950-1960, Supervisor of Postgraduate Training in Anaesthesia for the Postgraduate Committee of the University of Sydney from 1953-1962 and Senior Visiting Anaesthetist to the Special Unit for the investigation of Cancer at the Prince of Wales Hospital from 1956-1963. Later he was to become Lecturer in Anaesthetics for the NSW Cancer Council and Chief Examiner for the Diploma in Anaesthesia of the University of Sydney.

Len Shea was appointed Secretary-Treasurer of the NSW section of the Australian Society of Anaesthetists from 1949-1950 and became Chairman of the Section in 1953. He was later appointed as President of the Society in 1962.

Len was a foundation Fellow of the Faculty of Anaesthetists in 1952 and elected to the Board of Faculty in 1956. In 1956-1960 as first Chairman of the Court of Examiners he determined the structure and quality of the examinations. From 1964-1966 he was Dean of the Faculty. The climax of his involvement with the Faculty came with the public and international recognition of his contribution when in 1968, during the World Congress of Anaesthesiologists in London, he was elected to the Fellowship of the Faculty of Anaesthetists RCS. He was honoured by our Faculty/College with the Faculty Medal in April 1980. The Faculty of Anaesthetists RACS Medal permits recognition of outstanding contributions by a Fellow of the Faculty in the fields of anaesthesia and/or intensive care for clinical, educational or research achievements.



It is impossible not to be impressed at the warmth and generosity with which his citation for the Faculty Medal and his obituaries were written. He had the unquestionable respect and admiration of his contemporary colleagues. I will leave the last words to Dr Brian Pollard in his obituary for Len "In those who were fortunate enough to know him, Len elicited warmth, admiration, respect and love. For many, he was the exemplar of the good man and the good doctor, who exerted a profound influence on their lives. It is most gratifying to see how many of his young colleagues have, under his influence, come forward to maintain the tradition of service which he embodied. He deserves to be remembered always because he was an outstanding man."

Terry Loughnan

I am indebted to and acknowledge the following sources in preparation of this essay.

Brian Pollard; Obituary :Leonard Thomas Shea. Anaesth Int Care 16, 2.May 1988 p228-229
 Ross Holland; Obituary Dr L.T.Shea FARACS Bulletin Nov 1987 p39
 Brian Dwyer; Citation for Dr L Shea. FARACS Deans Newsletter April 1980
 Gwen Wilson; Fifty Years, The Australian Society of Anaesthetists, 1987 ISBN 0 90981401 5



ACCC Info kit for the medical profession

Straight-forward and accessible information on how the competition and fair trading laws apply to and protect doctors.

A new info kit on doctors' rights and obligations under the competition and fair trading laws – the ACCC Info kit for the medical profession – has recently been launched by the Australian Competition and Consumer Commission (ACCC).

The ACCC recognises that doctors have limited time to familiarise themselves with everything they need to know to comply with the competition and fair trading laws. The ACCC Info kit for the medical profession has been developed with this in mind.

Designed as a ready reference tool for doctors and practice managers, the ACCC Info kit for the medical profession contains short summary guides and leaflets with information on how the Trade Practices Act affects the medical profession. The kit contains:

- **A Prescription for Good Practice**, a handy two page summary of the key issues covered in the kit.

- **Medical roster checkup and leaflet** with guidance on the often misunderstood issue of medical rosters.

- **Anatomy of the ACCC**, explains the role and functions of the ACCC

- **Diagnosing unconscionable conduct – what does it mean for doctors?** Sets out the protection afforded under the Act for doctors subject to harsh or oppressive conduct when dealing with larger parties.

- **Cutting a deal – what doctors need to know about collective negotiations.** Explains how the competition laws apply to collective bargaining and agreements.

- **Setting your fees straight** provides guidance on how doctors can set their fees in accordance with the requirements of the Act.

- **Straight talking with your patients** explains the fair trading laws relevant to advertising medical services and dealings with patients.

The ACCC Info kit for the medical profession brings together information specifically drafted for doctors, drawing on advice and assistance provided by representatives of the medical profession.

The ACCC is undertaking a broad ranging and intensive program to distribute the Info kits, to ensure that all GPs, specialists and other medical professionals are aware of the Info kit and its contents. The ACCC is responsive to complaints and inquiries, and staff will provide guidance to doctors on their rights and obligations under the Act.

The ACCC Info kit for the medical profession is a free publication. For copies or further information please contact the ACCC Infocentre on 1300 302 502, or see the ACCC website www.accc.gov.au

Handbook for the Management of Health Information in Private Medical Practice

Fellows who would like to read a concise guide to the implication of Privacy Legislation for Management of Health Information will find this handbook useful.

It has been published by the RACGP and the CPMC with the support of the General Practice Computing Group, and covers a range of topics, including:

- Quality and content of medical records
 - Patient consent
 - Advising patients when collecting personal information
 - Patient access to medical records
 - Using and disclosing personal health information
 - Medical research
 - Quality assurance and continuing professional development
 - Data security and retention
 - Health provider identified health information
 - Establishing a practice policy on personal health information
 - Guidelines for security, storage and transfer of personal health information
- The 23 page document can be downloaded from www.racgp.org.au/publications**





Undergraduate Prizes in Anaesthesia



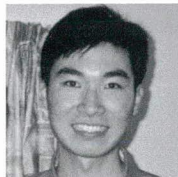
The recipient of the 2004 ANZCA Prize within the **Faculty of Health Sciences, The University of Auckland** was *Mr Vaughan Beckley*.

Mr Beckley's award was presented to him on 17th January 2005.



The recipient of the 2004 ANZCA Prize within the **University of Tasmania** was *Ms Columbine Daintree*

Ms Daintree's award was presented to her in December.



The recipient of the 2004 ANZCA Prize within the **Christchurch Clinical School of Medicine, University of Otago** was *Mr Ruoh Whay Sim*.

Mr Sim's award was presented to him during the Prize Giving and Farewell Function for the Christchurch School of Medicine and Health Sciences 2003/2004 Trainee Interns on Thursday 18th November 2004.

The Prize was presented by Professor Edward Shipton, Head of Department, Anaesthesia, Christchurch School of Medicine and Health Sciences.

Specialist Re-Entry Program (SREP)

The Australian Government has developed a plan to assist specialists who want to return to practice and who would like to spend time refreshing their knowledge and skills in a private practice setting.

Government funds are available to assist specialists who:

- Hold Fellowship of the College
- Hold current medical registration
- Hold current medical indemnity
- Intend to return to the specialist medical workforce in Australia

It is anticipated that the Fellow:

- Will have been absent from specialist clinical practice for between six months and ten years
- Will have negotiated a placement in a private practice of their choice
- Will have negotiated with an appropriate mentor for support

Funds will be provided for administrative costs for the relevant practice, for mentor support and training and for colleges for administrative support.

The specialist concerned cannot be paid by the Government, which anticipates the person will bill Medicare for services to private patients.

Note: *The project officers have indicated that, should there be little interest in the above scheme, and if there are applications from specialists who would prefer their experience to be in a public hospital setting, the department may be able to access the funds normally reserved for the private practice, mentor and training.*

The scheme will operate for four years, from July 2004.

For more information please contact either:

SREP Project Officer
Tel: (61 2) 6289 8034;
Website www.health.gov.au
or
Ms Jill Humphreys
Australian and New Zealand College of Anaesthetists
Tel: (61 3) 8517 5336;
Email jhumphreys@anzca.edu.au



Professional Documents Under Review

In line with College policy, the following Professional Documents are due for review in 2005:

PS4 – Recommendations for the Post-Anaesthesia Recovery Room

PS15 – Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery

PS18 – Recommendations on Monitoring During Anaesthesia

PS40 – Guidelines for the Relationship Between Fellows and the Healthcare Industry

PS41 – Guidelines on Acute Pain Management

PS42 – Recommendations for Staffing of Departments of Anaesthesia

T1 – Recommendations on Minimum Facilities for Safe Anaesthesia Practice in Operating Suites

T2 – Recommendations on Minimum Facilities for Safe Anaesthesia Practice Outside Operating Suites

TE6 – Guidelines on the Duties of an Anaesthetist

TE18 – Guidelines for Assisting Trainees with Difficulties

The Executive will welcome any input or suggestions relating to these documents which will be considered during the review.



New Zealand Office

The three ANZCA New Zealand office staff members are very much a team, so it seemed appropriate to do a combined profile for the Bulletin. The accompanying photograph bears witness that we enjoy our time at Elliott House and are spoiled at Christmas time! From left to right in the photo are: Jan Brown, Lorna Berwick and Heather Ann Moodie.



Heather Ann is the 'new kid on the block', having started in August 2002 as Executive Officer. Lorna has been the administrator for the Faculty of Anaesthetists (and initially RACS) since the late 70s and thence moved on to work for ANZCA. She is the fount of all knowledge and many anaesthetists (and surgeons) have been guided through their training and future careers by Lorna. It was a great day for Lorna when Jan joined the staff in 1998 to help with both ANZCA and JFICM work. Between us, we cover a large range of tasks on behalf of ANZCA and JFICM with the help of dedicated teams of committee members who are fun to work with.

New Zealand, as a country, has different legislation, health systems and agencies compared to Australia and therefore requires separate responses to many issues affecting anaesthetists. The new Health Practitioners Competence Assurance Act (HPCAA) and other legislation have focused our minds with topics such as scopes of practice, protected quality assurance activities, restricted activities and nurse

practitioners. There are other activities that also have different systems to Australia, such as: Overseas Trained Specialist interviews that we do on behalf of the Medical Council (MCNZ); the MCNZ vocational registration process that recognizes anaesthesia and intensive care as separate vocational branches of medicine; the different training year (New Zealand starts training more than a month earlier than Australia); committee meetings (SoTs and Trainees) that need to be held by teleconference because of the geographical spread from Whangarei in the north to Invercargill in the south (2,000km). This geographical spread also affects face-to-face meetings such as the annual meeting for the Trainees Committee and our National Committee as they need to fly into Wellington three times a year. I do not think this is a hardship for the Committee, as Wellington is known for its great restaurants and fantastic coffee. Elliott House is close to Caffè L'affare, a national icon as far as coffee is concerned. We'll take you there for lunch if you come to Wellington. Our city is a

great place to be....weekends like last with the Sevens Rugby, balmy weather lapping 30 degrees and topped off with a huge fireworks display over the harbour to herald the Chinese New Year (we are a sister city to Beijing and Xiamen).

Elizabeth Woods in her Bulletin staff profile mentioned she is enjoying the Melbourne shopping. Wellington has great shops too. However, Lorna, Jan and I are always pleased to be invited to an ANZCA House workshop as Melbourne is special. The staff and Council members always provide a warm welcome to their trans-Tasman cousins and we definitely feel part of the ANZCA family. We appreciate the support and friendship and of course the new iMiS system has made information sharing so much easier.

We look forward to welcoming many Fellows and staff to our country during the Auckland ANZCA ASM in May this year.

Heather Ann Moodie, Executive officer



Celebrations

Dr Hugh Timothy Spencer

On Friday 29th October 2004, a tribute meeting in honour of Dr Hugh Spencer was held at the Bryant Education Centre, Waikato Hospital followed by a dinner at the Narrow's Landing. Dr Spencer retired from the Waikato Anaesthetic Department in 2004 after almost 30 years of service, having started as a registrar in 1975. Hugh was Director of the Department from 1986 – 1996.

This excellent meeting, organized by his friends and colleagues in the Department with no company sponsorship, was very well attended, with many old friends of Dr Spencer arriving from out of town to share this special day with him. The profits from this meeting went to WFSA Pacific section to assist with education for Pacific Island anaesthetists.



Dr Hugh Spencer (left) and Dr Peter Cooke, Chair of the New Zealand National Committee



Dr Hugh Spencer (right) with wife, Margaret and Dr Kester Brown

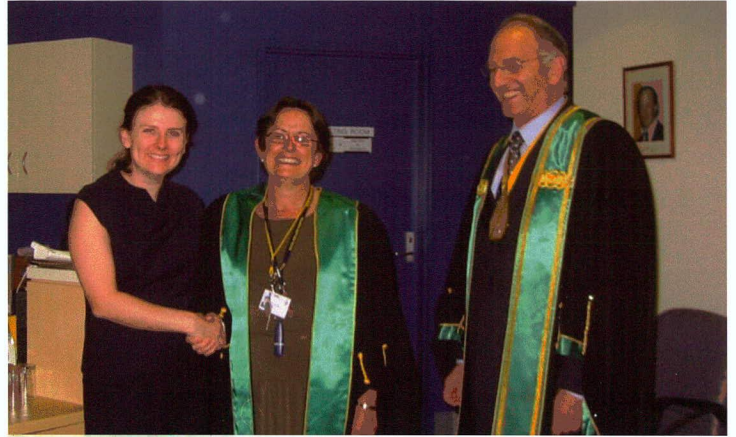
Dr Spencer has not rested on his laurels since this meeting, nor has he settled down with his books and slippers, but has taken off to do locums around New Zealand. Immediately after retirement he and Margaret went on a lengthy trip to the UK, where Hugh managed to combine holiday, visiting family and a few locums thrown in there as well just to keep him out of mischief!



Faculty of Pain Medicine



Peter Georgius with Penny Briscoe and Milton Cohen



Brenda Cassidy with Penny Briscoe and Milton Cohen



Court of Examiners

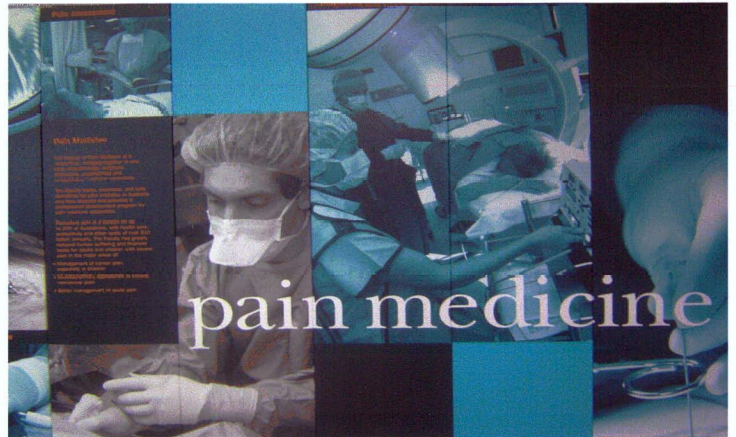
Back: Drs David Jones, Frank New, Matthew Crawford, Bruce Rounsefell, Prof George Mendelson, Dr Carolyn Arnold, Prof Rob Helme, Drs Pam Macintyre, Robyn Campbell, Ray Garrick
Front: Drs Roger Goucke, Penny Briscoe (Chair), A/Prof Milton Cohen, Dr Lindy Roberts, Prof Peter Reilly, Dr Meredith Craigie



Penny Briscoe (Chair) and Margaret Benjamin (former Executive Officer)



Professor Greg Whelan, Chapter of Addiction Medicine with the Dean, Assoc Professor Milton Cohen



A section of the new display in the foyer at ANZCA House.



Supervisor of Training Certificates (NSW)

Dr Maggie Bailey, St George Hospital and Dr Mark Priestley, Westmead Hospital were presented with Supervisor of Training Certificates at the NSW Regional Committee Meeting in December 2004.

Picture Left

Back: Drs Jo Sutherland, Michael Amos, Ross Kerridge
Front: Drs Greg O'Sullivan, Maggie Bailey, Michael Jones (Chairman), Mark Priestley, Tracey Tay.



Faculty of Pain Medicine

Dean's Message

The Faculty has now submitted its response to the series of questions posed by the economics subcommittee of the Recognition of Medical Specialties Advisory Committee of the Australian Medical Council. Pain Medicine is the first candidate for a "new" specialty to be processed in this way. Consistent with the current climate, the AMC is very sensitive to the economic implications of a new specialty before any submission is made to the Minister. These questions addressed the "wise use of existing health care resources" to which we were able to mount a robust response. Fellows may peruse these documents on the Faculty website.

By a fortunate coincidence, "our" adopted Journal, Pain Medicine, published by the American Academy of Pain Medicine, has been involved in a parallel process. In a recent issue, The Case for Pain Medicine was argued by Scott Fishman, the new President of the AAPM, Rollin Gallagher, Editor of Pain Medicine, FPM Fellow Daniel Carr, MD and Louis Sullivan, a former US Secretary of Health and Human Services [Pain Medicine 2004, 5:281-286]. They concluded: "Patients in pain require a specialty that is unencumbered by the boundaries of traditional disciplines, one that is able to assimilate diverse knowledge and treatments in order to provide sound care. Physicians, who are now feeling increasingly damned if they do or damned if they don't treat pain, need a discrete specialty to set standards, to produce specialty consultants, and to produce role models, teachers, and researchers as the science and practice of pain medicine continues to expand". The Faculty has passed this document on to the AMC, further reinforcing our case first presented some eighteen months ago.

Given the existence of the Faculty as a body of specialty consultants actively providing guidance and leadership in a new discipline which has been articulated in detail, taken together with strong economic and humanitarian arguments to address the unmet community need of managing pain of all types, this is a unique opportunity for the Australian

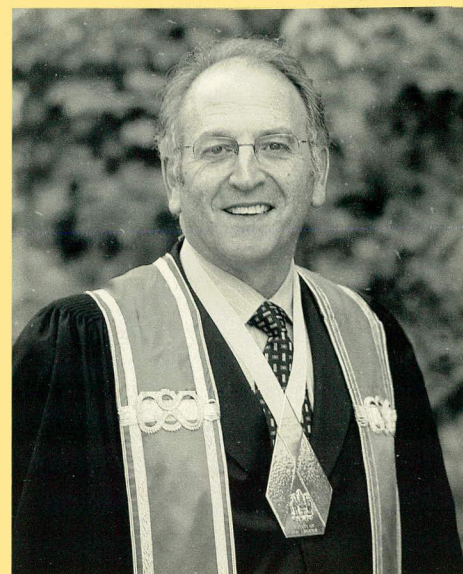
Government to take a world-first step by recognising Pain Medicine as a specialty. We will find out in July.

In responding to the challenge of providing more opportunities for training in Pain Medicine, and anticipating outside pressures to make more use of the private sector, the Faculty has modified its approach to accreditation of training units. Rather than requiring strict conformity with a set of requirements, training units will be assessed on the basis of what they can offer to trainees in terms of variety of pain medicine experience, teaching and learning. In a complementary way, the programs of individual trainees can be tailored according to required and desired exposure. It is possible therefore that a training program may occur in more than one training unit. The Faculty has recently accredited Axxon Health, a private facility in Brisbane, as a training unit. It is hoped that more potential units will put

"In responding to the challenge of providing more opportunities for training in Pain Medicine ...the Faculty has modified its approach to accreditation of training units."

themselves forward for accreditation under the new principles and help to boost opportunities for training.

The Refresher Day and ASM in Auckland will emphasise the role of the brain in pain, continuing the mission of our discipline to integrate neurobiology, psychobiology and sociobiology. A glance at the program for both meetings will reveal a rich opportunity for Fellows, Trainees and non-Fellows alike to broaden knowledge and skills. This should whet the appetite for the World Congress on Pain in Sydney in August, when as a Faculty we will be meeting with the American Academy of Pain Medicine to explore cooperation in developing our exciting discipline.



Milton Cohen
Dean



Report

Highlights from the Board Meeting

22 November 2004

Fellowship

Professor Robert Boas FANZCA, NZ, was elected to Honorary Fellowship. Associate Professor Vic Callanan FANZCA FJFICM, QLD, was elected to Fellowship. The first three Fellows to be admitted to Fellowship via the alternate pathway were confirmed: two are FAFRM (RACP), one FRACP.

Intercollegiate Relationships

The November Board meeting was addressed by Professor Greg Whelan FRACP, the immediate past-Chairman of the Chapter of Addiction Medicine (RACP). Dr Michael Chou, Chairman of the AFRM (RACP) Examination Committee attended the examination in Adelaide in October as an observer. The Faculty is actively involved with the Joint Diploma in Palliative Medicine Working Party being developed by the Chapter of Palliative Medicine (RACP).

Education

The Education Committee met face-to-face in early November. The size of the Education Committee has been increased, to include Dr Tim Semple, Dr Julia Fleming and Prof Stephan Schug. Dr Tim Semple was appointed as the Supervisor of Supervisors of Training. A Faculty Supervisor of Training workshop will be held at the Auckland meeting. The Supervisor of Training Support Kit, extensively revised from the ANZCA model, was finalised and the new Trainee Support Kit further developed and aligned with it. It was anticipated that the Trainee Support Kit would be available for use by trainees early in 2005. The Faculty Professional Document on Guidelines for Implantable Pumps for Intrathecal Therapy was finalised.

AAPM Pain Medicine Journal

The Dean advised that a nomination to the senior Editorial Board is still required.

NHMRC Acute Pain Management: Scientific Evidence Revision

It was noted that a second draft of the document would be posted on the ANZCA website for

public consultation mid-November and an advertisement placed in The Australian on 6 November 2004.

Maintenance of Professional Standards

Fellows were to be reminded that their MOPS returns are due by 28 February 2005. A random audit of MOPS returns was proposed.

Examination

Dr Ray Garrick FRACP was appointed Deputy Chairman, Examination Committee.

2004 Examination

P Briscoe reported that eighteen candidates had presented and fifteen were successful. A report on the examination will be prepared for circulation early in 2005. Dr Michael Chou, Chairman of the AFRM (RACP) Examination Committee had attended the examination as an observer.

Barbara Walker Prize for Excellence in Pain Management

The Board noted that Dr Eric John Visser, FANZCA had been awarded the Prize and congratulated him on this achievement.

Merit Awards

The Board congratulated Merit Award recipients Dr Jane Munro, FRACP Trainee and Dr Marc Russo FANZCA.

2005 Examination

Sydney was nominated as the most likely venue for the 2005 Examination.

Hospital Accreditation

The Faculty has responded to the challenges of creating opportunities for multidisciplinary experience for trainees. A new template for submission by Units is in preparation. Units will also need to submit the trainees' weekly program for scrutiny as part of their accreditation. The Board will consider a program for site reviewers

similar to the ANZCA guidelines.

Axxon Health, Qld

The Board approved Axxon Health for training for two years from the commencement of 2005.

Linking Assessment to Training

It was agreed that the Faculty should be involved in the AMC Workshop to be held on 17 and 18 March 2005.

Recognition of Pain Medicine as a Specialty

Communication had been received from ROMSAC requesting more economic data to support the FPM's application for specialty recognition and a meeting had been held in Canberra for clarification of the questions. Data and information is currently being sourced and a Workforce Survey questionnaire is proposed, which will be accompanied by a letter explaining the urgency for receiving this data. The AMC have been advised that the Faculty's response will be available by the end of January and this will go to the AMC meeting in July 2005.

2005 Auckland Annual Scientific Meeting and Refresher Course Day

Programs have been finalised and registration brochures will be circulated early in 2005.

The Faculty Dinner will be held at the Wintergarden Pavilion, Auckland. The Foundation Visitor, Professor Mark D Sullivan will be giving presentations in Brisbane on 10 and 11 May, following the ASM.

2005 IASP 11th World Congress on Pain, 21-26 August

It was agreed that the Faculty should maximise its involvement in this event with a promotional booth and other activities.

Honorary Historian

Dr John Quintner has volunteered to undertake the role of Honorary Historian for the Faculty.



FPM Trainee Awarded Prestigious NICS Fellowship



Jane Munro
Faculty of Pain Medicine
Trainee

The National Institute of Clinical Studies has awarded its 2005 Fellowship to Dr Jane Munro, from the Department of General Paediatrics at the Royal Children's Hospital in Melbourne, placing her amongst a select group of health professionals identified by NICS as emerging leaders of evidence-based health care in Australia.

Dr Munro has just completed her final year of paediatric physician training as the General Medical and Paediatric Rheumatology Fellow at the Royal Children's Hospital in Melbourne and is now doing her compulsory year towards Fellowship of the Faculty of Pain Medicine. She obtained a Merit Award at the Faculty Examination in October 2004.

During her two-year Fellowship, Dr Munro will be supported by NICS to undertake an implementation project to improve pain management in children and adolescents undergoing medical procedures such as blood tests, wound dressings and intravenous line insertions, at the Royal Children's.

Prior to applying for the NICS Fellowship, Dr Munro had travelled to a number of international centres of excellence, on a Churchill Fellowship, to look at paediatric pain management teams, leading to the development of a number of measures to introduce best practice in paediatric procedural pain management at the Royal

Children's Hospital.

Dr Munro said: "The NICS Fellowship and project is an excellent opportunity to establish alliances, work in an interdisciplinary and collaborative model, contribute to the knowledge base in a relatively new field and build capacity within my institution regarding evidence-based health care practice".

"Procedural pain management in paediatric settings has been described as the "black hole" of pain management in children," she explained. "Practice is inconsistent despite the impressive array of evidence that could be applied in this area".

Through the development of interventions that promote the adoption of evidence into practice, Dr Munro expects to see organisation practice changes around procedural pain management.

Dr Munro will investigate the barriers to proper pain relief for children and work on ways of overcoming these. She will take up her National Institute of Clinical Studies Fellowship in February, 2005.

New Items Available from the Faculty

Order forms for additional copies of the *Pain Orientated Physical Examination DVD* are available from the Faculty Office.

Australia Day Honours

The Faculty congratulates A/Prof Vic Callanan FANZCA FFPANZCA and Prof Garry Phillips FANZCA FJFICM on being appointed as Members of the Order of Australia.

Admission to Fellowship of the Faculty of Pain Medicine:

By training and examination:

Dr Eric Visser WA

By examination (A.I. 4.4)

Dr Kar Man Chan Qld

Dr Hilson Sheppard Vic

Dr Clive Sun NSW

By election:

Prof Victor Callanan Qld

FPM MOPS Program

MOPS Participants are reminded that their 2004 Annual Returns were due by the end of February

Statements of Participation have been issued to all participants who have submitted a Return

Those submitting a paper return are asked to ensure that the fields at the head of the Annual Return are completed (Name, MOPS Number, Region etc.)

Participants with an Online Diary should follow the prompts in the User Administration section of their Diary to submit their Annual Return.

Please contact Deandra Burrows at the MOPS Office if you have any difficulties

Tel: +61 3 9510 6299

Fax: +61 3 9510 6786

Email: cme@anzca.edu.au



Professional Documents

P = Professional PS = Professional Standards

PM1 (2002) Guidelines for Trainees and Departments Seeking Faculty Approval of Posts for Training in Pain Medicine

PM2 (2003) Requirements for Multidisciplinary Pain Centres Offering Training in Pain Medicine (under revision)

PM3 (2002) Lumbar Epidural Administration of Corticosteroids

PS3 (2003) Guidelines for the Management of Major Regional Analgesia

PS38 (2004) Statement Relating to the Relief of Pain and Suffering and End of Life Decisions

PS40 (2000) Guidelines for the Relationship Between Fellows and the Healthcare Industry

PS41 (2000) Guidelines on Acute Pain Management

PS45 (2001) Statement on Patients' Rights to Pain Management

PS48 (2003) Statement on Clinical Principles for Procedural Sedation

PS49 (2003) Guidelines on the Health of Specialists and Trainees

College Professional Documents Adopted by the Faculty:

PS4 (2000) Recommendations for the Post-Anaesthesia Recovery Room (*Adopted February 2001*)

PS7 (2003) Recommendations on the Pre-Anaesthesia Consultation (*Adopted November 2003*)

PS8 (2003) Guidelines on the Assistant for the Anaesthetist (*Adopted November 2003*)

PS9 (2001) Guidelines on Conscious Sedation for Diagnostic, Interventional Medical and Surgical Procedures (*May 2002*)

PS10 (2004) The Handover of Responsibility During an Anaesthetic (*Adopted February 2001*)

PS15 (2000) Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery with amendment to the title to read Recommendations for the Perioperative Care of Patients Selected for Day Care Procedures (*Adopted February 2001*)

PS18 (2000) Recommendations on Monitoring During Anaesthesia (*Adopted February 2001*)

PS20 (2001) Recommendations for Responsibilities of the Anaesthetist in the Post-Operative Period (*Adopted February 2001*)

PS31 (2003) Recommendations on Checking Anaesthesia Delivery Systems (*Adopted July 2003*)

Joint Faculty of Intensive Care Medicine

Dean's Message

Kia Ora (greetings),

I trust you all had a splendid festive season. I have just had the opportunity to visit the Western and South Australian Regional Committees and am impressed with the contributions made by our Fellowship through these avenues. I was also able to visit a number of ICUs and talk to the Fellows about ongoing issues. It is very important that the JFICM Board keeps the communications open to both the Committees and individuals within our Fellowship. From time to time the Board receives personal letters from Fellows that are taken seriously, often being debated at Board level. We encourage your input.

Trainees

It is interesting to note the recent Trainee statistics. We now have 524 registered active Trainees. Twenty four percent are female. Nearly forty percent of these are training only for the FJFICM, although the majority of these will have already completed other specialist programs. Thirty four percent are attempting a dual FANZCA and FJFICM, 11% a dual FRACP and FJFICM and 15% a dual FACEM and FJFICM. Accurate statistics are difficult in view of the great proportion of trainees undertaking dual certification – although active, they may spend up to two-three years in their 'primary' specialty, whilst still registered with the Joint Faculty. However, it is obvious that the demography is changing and the numbers are encouraging. The motivation for a separate Primary Examination is partly in response to these figures. It is important to note that the Trainees will still be able to "qualify" for entry into the Advanced Training posts from most of the main Primary examinations, and the new JFICM Primary will not be an "exclusive" entry qualification. Incidentally, we will be looking for experienced Fellows who may be eligible to examine for the JFICM Primary, and if you are interested, please let our Executive Officer know.

Rural Issues

It has been pleasing to note the establishment of a Conjoint Rural Committee which reports to both the JFICM and ANZICS Boards. Duties include investigating ways to:

- a) attract FJFICM intensivists to rural practice
- b) better support intensivists in rural practice
- c) allow ICU training in rural ICUs
- d) facilitate CME in rural environments

In the past, rural issues have come to the fore from time to time but we have never had a formal structure to deal with these. I am sure this has resulted in frustration for our rural colleagues. The Committee has been convened by Steve Edlin and is to be chaired by John Lambert. It is composed of a JFICM Board member, an ANZICS Board member, an ACEM nominee, and 5 other rural representatives. The first meeting has been held and objectives set. Issues which Fellows or Trainees may have can be communicated via the Faculty Office and will be relayed to the Committee. Our thanks go to the ANZICS Board who have helped facilitate the process and are providing the secretariat. This is a good example of how JFICM and ANZICS are working constructively together. More detail is offered elsewhere in this Bulletin.

Hours of Work

Over recent years there has been increasing pressure to reduce hours of work that junior staff are allowed to do. While no one wants to go back to the "bad old days", it would seem that the evidence base to support some of the recent developments does not exist. There is an industry of groups talking about "safe hours", including the AMA – usually referring to safety for patients. This is partly driven by workforce awards that seem to be strenuously negotiated by representatives of junior staff groups, sometimes without support from the junior staff themselves. Also there is a lobby of sleep and occupational health experts and others who

continually extrapolate doubtful results as though they apply to the medical workforce and patient safety.

The above factors mean that intensive care registrars will soon be working to much shorter shift models and have far less hands-on experience. There will be less work satisfaction, and patients will increasingly lack continuity of care. As the registrars move on to become consultants, they may carry the same culture of work with them. This has profound implications for the way we work in intensive care. It may also mean that we have to extend training time to gain adequate experience in an environment when Government agencies are trying to shorten the time. It certainly means that there will have to be a vastly increased labour force.

In discussions with Trainees and various registrars at the end of their training, many perceive that the present trends are likely to disadvantage them. For instance, Trainees would rather work longer blocks of time with adequate time off between.

Senior Registrar Positions

Last year after much debate, the Regulations were amended to require Trainees to work in a "Senior Registrar" position for at least six months of their training. A senior registrar implies some longitudinal call i.e. across normal shifts, to learn to give continuity of call, at least for 24 hours. It also implies acting as an "acting senior" to the normal registrars and other junior staff. The idea is to train registrars to take responsibility in a way that they will shortly have to do as consultants.

We have been in discussions with a number of the bigger Units who employ registrars in mainly 12-15 hour shift patterns. Some of them would find it difficult with their current roster patterns, and we are running up against the newer award restrictions.



However, most ICUs still provide these positions. Trainees who have worked as "acting seniors" are universally commendatory and grateful for the experience. They learn when to stay and when to leave the ICU, and how to quickly synthesise material given to them by another registrar. They learn to think longer than one shift. In fact, they learn some of the essential responsibilities involved in becoming a consultant.

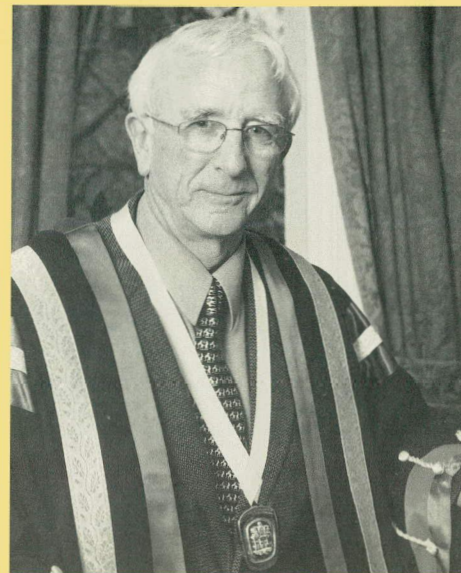
It is worth pointing out that if Senior Registrar positions cannot be accommodated in some of the major units, the smaller units would be grateful to have such trainees and give them excellent experience. Also this time may be fulfilled during the Advanced Training Elective year, and does not impede Trainees spending their Advanced Training Core years in major units.

ASM Meetings

Our first stand alone JFICM meeting is to be held in June and promises to be very exciting and will provide state of the art knowledge on neurosurgical issues. John Myburgh and his team have worked hard to produce an excellent program.

Fellows are also urged to attend the May ANZCA/JFICM/NZ ANZICS meeting in Auckland. That is also shaping up to be a very good program.

Jack Havill





JFICM ASM 2005, in association with ANZICS

Neurointensive Care: The Road Ahead

We are very excited about the historic, inaugural stand alone JFICM ASM to be held in Sydney from June 10 – 12 2005.

The two and a half day meeting is structured as a single theme meeting on all aspects of neuro-intensive care. We have finalised the program which is now present on the JFICM website at <http://www.jficm.anzca.edu.au/asm/>.

An exceptional international and national faculty will provide a state-of-the-art review of all aspects including traumatic brain injury, subarachnoid haemorrhage, stroke syndromes, acute spinal injury, research and ethics. In addition, we will be producing a handbook of monographs of all plenary lectures that will be included in the registration fee.

In addition to the scientific program, there will be two poster-oral presentations, which will include a session for trainees for consideration of the inaugural Felicity Hawker Medal for the best Formal Project prize. There will also be Supervisor of Training workshop and the annual general meeting of the JFICM.

An exciting social program is planned in the most beautiful of cities, including the first stand-alone admission ceremony for JFICM graduands. This will be a unique opportunity for newly qualified intensivists. Friday night promises to be "quintessential Sydney" and the meeting will precede the Queen's birthday weekend, allowing visitors to extend their visit to Sydney and beyond.

Make a note now of this meeting and plan your trip – be part of a new and exciting initiative for the speciality!!

ANZCA ASM 2005, Auckland

In association with ANZICS New Zealand

This year the JFICM meeting with ANZCA will take place on Monday 9th to Wednesday 11th May in Auckland. Our colleagues in New Zealand have developed a stimulating scientific program, which features Professor Keith Walley, who will speak on *The Heart in Sepsis* for the 2005 Foundation Visitor's Lecture. Other invited Speakers include Professor John Murkin of the University of Western Ontario, and Dr Jacques Creteur who will deliver the ANZICS New

Zealand Lecture 'pCO₂ Monitoring to Elevate Tissue Oxygenation'. Perfusion in shock, epidemics and terrorism, cerebral protection post cardiac surgery are also included. Workshops covering echocardiography plus other more generic topics will also be offered to delegates. The Intensive Care dinner will be held at the Tea Room at the Heritage Auckland Hotel. A ferry cruise to Waiheke Island, MRX match racing or the Grand Prix race day are other enticements to the City of Sails.

www.asm2005.com

J.A. Myburgh
ASM Officer

CHANGES TO THE REGULATIONS – the Medical ADAPT Course and format of the Fellowship Examination

Regulation 7.4 is a summary of training requirements, and has been amended to include completion of the Medical ADAPT Course as a component of training. Regulation 7.4.10 has been inserted:

7.4.10 Medical ADAPT Course

Trainees registering for training from 1st November 2004 are required to complete the Medical ADAPT Course prior to being granted Fellowship.

with Regulation 7.4.10 be renumbered as 7.4.11

Regulation 7.7 regarding the format of the Fellowship Examination has been amended to read

Content

7.7.11 The subjects for the Fellowship Examination will be the theory and practice of intensive care medicine, including relevant aspects of the basic sciences, anaesthesia and clinical medicine.

7.7.12 The examination comprises written and oral sections. The written section may be taken in cities of Australia and New Zealand or other areas at the discretion of the Board. The oral sections will be held in a capital city in Australia or New Zealand at the discretion of the Board.

Regulations 7.7.12.1, 7.7.12.2 and 7.7.12.3 have been deleted.



Honours

Congratulations are offered to the following Fellows of the Joint Faculty for the recognition of their achievements:

Associate Professor V.I. Callanan, AM,
Member of the Order of Australia

Dr J.H. Havill, ONZM, Officer of the New Zealand Order of Merit, New Zealand New Year Honour's 2005

Professor G.D. Phillips, AM, Member of the Order of Australia

Dr R.F. Raper, John Sands Medal, RACP Award



Rural Intensive Care

What's happening?

It is becoming increasingly recognized that rural Intensive Care practice, as well as having many attractions, has many limitations and frustrations. Over the last few years these difficulties have been discussed at regional and national meetings and more recently by the application of the new rural e-mail list.

The Joint Faculty and ANZICS have recently collaborated and formed a Conjoint Rural Committee to try and address rural issues, the most recurrent major themes seeming to be staffing issues and continuing education. The Conjoint Rural Committee had its first meeting in late November. The members of the Committee are Mike Corkeron (ANZICS representative) from Townsville, Queensland, Steve Edlin (JFICM Rural Focus Officer) from Perth, Western Australia, Craig Hore from Port Macquarie, NSW, Gerard McHugh from Palmerston North, NZ, John Lambert from Orange, NSW, Ross Freebairn from Hawke's Bay, NZ, Di Stephens from Darwin, NT (with Paul Goldrick as her locum while she is away on manoeuvres), and Marcus Skinner from Tasmania.

At the first meeting, John Lambert was nominated and unanimously elected as chairman. The Draft Terms of Reference were ratified, these being (a) investigating ways to attract FJFICM intensivists to rural practice (b) investigating ways to better support FJFICM and non-FJFICM intensive care practitioners in rural practice (c) investigating ways to allow intensive care training in rural ICUs and (d) to facilitate CME in rural areas.

The objectives of the group will be

- to try to encourage and enable doctors to do part of their intensive care training in rural areas, noting that frequently, trainees will return to these areas as specialists.
- the modelling of a system where every metropolitan hospital has a rural location to rotate through and for it to be actively used; looking at how rural problems are being managed in other parts of the world. Communication will be made initially with the

Canadian Intensive Care Authorities to see how rural intensive care issues are being addressed there.

- acknowledgement of the fact that many rural intensive care units are being staffed by non intensive care trained specialists and that they are doing an excellent job; this committee feels that it represents them as well.
- a need to encourage metropolitan hospitals to give better feedback about the care of patients transferred to them from rural practitioners, so that continued learning occurs.
- to encourage the making of rural training appealing to trainees.
- developing guidelines for standards of care in rural intensive care practice.
- developing guidelines for rural employers about minimal workforce issues.
- lobbying at national level to get adequate funding in rural areas.

The Mike Cowdroy Regional and Country ICU Trust Fund, (see page 45 of this issue of The Bulletin), was discussed and the decision to encourage rural intensive care nurses was made by means of funding them to attend the ACCCN/ANZICS annual meeting.

Steve Edlin
Rural Focus Officer

Supervisors of Training in Intensive Care

The following have been appointed as Supervisors of Training:

Dr P. Goldrick

Royal Darwin Hospital

Dr P.D. Cooper

Royal Hobart Hospital

Dr David Evans

Royal Adelaide Hospital

Dr Marc Ziegenfuss

Prince Charles Hospital

Admission to Fellowship of the Joint Faculty of Intensive Care Medicine

The following have completed all requirements for admission:

Admission to Fellowship by examination under Regulation 5.1:

Anthony Martin Cross

Vic

Admission to Fellowship by OTS Assessment, under Regulation 5.2:

Jorge Luis Brieua

NSW



The Mike Cowdroy Regional and Country ICU Trust Fund

The MIKE COWDROY REGIONAL AND COUNTRY ICU TRUST FUND was set up as a result of the tragic death of Mike Cowdroy, a 33 year old who, despite completing a Commerce course at the University of New South Wales, was following his dream and pursuing success in Country Music. He was a songwriter and guitarist in the band 'Southbound' which had been nominated as one of the 5 finalists for a 'Golden Guitar' at the Tamworth Country Music festival.

He was involved in a car crash on his way to a band engagement in Tamworth in October 2003. He was initially treated in the intensive care unit of Tamworth Base Hospital then transferred to John Hunter Hospital, Newcastle where he subsequently died from his injuries. 6 people benefited from the decision to donate Mike's organs. His parents, Peter and Annie were highly thankful of the care given to their son in these intensive care units and asked that, instead of floral tributes, money was donated to be used to further rural and regional intensive care in Australia. Thus the Mike Cowdroy Trust Fund came into existence.

Already a fair amount of money has been put into this fund. The Conjoint Rural Committee was asked to decide on ways that this money could be used to promote and help rural and regional intensive care practice in Australia. After due discussion, it has been decided to recommend using the interest from this Trust Fund to help a

nurse from a rural / regional setting present a paper, poster or project at the annual ANZICS/ACCCN meeting. This would help pay for travel, accommodation and registration to the meeting. If there were more than one applicant, the committee would be the judge of the best presentation.

On 18th January 2005, Mike's father Peter was at the Tamworth Country Music Festival where the Songwriting Award has been named after Mike. He presented the prize to the winners and used it as a forum to give more publicity to the Trust and its future use.

It is hoped that with time, more publicity and more donations for this Trust fund, more use might be made of it in the future for rural intensive care issues. (Contributions are encouraged and can be made by cheque payable to The Mike Cowdroy Regional & Country ICU Trust Fund, to The Trustees, Mike Cowdroy R & C ICU Trust Fund, 77A Telegraph Rd, Pymble NSW 2073.

Steve Edlin

on behalf of The Conjoint Rural Committee.

Review Policy Documents

The following policy documents and joint statements are due for review during 2005. Fellows are invited to forward comments to the JFICM Executive Officer.

- IC-2 Duties of an IC specialist
- IC-4 Supervision of Trainees
- IC-7 Secretarial Services
- IC-8 Quality Assurance
- PS 40 Guidelines for the Relationship between Fellows and the Healthcare Industry

Documents can be accessed at:
www.jficm.anzca.edu.au/publications/policy/index.htm

The G.A. (Don) Harrison Medal for 2004

In October 2004 the Board of the Joint Faculty awarded the G.A. (Don) Harrison Medal for 2004 to Dr Carole Foot from Queensland.

This medal was established by the Faculty of Intensive Care in 1994 and is awarded to the candidate who achieves the highest mark in the calendar year provided that the candidate's performance is of sufficient merit.

Dr Foot is a Fellow of the Australasian College for Emergency Medicine who is currently completing her intensive care training at The Prince Charles Hospital having previously trained in intensive care at the Princess Alexandra Hospital.

The Board wishes to congratulate Dr Foot on her outstanding performance at the April/May 2004 Fellowship Examination.





Joint Faculty of Intensive Care Medicine

Policy Documents

IC-1 (2003) Minimum Standards for Intensive Care Units

IC-2 (2000) The Duties of an Intensive Care Specialist in Hospitals Accredited for Training in Intensive Care

IC-3 (2003) Guidelines for Intensive Care Units seeking Accreditation for Training in Intensive Care Medicine

IC-4 (2000) The Supervision of Vocational Trainees in Intensive Care

IC-5 (1995) Withdrawn

IC-6 (2002) The Role of Supervisors of Training in Intensive Care Medicine

IC-7 (2000) Secretarial Services to Intensive Care Units

IC-8 (2000) Quality Assurance

IC-9 (2002) Statement on the Ethical Practice of Intensive Care Medicine

IC-10 (2003) Minimum Standards for Transport of the Critically Ill

IC-11 (2003) Guidelines for the In-Training Assessment of Trainees in Intensive Care Medicine

IC-12 (2001) Examination Candidates Suffering from Illness, Accident or Disability

IC-13 (2002) Recommendations on Standards for High Dependency Units Seeking Accreditation for Training in Intensive Care Medicine

IC-14 (2004) Statement on Withholding and Withdrawing Treatment

IC-15 (2004) Recommendations of Practice Re-entry for an Intensive Care Specialist

PS38 (2004) Statement Relating to the Relief of Pain and Suffering and End of Life Decisions

PS39 (2003) Minimum Standards for Intrahospital Transport of Critically Ill Patients

PS40 (2000) Guidelines for the Relationship Between Fellows and the Healthcare Industry

PS45 (2001) Statement of Patient's Rights to Pain Management

PS48 (2003) Statement on Clinical Principles for Procedural Sedation

PS49 (2003) Guidelines on the Health of Specialists and Trainees



Professional Document: Review TE7 (2005)

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

Guidelines for Secretarial and Support Services to Departments of Anaesthesia

Introduction

All Departments of Anaesthesia require assistance from secretarial and support services to allow the medical, nursing and technical officers within the Department to perform their duties effectively. For those Departments approved for College trainees, the secretarial, administrative and educational support needed will require the appointment of appropriate staff within the Department. The number of such staff should be adequate to fulfil all required duties. For large Departments, more than one full-time secretarial staff member may be required.

Duties of Secretarial and Support Staff

The duties of secretarial and other support staff will fall into three main areas: individual support, departmental administrative support and departmental educational support.

1. Individual Support Duties Include:

Provision of general secretarial services to individual specialists, trainees and other members of the Department, including the handling of correspondence, filing, appointments, telephone answering and mail.

Assistance with the operation of computer based information and data processing services.

2. Administrative Support Duties Include:

Preparation, circulation and updating of departmental duty rosters, maintenance of departmental and medical records and general administration.

Preparation and distribution of operating lists and facilitation of the deployment of medical officers for their service and other requirements.

3. Educational Support Duties Include:

3.1 Co-ordination of the administrative aspects of continuing medical education, clinical review, research and quality assurance activities.

- 3.2 Preparation and distribution of material for departmental meetings, including tutorials, peer review, clinical audit and quality assurance meetings.
- 3.3 Facilitation of correspondence between the College, trainees and Supervisors of Training. See College Professional Document TE5 Policy for Supervisors of Training in Anaesthesia.
- 3.4 Maintenance of the departmental library including books, journals, and other audio-visual material and preparation of visual display material.
- 3.5 Provision of secretarial and administrative assistance to the Supervisors of Training and Module Supervisor(s) in the performance of their duties (see College Professional Documents TE2 – Policy on Vocational Training Modules and Module Supervision, and TE5 – Policy for Supervisors of Training in Anaesthesia).

4. Other Responsibilities:

Depending on other facilities and support at the hospital, secretarial assistance may be required for performance of literature searches, photocopying and circulation of documents from within the department, other departments of the hospital and other libraries.

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T Technical

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

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Promulgated:(as E7): 1989
 Reviewed: 1994, 1999
 Date of current document: Feb 2005

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College Website: www.anzca.edu.au



Professional Document: Review TF9 (2005)

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

Guidelines on Quality Assurance in Anaesthesia

1. Introduction

- 1.1 Quality Assurance can be defined as “an organised process that assesses and evaluates health services to improve practice or quality of care”. Quality Improvement is a term often used to encapsulate the concept of a “cycle of quality” described in section 2.
- 1.2 The objective of Quality Assurance programs is to ensure that high standards of clinical practice are maintained through regular assessments. The results of such assessments should be evaluated and actioned as necessary.
- 1.3 All anaesthetists and trainees should participate in Quality Assurance programs, including regular attendance at QA meetings.
- 1.4 Quality Assurance programs must evaluate clinical care to ensure consistency with accepted professional standards, including relevant professional documents issued by the College.

2. Process of Quality Assurance Programs

Steps in a Quality Assurance program can be considered as *Planning, Implementation, Review, and Setting Standards*. The steps are repeated continually or at appropriate intervals for on-going Quality Assurance programs.

- 2.1 *Planning* involves careful design and preparation of a project, such as defining the topic to be evaluated and the data to be collected, and methods to collect and analyse data.
- 2.2 *Implementation* involves collection and data analysis, review of results, and determining action to be taken, i.e. to:
 - 2.2.1 Monitor and evaluate the quality and appropriateness of patient care.
 - 2.2.2 Identify areas of deficiency or risk (risk is defined as a chance of injury or adverse consequence).

- 2.2.3 Implement changes where necessary and monitor any changes made, including the safe implementation of new methods of treatment.

- 2.3 *Review* involves monitoring the outcome of changes introduced from 2.2.3 to “close the loop”. Showing the outcome or impact of a Quality Assurance program on health care is an important component of the program.

- 2.4 *Setting Standards* involves writing the improvements achieved into new official regulations, guidelines, or standards.

3. Quality Assurance Programs

Quality Assurance Programs may include.

- 3.1 Anaesthesia Service Structure and Performance: the overall performance and resources of the Service in comparison with accepted criteria (such as ANZCA policies and guidelines) and those of other equivalent Services in the region. These include:
 - 3.1.1 Staff
 - 3.1.1.1 Numbers and qualifications.
 - 3.1.1.2 Criteria and process of selection and appointment.
 - 3.1.1.3 Workload, allocation of work and supervision.
 - 3.1.1.4 Participation in educational activities including teaching, research and quality assurance.
 - 3.1.2 Physical Facilities
 - 3.1.2.1 Equipment, including compliance with standards, maintenance and replacement.
 - 3.1.2.2 Service space.
 - 3.1.2.3 Facilities for teaching, education, and research.

- 3.1.3 Management, including budgets, expenditure, and cost effectiveness.

- 3.2 Criteria-based audit: performance evaluation according to predetermined criteria (usually reported outcomes of peer groups). In areas without published criteria, new criteria can be established by original study or a consensus of peers. Performance in relation to ANZCA Clinical Indicators is an example of a criteria based audit

- 3.3 Clinical Guidelines, Policies, or Protocols: recommended methods of clinical practice. Anaesthetists should check for compliance with guidelines, policies, or protocols and regularly review them.

- 3.4 Critical Incidents: voluntary reports by staff on events that led to, or could have led to an adverse outcome in patients or staff members. A program must analyse the incidence, causes, contributing and mitigating factors, and outcome of critical incidents (see paragraph 3.8, root cause analysis). Strategies for improvement should be recommended. An evaluation of outcome from implementing changes is expected.

- 3.5 Risk Management: actions to reduce risks to patients and staff in anaesthesia. A Risk Management program undertakes identification of risks, assessment of risk factors, and control of risks.

- 3.6 Peer Reviews: evaluation of clinical performance by peers. Areas to review include communication with patient and relatives, patient selection, anaesthesia techniques, monitoring and investigations used, record keeping, perioperative care, and patient follow up and outcome. Main methods are:
 - 3.6.1 Participation in mortality and morbidity meetings.
 - 3.6.2 Reviews of randomly selected cases.



3.6.3 Practice review of an anaesthetist by a peer.

3.7 Patient Surveys: satisfaction surveys of patients. A program could survey satisfaction with communication, managing relatives, anxiety alleviation, informed consent, pain management, and anaesthesia procedures rendered. Issues such as confidentiality and patient anonymity should be addressed.

3.8 Root cause analysis: analysis of systems errors associated with anaesthesia and peri-operative care including pain management, with participation in institutional QA activities focusing on root cause analysis.

3.9 Reporting to external national and (Australian) State/Territory programs including:

3.9.1 Mortality, and Mortality and Morbidity Committees.

3.9.2 Adverse Reactions Committees.

3.9.3 Sentinel Events Programs.

3.9.4 Critical Incident Reviews.

3.10 Audit of QA programs: Quality Assurance Programs should be reviewed extensively from time to time to ensure that remedial steps are taken wherever problems are identified and that continued review follows.

4. Quality Assurance Resources

4.1 Formally constituted Departments of Anaesthesia should appoint a Quality Assurance Co-ordinator normally for a period of two years, with eligibility for re-appointment. The QA Co-ordinator will be responsible for the implementation and supervision of the Quality Assurance programs. Appropriate time and secretarial and other support should be allocated to this Co-ordinator.

4.2 The Quality Assurance Co-ordinator should ensure that the above College guidelines are implemented within the limits of the size of the Department.

4.3 Anaesthetists who work outside a formally constituted Department of Anaesthesia should participate in an appropriate Quality Assurance program.

4.4 Sufficient resources of people, time and support should be available for all anaesthetists and trainees to participate fully in QA programs.

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Promulgated:	1983
Reviewed:	1987, 1993, 1999
Date of current document	Feb 2005

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College Website: www.anzca.edu.au



Professional Document: Review PS28 (2005)

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

Guidelines on Infection Control in Anaesthesia

1 Introduction

In order to ensure that the practice of anaesthesia is as safe as possible for patients, anaesthetists and other health care workers it is imperative that infection risks to all parties be minimised.

It is impossible to issue guidelines which if observed would ensure that infection was never transmitted via anaesthetic apparatus. What follows are guidelines based on current understanding of the risks of such transmission. In certain clinical situations there may be a need to adopt more stringent practices. These guidelines should be considered with documents on this subject issued by other Authorities.

2. Definitions

Decontamination: The removal of micro-organisms and unwanted matter from contaminated materials or living tissue.

Disinfection: The inactivation of non-spore forming micro-organisms using either thermal or chemical means.

Sterilisation: Complete destruction of all micro-organisms, including spores.

Asepsis: The prevention of microbial contamination of living tissues or sterile materials.

For disinfection or sterilisation to occur there must have been previous thorough decontamination.

For technical aspects of these procedures the reader is referred to the Code of Practice for Cleaning, Disinfecting and Sterilising Reusable Medical and Surgical Instruments and Equipment, and Maintenance of Associated Environments in Health Care Facilities (AS/NZS 4187, 4815, or equivalent protocol).

3. Minimisation of Infection Risk to Patients

Measures to protect patients against acquiring infections through anaesthesia procedures need to address (i) risks related to invasive procedures; (ii) risks or potential risks related to airway

management. In both situations appropriate levels of sterility, disinfection and decontamination are to be applied to all equipment used. A microbiologist should be consulted about any matters requiring clarification with local application of this policy.

Handwashing by the anaesthetist and the anaesthetic assistant is the most important infection control measure. Hands should be washed before touching a new patient or equipment to be used on a new patient, after leaving a patient, whenever they become contaminated and before any invasive procedure. Gloves are to be removed after procedures to minimise contamination of the work place. Hands should be washed before and after use of gloves.

3.1 Invasive Procedures

Invasive procedures are to be performed with aseptic technique.

3.1.1 Vascular Cannulation

The cannulation site is a potential portal of entry of micro-organisms into the subcutaneous tissues and circulation. The anaesthetist's hands must be washed and protective gloves should be worn. The skin should be disinfected with an appropriate preparation prior to cannulation being performed in a manner which ensures that the tip and shaft of the cannula remain sterile.

3.1.2 Central Vascular Cannulation

The insertion of central venous and pulmonary artery catheters carries added infection hazards for the patient. Cannulation of central veins is to be performed using full aseptic technique including the wearing of facemask, sterile gown and gloves, and the use of a sterile field bordered by sterile drapes is required.

3.1.3 Regional Anaesthesia

When regional blocks are being

performed, the hands should be washed and gloves worn, the skin should be disinfected with a suitable preparation and the procedure done in such a way that the needle remains sterile. When a spinal or epidural block is being performed, and when a regional anaesthesia catheter is to be left indwelling, full aseptic technique including the wearing of facemask, sterile gown and gloves, and the use of a sterile field bordered by sterile drapes is required.

3.2 Anaesthetic Apparatus

The following measures are intended to minimise the risk of transmission of infection in the respiratory tract via anaesthetic equipment. This policy does not address the processing of equipment during long term ventilation.

3.2.1 Disposable Items

Items of airway equipment to be placed in direct contact with the respiratory tract such as endotracheal tubes and airways labelled by the manufacturer as disposable or for single use only should not be reused.

3.2.2 Devices to be sited in the upper airway

Devices passing through the mouth or nose will become contaminated in the upper airway. Endotracheal tubes, nasal and pharyngeal airways should be kept sterile until used.

Reusable face masks must be thoroughly decontaminated and then undergo disinfection prior to each use. Items to be placed in the upper airway which may cause bleeding e.g. laryngoscope blades and temperature probes, must be disinfected before reuse. It is not ordinarily necessary to package these items separately while they await their next use. Where the manufacturer advises



that a particular piece of equipment is to be sterilised before use, e.g. the laryngeal mask, that advice is to be followed. Laryngoscope handles should be decontaminated between uses.

There should be separation of unused items and soiled items during use.

3.2.3 The Breathing Circuit

For each patient the breathing circuit should have been sterilised, or decontaminated and disinfected or protected by the use of appropriately positioned new filters. When a filter is used it is recommended that disposable items between the patient and the filter be disposed of and non-disposable items, including in-line measurement devices, be decontaminated and disinfected prior to reuse.

3.2.4 Sampling Lines for Side Stream Gas Analysis

These need not ordinarily be sterilised before reuse because of the one way flow of gas through them. Sampled gas from a capnograph or other such measurement device should not be returned to the anaesthetic circuit unless it is first passed through a viral filter.

3.2.5 Carbon Dioxide Absorbers

When a filter is used in the circuit as described in 3.2.3 above, sterilisation of the carbon dioxide absorber prior to every case is not necessary nor with most models is it practicable although disposable versions and models capable of being sterilised are available. The device including the unidirectional valves should be disinfected regularly.

3.2.6 Ventilator Circuits and Bellows

These items should be cleaned and disinfected regularly.

3.2.7 Flexible Laryngoscopes and Bronchoscopes

The College endorses the policy on the care and handling of these instruments and accessory equipment laid down in the appropriate National Standard. High level disinfection is the minimum level of processing required.

3.3 Presentation of Drugs for Injection

Because of the potential for cross infection, incompletely used ampoules, vials and syringes must be discarded after each patient use.

3.4 Patient Factors

In immunosuppressed or immune deficient patients to whom infection poses a particular threat, there may be reason to apply more stringent practices than those outlined.

4. Prevention of Infection of Health Care Workers

4.1 Health care workers should protect themselves from exposure to blood or body substances by wearing gloves, protective eyewear or face shields, masks, gowns and/or plastic aprons when there is potential for splashing, splattering or spraying of blood or body substances.

4.2 Sharps must be handled with care at all times, disposed of safely immediately following use, and not be resheathed, bent, broken or manipulated by hand.

4.3 Any person exposed to a needlestick or other blood or body fluid incident should access and follow the protocol for this in the institution in which it occurs. This includes having a medical evaluation with particular reference to the risk of infection with HIV, HBV or HCV. The Australian National Council on AIDS, Hepatitis C and Related Diseases has published a comprehensive Bulletin for the management of exposure to blood and body fluids contaminated with blood, including needlestick/sharp injuries. It is available at www.ancard.org/pubs/index.htm#bulletins

4.4 Vaccination recommendations for health care workers are contained in the most recent edition of the Australian Immunisation Procedures Handbook. It is available at www.1.health.gov.au/immhandbook diseases, or www.immunise.health.gov.au.

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 Reviewed: 2004
 Date of current document Feb 2005

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Australian and New Zealand College of Anaesthetists

Professional Documents

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

- TE1 (2003) Recommendations for Hospitals Seeking College Approval for Vocational Training in Anaesthesia *Despatched with August 2003 Bulletin*
- TE2 (2003) Policy on Vocational Training Modules and Module Supervision *Despatched with August 2003 Bulletin*
- TE3 (2003) Policy on Supervision of Clinical Experience for Vocational Trainees in Anaesthesia *Despatched with August 2003 Bulletin*
- TE4 (2003) Policy on Duties of Regional Education Officers in Anaesthesia *Despatched with August 2003 Bulletin*
- TE5 (2003) Policy for Supervisors of Training in Anaesthesia *Despatched with August 2003 Bulletin*
- TE6 (2000) Guidelines on the Duties of an Anaesthetist *Bulletin July 2000, pg 86*
- TE7 (2005) Guidelines for Secretarial and Support Services to Departments of Anaesthesia *Bulletin February 2005, pg 56*
- TE8 (2003) Guidelines for the Learning Portfolio for Trainees in Anaesthesia *Despatched with August 2003 Bulletin*
- TE9 (2005) Guidelines on Quality Assurance in Anaesthesia *Bulletin February 2005, pg 57*
- TE10 (2003) Recommendations for Vocational Training Programs *Despatched with August 2003 Bulletin*
- TE11 (2003) Formal Project Guidelines *Bulletin November 2003, pg 92*
- TE13 (2003) Guidelines for the Provisional Fellowship Program *Despatched with August 2003 Bulletin*
- TE14 (2001) Policy for the In-Training Assessment of Trainees in Anaesthesia *Bulletin November 2001, pg 84*
- TE17 (2003) Policy on Advisors of Candidates for Anaesthesia Training *Despatched with August 2003 Bulletin*
- TE18 (2000) Guidelines for Assisting Trainees with Difficulties *Bulletin March 2001, pg 76*
- EX1 (2001) Policy on Examination Candidates Suffering from Illness, Accident or Disability *Bulletin November 2001, pg 75*
- T1 (2000) Recommendations on Minimum Facilities for Safe Anaesthesia Practice in Operating Suites *Bulletin March 2001, pg 68*
- T2 (2000) Recommendations on Minimum Facilities for Safe Anaesthesia Practice outside Operating Suites *Bulletin March 2001, pg 72*
- PS1 (2002) Recommendations on Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia *Bulletin November 2002, pg 78*
- PS2 (2001) Statement on Credentialling in Anaesthesia *Bulletin March 2002, pg 65*
- PS3 (2003) Guidelines for the Management of Major Regional Analgesia *Bulletin March 2003, pg 70*
- PS4 (2000) Recommendations for the Post-Anaesthesia Recovery Room *Bulletin November 2000, pg 72*
- PS6 (2001) Recommendations on the Recording of an Episode of Anaesthesia Care (the Anaesthesia Record) *Bulletin November 2001, pg 77*
- PS7 (2003) Recommendations on the Pre-Anaesthesia Consultation *Bulletin November 2003, pg 87*
- PS8 (2003) Guidelines on the Assistant for the Anaesthetist *Bulletin November 2003, pg 89*
- PS9 (2001) Guidelines on Conscious Sedation for Diagnostic, Interventional Medical and Surgical Procedures *Bulletin June 2001, pg 88*
- PS10 (2004) Guidelines on the Handover of Responsibility During an Anaesthetic *Bulletin November 2004, pg 79*



- PS12 (2001) Statement on Smoking as Related to the Perioperative Period *Bulletin* November 2001, pg 79
- PS14 (1998) Guidelines for the Conduct of Major Regional Analgesia in Obstetrics *Bulletin* November 1998, pg 81
- PS15 (2000) Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery *Bulletin* November 2000, pg 75
- PS16 (2001) Statement on the Standards of Practice of a Specialist Anaesthetist *Bulletin* November 2001, pg 81
- PS18 (2000) Recommendations on Monitoring During Anaesthesia *Bulletin* November 2000, pg 78
- PS19 (2001) Recommendations on Monitored Care by an Anaesthetist *Bulletin* November 2001, pg 82
- PS20 (2001) Recommendations for Responsibilities of the Anaesthetist in the Post-Operative Period *Bulletin* November 2001, pg 83
- PS21 (2003) Guidelines on Conscious Sedation for Dental Procedures *Bulletin* June 2003, pg 93
- PS24 (2004) Guidelines on Sedation for Gastrointestinal Endoscope Procedures *Bulletin* August 2004, pg 66
- PS26 (1999) Guidelines on Providing Information about the Services of an Anaesthetist *Bulletin* November 1999, pg 63
- PS27 (2004) Guidelines for Fellows who Practice Major Extracorporeal Perfusion *Bulletin* February 2004, pg 66
- PS28 (2005) Guidelines on Infection Control in Anaesthesia *Bulletin* February 2005, pg 59
- PS29 (2002) Statement on Anaesthesia Care of Children in Healthcare Facilities without Dedicated Paediatric Facilities *Bulletin* November 2002, pg 90
- PS31 (2003) Recommendations on Checking Anaesthesia Delivery Systems *Bulletin* August 2003, pg 85
- PS37 (2004) Statement on Local Anaesthesia and Allied Health Practitioners *Bulletin* February 2004, pg 69
- PS38 (2004) Statement Relating to the Relief of Pain and Suffering and End of Life Decisions *Bulletin* November 2004, pg 80
- PS39 (2003) Minimum Standards for Intrahospital Transport of Critically Ill Patients *Bulletin* June 2003, pg 90
- PS40 (2000) Guidelines for the Relationship Between Fellows and the Healthcare Industry *Bulletin* March 2000, pg 55
- PS41 (2000) Guidelines on Acute Pain Management *Bulletin* November 2000, pg 80
- PS42 (2000) Recommendations for Staffing of Departments of Anaesthesia *Bulletin* March 2001, pg 63
- PS43 (2001) Statement on Fatigue and the Anaesthetist *Bulletin* March 2002, pg 69
- PS44 (2001) Guidelines to Fellows Acting on Appointments Committees for Senior Staff in Anaesthesia *Bulletin* March 2002, pg 71
- PS45 (2001) Statement on Patients' Rights to Pain Management *Bulletin* March 2002, pg 72
- PS46 (2004) Recommendations for Training and Practice of Diagnostic Perioperative Transoesophageal Echocardiography in Adults *Bulletin* February 2004, pg 70
- PS47 (2002) Guidelines for Hospitals Seeking College Approval of Posts for Vocational Training in Diving and Hyperbaric Medicine *Bulletin* November 2002, pg 82
- PS48 (2003) Statement on Clinical Principles for Procedural Sedation *Bulletin* June 2003, pg 97
- PS49 (2003) Guidelines on the Health of Specialists and Trainees *Bulletin* August 2003, pg 89
- PS50 (2004) Recommendations on Practice Re-entry for a Specialist Anaesthetist *Bulletin* February 2004, pg 73