Australian and New Zealand College of Anaesthetists

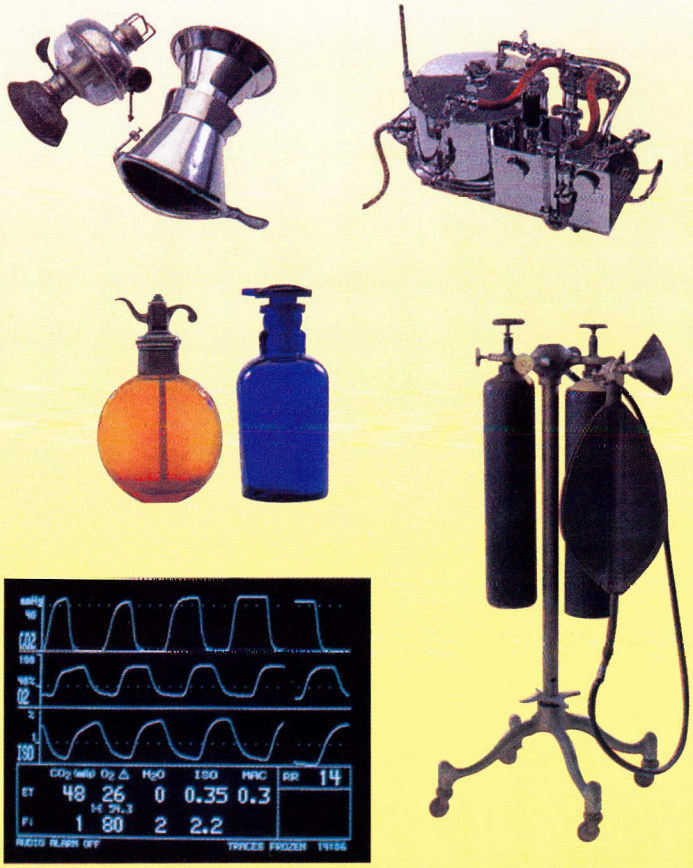
ABN 82 055 042 852

Joint Faculty of Intensive Care Medicine
Faculty of Pain Medicine

Bulletin

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

Inside ....



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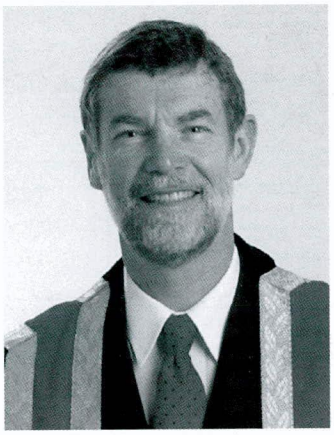


President's Message

Richard J Willis, ANZCA

College Council Meetings have large agendas that deal with many important matters, some of general interest and many not, but there are always some that assume greater importance. On this occasion, I would like to review some current issues that are foremost in our discussions.

FANZCA Training Program

All current trainees and new trainees at the commencement of this training year are subject to the requirements of the revised training program. The changes to training have involved a massive commitment by many Fellows to the development, structuring and implementation of the changes. While I have no doubt that this will result in a significant enhancement of training, there have been many hurdles encountered that have made the process challenging. The concern that the application of the program to all current trainees as well as new ones would result in unacceptable extra commitments has largely proven unfounded – if anything, the implementation rules for current trainees have been lenient, with generous credit being granted retrospectively for previous training and experience. While slow in coming, the recent release of the very detailed Learning Portfolio has alleviated another area of concern. An extra workload for Supervisors of Training has been an issue that the designers of the program have attempted to address at each stage of development and have succeeded in minimising. Assessment of Module completion has caused some confusion and concern from supervisors who interpreted the process as more complex than was intended. It is described in Professional Document TE2 (2003). For most Modules, trainees self-assess that they have met the core aims of the particular Module. This is then discussed with the supervisor.

The abolition of accredited 'training posts' in favour of accredited 'training hospitals' and the resultant potential increase in the number of trainees has been a matter of great concern to many supervisors of training and organisers of rotational training programs. The decision to make this change was independent of the revision of the training program but will undoubtedly impact on the latter. I can assure all Fellows and trainees that the decision was taken with full recognition of the potential problems, but has already been vindicated by the direction that the ACCC has taken with the College of Surgeons. It is fairer for trainees, it has helped defend the College against misplaced 'closed shop' accusations, and it will help address the shortage of anaesthetists. I have no doubt that the correct course of action was taken by ANZCA. The challenge will be to find innovative ways to help trainees to get subspecialty training if this becomes limited due to extra trainee numbers. In summary, the revised training program is up and running now without too much fuss. Supervisors who are having difficulties are urged to seek advice or assistance from the College. I thank all those Fellows who have assisted in any way with the development of the program, offering constructive criticism or helping with implementation and supervision in the hospitals. In particular, I want to mention the huge contribution of Past President Teik Oh who was the architect of the changes and Leona Wilson who, as Chair of Education and Training, organised and initiated the lion's share of the implementation.

Workforce

I have mentioned the problems of health workforce on previous occasions in this column and am somewhat reluctant to further pursue the issue, but it is assuming even greater importance and is now well recognised at the highest levels of government and the public service as the major ongoing problem for the provision of health care services. The medical workforce had its growth seriously limited worldwide by the reluctance of many western

governments to increase medical student numbers during the late 1980s and 1990s in the mistaken belief that there were too many doctors and presumably that this initiative would limit expenditure. Shorter working hours, fatigue issues and part-time employment coupled with increased demand for services from an ageing population combined to give rise to the current shortage of workforce. Shortages of anaesthetists have been evident for some time. It is now apparent that there are other specialties that are worse off than ours, and we do have the advantage of still being able to recruit high quality new trainees at a time when other specialties are having more difficulty. I suspect that lifestyle issues play a role in the choice of Anaesthesia as a career.

Shortage of Anaesthetists

What is the true state of the 'anaesthetist shortage'? It is notoriously difficult to assess the balance between medical workforce supply and demand despite the excellent work of AMWAC (Australian Medical Workforce Advisory Committee). Although Health Department officials in most states of Australia still nominate anaesthesia as a specialty with workforce shortages, it is my impression that the position is a little better than it was two years ago. As the number of anaesthetists who pass the Final examination for FANZCA is one indicator of the increase in workforce supply, it is pleasing to note that there has been an increase of 25 to 30% for each of the last two years. Whether this will continue, one can only speculate, but the number of trainees will probably increase from this year due to the reasons explained in the first paragraph.

Area-of Need (AoN)

Anaesthetists are involved in the provision of clinical service for a wide variety of surgical, investigational and therapeutic procedures. A shortage of anaesthetists limits the availability of these procedural services and therefore is likely to result in an early political response to address the deficit. The nomination of Area-of Need (AoN) positions is one of the expedient responses that has occurred. Despite there being a documented process for AoN designation and management that was developed by the Australian Medical Council (AMC), there are multiple abuses of the process with the AMC often being bypassed. The supervision and further training of AoN incumbents is usually fragmented and often non-existent. Recognising this chaotic situation, the Commonwealth Department of Health and Ageing has organised two major workshops for early in the year to examine appropriate solutions. This comes as welcome news to the medical Colleges that have struggled with the increasing demand for assessment, supervision and accreditation of AoN doctors.

Availability of Anaesthetists for Emergency Anaesthesia

The College continues to get sporadic but increasing numbers of letters from hospitals and from other specialists regarding the availability of anaesthetists for emergency services. Most of the problems seem to arise from the private obstetric sector where anaesthetists are required at short notice to provide epidural analgesia for labour or anaesthesia for caesarean section. Such concerns have been raised in most states of Australia. It is NOT a problem in New Zealand due to the different style of private obstetric practice there. The reasons for this particular area of shortage in Australia are multiple and understandable. Nevertheless, there remains a real concern that there is the potential for adverse outcomes that would be tragic for the patients, all personnel concerned and for the profession. The problem is easily identified but the solutions are difficult, outside the control of the College and require the cooperation of the administrators in the obstetric hospitals, the obstetricians and the anaesthetists. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, ANZCA, the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine are developing a joint statement on obstetric anaesthesia that will seek to address this and other issues. This statement will relate to appropriate standards of care. I sincerely hope this will be useful in improving the availability of anaesthetists for emergency obstetrics.

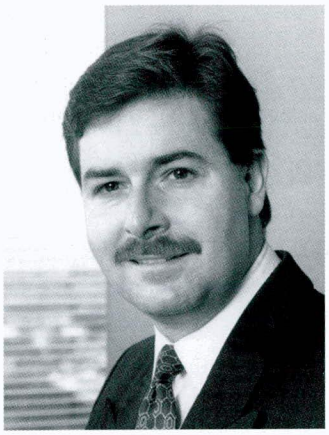
Annual Scientific Meeting

The next ASM will be held in Perth from 1st to 5th May 2004 where an enthusiastic and hard-working Organising Committee has prepared an exciting program for us. I encourage all Fellows and trainees to attend the extensive scientific program that includes presentations and workshops from a group of invited speakers with wide and varied interests. The social program likewise includes great variety with something that will appeal to every registrant. Perth is a beautiful city that is always popular for conferences and provides a base for the exploration of other parts of Western Australia. I look forward to meeting you all in Perth.

And finally.....

My term as President and Councillor finishes at the Perth ASM. It has been a pleasure serving the College over the last twelve years. I thank the Fellows, trainees and College staff who have assisted me in so many ways over this period. I will treasure the memories.

Richard Willis
President



Law Report

Michael Gorton AM, LLB., B.Comm, FRACS (Hon), FANZCA (Hon)
College Honorary Solicitor
Partner – Russell Kennedy, Solicitors

Family Histories and Privacy Laws

Since the introduction of new privacy laws in December 2001 there has been the potential for conflict between the requirements of the legislation and the usual practice of doctors taking family histories, which involve the collection of health and social information of other family members and third parties.

Sound medical practice may require obtaining information about the medical social and family history of others.

In particular, there is contemporary concern regarding the disclosure of genetic information of family members and third parties. Breaches of genetic privacy raise the possibility of discrimination and insurance implications.

These issues have been addressed by the Federal Privacy Commissioner in a Public Interest Determination ("PID") currently applicable.

The PID, in general terms, exempts doctors from complying with the requirement to obtain the consent of third parties, before collecting information regarding them and their medical, social and family history.

The PID permits a doctor to collect health information from a patient about a third party, without the third parties consent, if:-

- the collection of the social, family or medical history is **necessary** for the treatment of the patient; and
- the information is relevant to the family, social or medical history of the **patient**.

Where information is collected regarding third parties (including family members) under this exemption, doctors are still required to otherwise observe the privacy protections required under privacy legislation. That is, the information should still only be used for the purpose for which it was collected (treatment of the patient). It should not otherwise be unlawfully disclosed and the information should be stored in a secure and confidential manner.

The question arises as to whether a third party can, using access rights under privacy legislation, require a copy of the information from the doctor – even though the third party is not the patient of the doctor. The doctor will still be holding medical, social and other information in relation to the third party, and, theoretically, is therefore accessible by the third party by request. However, the doctor could refuse to disclose the information held and refuse access to the third party, where to do so would infringe the confidentiality of the existing patient, or otherwise have negative or adverse consequences.

The PID is effective for a period of 5 years from December 2002, at which time it will be reviewed.

In relation to the interesting question of access to genetic information, the PID notes that it may be possible for a genetic relative to access genetic information held by a doctor in relation to a patient. Ordinarily such a request would be refused on the basis of privacy legislation and strict confidentiality. However, there may be good and pressing medical reasons why access to genetic information should be available, and the PID leaves open the question of access in these circumstances, and access by a genetic relative is left as a matter of judgement for the doctor. However, the usual patient confidentiality is likely to override this aspect of privacy legislation. Patient confidentiality should not be breached. If in doubt, or if there is a pressing need for access, legal advice should be obtained.

Insurance – A Brave New World

As a consequence of the medical indemnity crisis, Medical Defence Organisations now offer professional liability insurance contracts to doctors, as required under Australian legislation operating from 1 July 2003.

Previously, Medical Defence Organisations operated on a "discretionary" basis, and operated as a mutual organisation, like a club, for the benefit of its members. The Board of the MDO provided indemnity cover for the members of the MDO.

However, since 1 July 2003, MDO's are only able to offer insurance contracts to provide professional indemnity cover for doctors. Accordingly, professional indemnity is now an insurance contract in a strict legal sense. It is like your motor vehicle or house insurance policy, and has similar contractual issues.

Doctors should therefore be aware of some of the unexpected consequences of this change.

Extent of coverage

Under the previous mutual arrangement, MDO's offered a broad range of cover and benefits to members. The new insurance contract will provide insurance cover only in accordance with the strict wording of the policy. Accordingly, the general professional indemnity insurance contracts may not cover such items as:

- appearances before the Medical Board or Tribunal for allegations of misconduct.
- claims against a doctor for discrimination or harassment.
- criminal proceedings.
- general legal advisory services.

Under the new arrangements where coverage is strictly on the basis of the contract, the terms and conditions of the policy will determine the precise extent of coverage. If it is not specified, then the insurer could refuse to cover.

Exclusionary provisions

If you have read your car insurance or home insurance policy, you will note that it contains a detailed list of items that are excluded. There is generally a list of circumstances or occurrences where the policy will not operate. You should read these carefully and be aware of the areas not covered under the policy. Sometimes it is possible to have those exclusions deleted, but presumably an additional premium will apply.

Duty of disclosure

Contracts of insurance have special obligations at law. They are said to be contracts *"uberrimae fidei"*, meaning that they are contracts of the utmost good faith. It implies obligations between the insurer and the insured doctor similar to the relationship between doctor and patient, solicitor and client, trustee and beneficiary.

One of the consequences of this special relationship is that insured doctors must disclose to the insurer information regarding risks, claims or circumstances which may give rise to claims. The insurance policy proposal itself will carry a warning to you that you must "disclose to the insurer every matter that you know, or could reasonably be expected to know, that is relevant to the insurers decision whether to accept the risk of insurance". The warning will also advise if you fail to comply with your duty of disclosure, the insurer may be entitled to reduce liability under the policy or cancel the policy entirely.

Accordingly, because this is a policy of professional indemnity insurance for doctors in the course of their practice, doctors would be required to advise the insurer (at the time of initially taking out the policy and on reinstatement or renewal) details of any claims or circumstances which could give rise to claims.

This is an extensive duty, and will require doctors to be far more careful and considerate in keeping details of potential claims, potential errors and mistakes, even though no claim has arisen and even though the patient may be completely unaware of the circumstances.

The potential for MDO's to rely on a breach of this duty is significant. Although in the past, Medical Defence Organisations, because of their membership based mutual arrangement, have rarely relied on this right or refused cover, the new commercial approach to professional indemnity insurance may produce a change in attitude. It is assumed that Medical Defence Organisations will continue to act in the best interests of their members and provide some latitude in dealing with members and insurance coverage. However, in the not too distant future members may be transferring from insurer to insurer (as they can under the new arrangements) as premium rates change from year to year. Under circumstances where doctors may be more fickle and move or change from insurer to insurer, then the insurance company may not be as lenient and may be prepared to take technical legal points in relation to the duty of disclosure - and refuse cover where proper disclosure has not been made.

Obligation to give notice

Similarly with the duty of disclosure, the insurance policy itself will contain a term or condition that requires the doctor to notify the insurer immediately a claim arises or circumstances occur which could give rise to a claim. No doubt, the more cautious doctors will inundate their insurer with notice of circumstances where there is potentially a claim. In any event, it is not unknown in the

broader commercial world, for an insurer to deny insurance coverage where the insured failed to give the insurer notice of the claim within a reasonable time of the circumstances arising.

For the reasons above, in the new commercial world, it may not be long before MDO insurers start taking these technical legal points as well.

Coverage period

The new insurance contracts will cover doctors for fixed periods of time. It will therefore be important for the doctor to diarise this time period and ensure that insurance policies are renewed promptly. If the policy is not renewed, it lapses, and coverage will not apply.

Under the previous mutual Medical Defence Organisation, membership of the MDO was critical, and did not necessarily lapse or terminate if members were late with payment of premium/membership fees.

Under the new commercial arrangements renewal of the policy of insurance on a timely basis will be critical.

Doctors are also reminded that they must maintain insurance not just for the period of their practice, but for the future period during which claims may arise after they retire or cease practice. Either full "tail cover" should be arranged with your insurer, or you may be required to maintain insurance on an ongoing basis after retirement.

The current legislation contains mandatory provisions for insurers to provide this type of cover for doctors who are retiring in the next few years. However, those provisions are subject to review, and may change in the next year or two. It is also not clear whether premiums for this type of cover will be at the relatively low rates offered this year. For those retiring in the next 5-10 years, they will need to keep an eye on this issue, to determine the likely cost of full cover once they retire.

Brave new world

At this stage most of the Medical Defence Organisations have indicated that they propose to continue as a membership based organisation, seeking to assist members as best they can. Some latitude with the "strict rules" of the contracts is expected.

However, as noted above the insurance market is increasingly commercial and competitive. For those doctors who change insurers on a year by year basis, and therefore do not maintain loyalty to any particular Medical Defence Organisation, then it may be that the Medical Defence Organisation/insurer will give less latitude, and strictly enforce the terms of the contract and the duty of disclosure.

It will be interesting to see how the new regime operates in the years to come.

Series on Past Deans and Presidents

Dr Terry Loughnan

The following essay on Douglas George Renton is the first in a series of essays to be published in the Bulletin on the Past Deans of the Faculty of Anaesthetists, RACS and Past Presidents of ANZCA written by Dr Terry Loughnan. The Editorial Committee would like to record its thanks to Terry for such valuable insight into the lives of these men and women who have made such significant contributions to the life of our College and the teaching and practice of anaesthesia both in Australia and internationally.

Douglas George Renton

D.G. Renton was the inaugural Dean of the Faculty of Anaesthetists, Royal Australasian College of Surgeons. He was appointed in 1951 as interim Dean and then became Dean in 1954 and served until his death in 1955. He was succeeded by Dr Robert Orton.

Douglas Renton was born in Parkville, Melbourne on 9th March 1899 and died at the age of 56 years on 2nd May 1955 at his home. He was survived by his wife, son and daughter. He was educated at Scotch College Melbourne, and graduated as a doctor from the University of Melbourne in 1922. Undertaking his residency at the Alfred Hospital in 1922 and 1923, he then moved to the Women's Hospital in 1923-1924. In 1924, he experienced appendicitis that required surgery leaving him with serious adhesions that would require subsequent major surgery in 1925 and 1937.

This was a highly significant juncture in his career because thereafter he kept poor health for the remainder of his life. He practised from 1924-1928 as a general practitioner in Rochester, in rural Victoria, administering many anaesthetics during that time. However he was invalided for a year prior to commencing full time anaesthetic practice. In 1929 he returned to Melbourne as a "specialist anaesthetist" based on this experience in rural practice. As a sign of the times, and reflected in other anaesthetists of the era, he was attracted to anaesthesia as "a calling then deemed appropriate for the physically handicapped"(1). This was the reason for at least two of his colleagues at the Alfred Hospital, Robert Orton and J. Ellis Gillespie, entering the speciality. And indeed the triumvirate initially selected to negotiate formation of a Faculty of Anaesthetists within the College of Surgeons consisted of Renton, Ellis Gillespie, who sought a career in anaesthesia as a lighter alternative to general practice after illness experienced in the Army, and Lennard Travers who had been forced to terminate his career in specialist surgery because of very severe dermatitis.

Upon returning to Melbourne, Douglas Renton gained appointments at the Alfred, Women's and Austin Hospitals. At that time it was estimated that he was one of four full time anaesthetists servicing the needs of Melbourne hospitals. When the Australian Society of Anaesthetists was being formed in 1933 and applications were being sought, Douglas Renton was amongst the first six applicants. He rose to become Vice President of the ASA in 1947 and its Federal President from 1949-50. This is an extremely auspicious period because at the 1950 AGM of the ASA the Executive resolved to pursue a path of establishing a Faculty of Anaesthetists within the Royal Australasian College of Surgeons, and Douglas Renton was selected to convene this sub-committee. The other members of the sub-committee were Dr J. Ellis Gillespie and Dr Lennard Travers. This group subsequently co-opted Dr Harry Daly from New South Wales and Dr Gilbert Troup from Western Australia.

An interim Board was established from within this group with Renton as interim Dean for the period 1951-54 and he was then elected to be the inaugural Dean from 1954-55 when severe ill health forced his retirement.

Douglas Renton was a skilled anaesthetist despite a lack of formal training and in 1946 he was appointed as a full time anaesthetist to the neurosurgical unit of Hugh Trumble at the Alfred Hospital. He designed and built a circle system with carbon dioxide absorption unit in 1931, an example of which is in the Geoffrey Kaye Museum of the Australian and New Zealand College of Anaesthetists.(2). He was noted as a teacher of anaesthetic techniques to undergraduates and was a co-author of "Anaesthetic Methods" with Robert Orton and Geoffrey Kaye, one of the major anaesthetic texts of the era and believed to be the first anaesthetic text written in Australia.

Douglas Renton was conferred with the Diploma of Anaesthesia, Royal College of Physicians and Surgeons in 1939, the Fellowship of the Faculty of Anaesthetists of the Royal College of Surgeons in 1950 and Fellowship of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons in 1954. He has been honoured and his name perpetuated by the Renton Prize in the Australian and New Zealand College of Anaesthetists' Fellowship Examination.

To quote Gwen Wilson of Douglas Renton. He commenced "in the era when anaesthetists were both poorly paid and poorly regarded and by the time of his death....he had seen his speciality grown to acceptance and demand and he had himself played a major part in this transformation"[3]

A list of Renton's Publications is as follows [1]:

1932: Practical Anaesthesia, Australasian Medical Publishing Ltd.

1937: Gas Anaesthesia: the closed-circle absorption technique., Anaesth Analg 1:9

1938: Gas Anaesthesia: a critical survey of gas anaesthetic technique., Aust NZ J Surgery 8:74

1946: Anaesthetic Methods, Melbourne Ramsay. In collaboration with Robert Orton and Geoffrey Kaye

1949: Use of plastic tubing in intravenous therapy. Aust NZ J Surg 18:215

1949: Dead space in closed circuit anaesthetic apparatus., Med J Aust 2:51

1951: Aids to easy breathing., Med J Aust 2:531

1952: A flexible plastic tube adaptor for high pressure injections., Med J Aust 1:408

1953: Modification of the "Oxford" Inflation Apparatus., Anaesthesia 8:104

References

1. Obituary. Douglas George Renton: Med J Aust 1955;2:145-6
2. Westhorpe R. The Renton Circle., Anaesth Intens Care 22;4: August 1994 p 333.
3. Wilson G. "Fifty Years: the Australian Society of Anaesthetists 1934-1984." Published 1987. ISBN 0 90981401 5

UNDERGRADUATE PRIZE IN ANAESTHESIA

The recipient of the 2003 ANZCA Prize for The University of Auckland was Ms Rachael Luckie. Rachael's award was presented to her during the University Awards Ceremony held on 19 January 2004.

Highlights from the Council Meeting

FEBRUARY, 2004

WELCOME

The President welcomed Dr Peter Cooke, Chairman of the New Zealand National Committee, and Mrs Anne Kolbe, President, Royal Australasian College of Surgeons.

PRESIDENT-ELECT

Professor Michael Cousins has been elected to the position of President-Elect and will take office as President during the Annual Scientific Meeting in Perth in May 2004.

COMMUNICATIONS AND FELLOWSHIP AFFAIRS

Bulletin Survey

The results of the Bulletin survey have been collated are published elsewhere in this Bulletin.

EDUCATION AND TRAINING

FANZCA Training Program

With the commencement of the 2004 hospital year, the changes to the Training Program have now come into effect for all ANZCA trainees.

Supervisors of Training

SOT workshops during the ASM in Perth will focus on communication issues relating to Modules 2 and 12. Methods of assessing communication skills as part of the ANZCA training program are under consideration.

In-Training Assessment

The ITA process is due for review in 2004 and will be undertaken through the Education and Training Committee.

Clinical Teachers Course

A pilot course will be convened at ANZCA House on 27th and 28th March.

This initial course will be available only to invited representatives of each Australian State, New Zealand, Hong Kong, Singapore and Malaysia.

Trainees on College Committees

Council resolved that the elected New Fellow Representative and the Trainee Representative on the Education and Training Committee will be accorded voting rights.

EXAMINATIONS

Training of Examiners

A more structured training process for new Examiners is under development. Following the success of a trial workshop convened in February for Final Examiners, further workshops are being organised to include new Examiners for the Primary, Intensive Care, Pain Medicine, and Diving and Hyperbaric Medicine Examinations.

FINANCE

Rollback of Subscriptions in Advance

Council resolved to withdraw the policy of payment of subscriptions in advance from this year.

Pro-rata Payment of Subscriptions for New Fellows

Council has agreed to implement pro-rata payment of subscriptions for new Fellows based on the number of full calendar months left in the year from the date of their admission.

ANZCA International Scholarship

The ANZCA International Scholarship will be advertised for 2005. Council agreed that the Scholarship would be offered on an annual basis.

INTERNAL AFFAIRS

Overseas Trained Specialist Process

The Department of Health and Ageing has initiated national workshops to examine and revise the processes for assessment of Overseas Trained Specialists, particularly with regard to Area-of-Need positions. Recommended changes of processes are expected within the next three months.

Support Scheme for Rural Specialists

Following the success of the pilot Rural Crisis Management Courses run last year in Orange and Cairns, funding has been obtained to mount similar courses in Darwin and Launceston during 2004.

Committee of Presidents of Medical Colleges

The revised Constitution for the CPMC was accepted by Council.

ANZCA House Foyer

Plans are being developed for a display related to modern anaesthesia, intensive care and pain medicine in the foyer.

Museum

The Geoffrey Kaye collection and other historical exhibits will be relocated to part of level 6 at ANZCA House.

COLLEGE AWARDS AND ELECTION TO FELLOWSHIP

Orton Medal

Council awarded an Orton Medal to Dr Frank Moloney (NSW) for his outstanding contribution over many years to

College activities, particularly anaesthesia services in rural areas.

Election to Fellowship

Dr Roderick Harpin (NZ) was invited to accept Admission to Fellowship by Election under Regulation 6.3.1(b).

ANZCA Council Citations

ANZCA Council Citations were awarded to the following, and will be presented at an appropriate occasion:

- Dr John Aubrey Henry Williamson (SA) for his contributions to Diving and Hyperbaric Medicine, and incident monitoring.
- Dr Peter McCartney (Tas) for his contributions to Diving and Hyperbaric Medicine.
- Dr Hugh Spencer (NZ) for his contributions to teaching, both in New Zealand and the Pacific region, and in recognition of his long-standing commitment to the College as a member of the NZNC.

PROFESSIONAL DOCUMENTS

The following Professional Documents were approved and are printed elsewhere within this Bulletin:

PS27 *Guidelines for Fellows who Practice Major Extracorporeal Perfusion*

PS37 *Statement on Local Anaesthesia and Allied Health Practitioners*

PS46 *Recommendations for Training and Practice of Diagnostic Perioperative Transoesophageal Echocardiography in Adults*

PS50 *Recommendations on Practice Re-entry for a Specialist Anaesthetist*

Standards Conflict May Endanger Patients

In February this year, the Technical Committee of the International Standards Organization, TC121 Subcommittee 6, met in Melbourne.

One document under discussion dealt with pressure regulators in pipeline supplies. The pressure of supply of the pipeline was considered to be 400 kPa which matches the Australian Standard AS2896. However, further discussion revealed a difficulty. At this supply pressure, if a single fault occurs, the system is usually designed to limit the pipeline pressure to 1000 kPa. Examples of single faults are failure of a regulator to close or fracture of a valve seat. This overpressure has been considered safe for the pipelines and for equipment connected to it.

However, in Germany recently a hospital pipeline developed a fault which caused the pressure to rise to 1000 kPa. When this occurred all the ventilators in the ICU ceased functioning. Fortunately no patients were injured in this episode. The current ISO ventilator standard allows that the system may function only up to 800 kPa. Although many ventilators will continue to function up to 1000 kPa, not all will do so.

Therefore, it is important that ICUs check the specifications of their ventilators to ensure that, in the very unlikely case of an overpressure, their ventilators will continue to function. This specification should also be included in any new ventilators being purchased. Although a similar problem may arise with some anaesthetic machine ventilators, this should be manageable in the short term with hand ventilation.

Professor W John Russell
ANZCA Coordinator of Anaesthesia Representatives
to External Standards Committees

Communications Survey 2003: Results and Recommendations

A/Prof Kate Leslie
Communications Officer, ANZCA

A key goal of the Communications and Fellowship Affairs Committee of ANZCA is to ensure that Fellows and Trainees receive the information and news they both need and want about College affairs in the best possible format. The Committee therefore decided to conduct a survey to find out your views on the Bulletin, the ANZCA website and emailed information that you receive from the College. The survey was mailed to Fellows, Trainees and MOPS participants in November, 2003, with a deadline for response of December 31st, 2003. Many thanks to everyone who responded to the survey and to Juliette Mullumby at the College for her assistance with collating the results. The Committee was especially grateful for all the comments: on a wide range of topics, some full of praise, some with great suggestions and some highly critical!

1872 responses were received, giving an overall response rate of 41%: quite acceptable for surveys of this type. The age, training status (Fellow or Trainee) and specialty (Anaesthesia, Intensive Care Medicine or Pain Medicine) of the responders were equivalent to the overall membership of the College.

The Bulletin

Overall, responders thought that the Bulletin was a useful publication, gave a moderate or high priority to reading it, and read a substantial amount of it. There was a lot of support for continuing with four Bulletins per year. While there was support for publishing the Bulletin on the website, only a minority of responders wanted to receive an electronic version only at this time. Many people commented that they keep the Bulletin in their briefcase to read when they have a spare moment. Comment was also made about making the Bulletin more inclusive of people in different regions with different interests, with more news and information of value to the "ordinary" practitioner.

Details of survey results

- 1668 (89%) thought that the Bulletin was "extremely useful", "useful" or "of some use" whereas 204 (11%) thought that the Bulletin was "of little use" or "useless". Fellows (rather than Trainees) and those ≥40 years were more likely to find the Bulletin useful.
- 1404 (75%) of responders gave reading the Bulletin moderate or high priority. Fellows and those >60 years were more likely to give the Bulletin priority. Intensive Care Practitioners were less likely to give the Bulletin priority than those practicing Anaesthesia or Pain Medicine.
- 1438 (77%) read at least half of the Bulletin. Fellows, those >60 years and Anaesthetists were more likely to read at least half of the Bulletin.
- 151 (8%) thought that the number of editions should be increased to 6 per year.
- 585 (31%) thought that the Bulletin should be published on the College website.
- Reports on College affairs; feature articles on College, the activities of Fellows and general interest topics; professional documents, and notices and reports for CME activities around the regions were ranked higher in interest (all median rank = 2 out of 6; 1 = most interesting, 6 = least interesting) than citations for medals, profiles of notable Fellows and obituaries (median rank = 4 out of 6), or notices about forthcoming examinations, research grants, scholarships and the like (median rank = 5 out of 6). Information about the types of articles read will be useful in re-vamping the Bulletin.

The ANZCA Website and Email

The survey revealed substantial use of the College Website and significant interest in receiving information via email. 333 (18%) of responders consulted the College website a lot, 1159 (62%) consulted it sometimes and 358 (19%) never consulted it. 534 (29%) of responders thought that they would like to receive all their information via the internet: those <40 years were more likely to want information via the internet. A small minority of responders had no interest in receiving any information from the College, either via the Bulletin, email or from the website.

Recommendations

The Communications and Fellowship Affairs Committee has decided to continue with publishing four Bulletins, in hard copy, per year. However, as a result of the survey, we will make the following changes:

- Explore a fresh new look for the Bulletin including a new cover

- Seek more stories and pictures from the regions and from different groups in the College
- Move some of the "drier" copy to mail, email or website communication
- Publish the Bulletin on the ANZCA website
- Offer the option of email notification that the Bulletin has been posted on the website, rather than a hard copy
- Institute regular, concise email notices about important events and changes to the website

How you can contribute

- Send us a story from your region - about an item of interest in your Hospital or Department, results of a survey or government initiative in your region, a notable Fellow or Trainee, an overseas aid trip, a local CME meeting etc.
- Send us digital photos of the people and events in your region
- Ensure that we have your email address by completing the email section on documents from the College
- Give us feedback about our new initiatives

Copy, photos and comments should be posted or emailed to the CEO. (The Chief Executive Officer, ANZCA, 630 St Kilda Rd, Melbourne, 3004 or ceoanzca@anzca.edu.au)

Once again, thank you very much for participating in the ANZCA Communications Survey 2003. We hope that the results will help us improve communications for our Fellows and Trainees.

A/Prof Kate Leslie

Chairman, Communication and
Fellowship Affairs Committee

Geoffrey Kaye Museum of Anaesthetic History In the Spotlight

Tours of the Geoffrey Kaye Museum of Anaesthetic History are proving to be very popular with a wide variety of visitors. On the evening of Thursday 5 February, 2004 the Museum was pleased to host an important visit by 17 international representatives from the ISO Standards Committee 6. The representatives were very keen to visit the Museum while in Melbourne for a professional meeting.

The visit included a talk by Dr Rod Westhorpe, the Honorary Museum Curator, a special viewing of the Museum displays, and a behind the scenes tour of the recently upgraded Museum storage area. Dr Westhorpe's talk was received enthusiastically by all and provided a very informative and valuable insight into the history of the Museum and its unique international collection of anaesthetic material. The visit was a great success.

The Geoffrey Kaye Museum of Anaesthetic History is proudly managed by ANZCA, which recognizes its importance as one of the largest and most diverse collections of its kind in the world. Updates on the Museum will be a regular feature in the College Bulletin commencing with the June 2004 edition. The Museum display is changed on a regular basis.

Requests for tours of the Museum are most welcome. All tour bookings and enquiries regarding the Museum should be directed to, Ms Elizabeth Triarico, Museum Curator on: (03) 9510 6299 and/or etriarico@anzca.edu.au.

Dr Rod Westhorpe, Honorary Museum Curator, providing a valuable insight into the Museum Collection for the representatives from the ISO Standards Committee 6.

Representatives from the ISO Standards Committee 6 enjoying the Museum displays.

MANAGEMENT OF ANAESTHESIA FOR JEHOVAH'S WITNESSES

The booklet "Management of Anaesthesia for Jehovah's Witnesses", published by The Association of Anaesthetists of Great Britain and Ireland, provides a valuable resource for the anaesthetist when managing patients who have particular views on the use of blood or blood products.

A copy of the Guidelines is available to download from the AAGBI website (www.aagbi.org/guidelines.html)

ELECTROCONVULSIVE THERAPY (ECT)

24 December 2003

Dr Richard Willis
President
Australian and New Zealand College of Anaesthetists
630 St. Kilda Road
Melbourne VIC 3004

Dear Richard,

Electroconvulsive Therapy (ECT) is a valuable resource in the management of depression and other life threatening psychiatric illness. Anaesthesia has played a significant part in rendering this procedure benign, safe and acceptable.

The College has for some time had a policy on safe anaesthesia practice for ECT (refer Professional Document (T2) Recommendations on Minimum Facilities for Safe Anaesthesia Practice Outside Operating Suites; Section 4.2) and now that the great majority of anaesthesia for ECT is given by specialists in such facilities, morbidity and mortality are exceptionally rare.

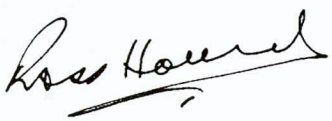
Nevertheless it has come to my attention that some of our colleagues are insisting that anaesthesia for ECT be administered in the Operating Suite, despite the existence of a unit meeting (or even exceeding) ANZCA standards in the same institution.

Those of us who are involved with patients undergoing ECT are aware of how emotionally fragile these people are, and most anything which adds to their understandable anxiety is most regrettable. Furthermore, they cannot be premedicated, since doing so interferes with seizure generation.

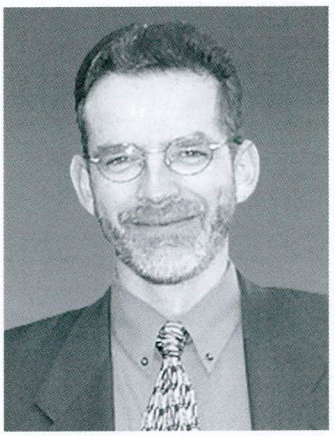
Purpose-built ECT suites, with their more friendly environment, absence of special clothing requirements and reduced formalities result in much greater acceptance of this valuable therapy. Conversely, insistence on conducting ECT in the intimidating atmosphere of an operating suite results in a significant reduction in the number of patients presenting. Most of those who fail to attend will have their depressive or other psychiatric condition either prolonged or unrelieved. Those who do are subjected to needless additional anxiety.

In a modern general hospital, with the ready availability of on-call intensive care or other specialist staff, there is no reason why the vast majority of ECT patients cannot be managed in facilities complying with College policy requirements where these exist. Refusal to do so is neither logical nor humane.

Yours sincerely,



Ross Holland, FANZCA



Education Report

Russell W. Jones, Director of Education, ANZCA

Communication Skills

Effective communication with colleagues, trainees, other medical staff, patients and their families is essential for anaesthetic, intensive care and pain medicine specialists. Tate, in the third edition of *The Doctors' Communication Handbook*[1], lists 17 skills for successful interpersonal communication. The specialist who masters these 17 skills will become a brilliant communicator.

1. **Listen with genuine interest**

   This shows other people that you are concerned about their message and value what they are saying.

2. **Create a conducive environment**

   Open, frank and honest communication can only occur in an environment of trust and mutual respect.

3. **Be encouraging**

   Encouragement fosters the belief that you are positively trying to influence the situation and the people with whom you are communicating.

4. **Show understanding and empathy**

   This allows you to see the situation from the other person's perspective. This is valuable because it allows you to communicate your needs in a way that is most likely to be appreciated by the other person.

5. **Check current understanding**

   Most communication does not occur in isolation; rather it builds on a foundation of existing knowledge. It is essential to check the accuracy of this knowledge so as to ensure that the message you are conveying is built on an appropriate foundation.

6. **Reflect/summarise and paraphrase answers**

   The rephrasing of another person's answer to your question demonstrates that you have been actively listening whilst also allowing you to confirm you have an accurate understanding of their answer.

7. **Use closed questions for exploration**

   Closed questions direct attention on issues of most relevance to you. It is the most efficient technique for keeping a conversation focused. However, because closed questions limit the scope of a response they may exclude related important information from the response.

8. **Use open questions for clarification**

   Open questions allow the other person to explain what they believe. This allows you to check that they have clear comprehension of the message you are communicating.

9. **Adopt a similar language and avoid jargon**

   Effective communication can only occur if both parties are using 'the same language'. This means choosing words, terms and phrases that have identical meanings for both parties.

10. **Use plural pronouns to indicate partnership**

    Using words such as "we" and "us" reinforces that both parties are working towards a common goal.

11. **Be provisional rather than dogmatic**

    Focusing on what is required or necessary is more effective than focussing upon personal opinions.

12. **Be descriptive not judgmental**

    Describing or classifying without expressing judgment is a constructive approach. If necessary, use appropriate arguments to allow the other party to make their own judgment.

13. Comment on the issues rather than the personalities.

Constructive communication avoids commenting on personalities. Such comments only obfuscate pertinent issues.

14. Encourage eye contact

Eye contact for approximately 70 to 80 percent of a conversation shows interest, attention and respect within most cultures. However, constant eye contact can be intimidating.

15. Give information in clear, simple terms and use repetition.

Clarity and simplicity are often the essence of good communication. Repetition emphasises key points.

16. Check understanding

Upon completion of a conversation it is essential to check that both parties fully understand what has been said and the precise nature of any subsequent actions.

17. Use silence

Silence allows both parties to consider the content and implications of what has been said, to identify areas requiring clarification and to prepare an appropriate response.

References

1 Tate P (2000) *The doctors communication handbook* (3rd ed). Radcliffe Medical Press, Oxford.

SUPPORT SCHEME FOR RURAL SPECIALISTS CONTINUES IN 2004

During 2003, two, two-day workshops on Clinical Crisis Resource Management were held in Orange, NSW (September) and Cairns (October).

The simulation team was led by Dr Brendan Flanagan and Dr Michele Joseph from the Southern Health Simulation Centre. A total of 80 rural specialists and 40 nurses were able to attend the courses.

Evaluation by participants and by the Hunter Institute of Mental Health, on behalf of the Committee of Presidents of Medical Colleges (CPMC), was extremely positive. As a result, the Commonwealth Department of Health and Ageing has agreed to fund further courses in 2004. Two, two-day courses have been confirmed, the first in Launceston on 14-15 May and 16-17 May and the second in Darwin on 6-7 August and 8-9 August. A third course in Albury on 12-13 November and 14-15 November is to be confirmed.

The CPMC requires the courses to be open to rural anaesthetists, intensivists, emergency physicians, physicians, surgeons, obstetricians and general practitioners, concentrating on the teamwork approach to Crisis Resource Management.

Application forms will be sent to rural specialists in the Northern Territory and Tasmania, and may be obtained by rural specialists in other states from Helen Morris at ANZCA (hmorris@anzca.edu.au).

Approval for MOPS points has been granted by:

	Category	Number
ANZCA	CME & QA	25 + 25
JFICM	CME & QA	25 + 25
ACEM	Accredited Workshop	2 points/hr
RACP	Learning Project	3 points/hr
RACS	Maintenance of Clinical Knowledge and Skills	14 hours
RANZCOG	PR & CRM	16 points
ACRRM	Practice Improvement	60 PDP points

A second project, joint RANZCOG/ANZCA and managed by RANZCOG is "Assessing Risk in Obstetrics and Maternity Anaesthesia." This project is designed to provide rural specialists with an opportunity to gain skills in risk management, develop and implement clinical audits, evaluate objectively adverse outcomes within a safety and quality framework, and provide them with support when managing these difficult events.

In 2003, this distance education program by videoconference was provided to rural anaesthetists and obstetricians in Victoria, Queensland and New South Wales. Further information on the program for 2004 is available from Dr Gabby Fennessy at RANZCOG (gfennessy@ranzcog.edu.au).

Admission to Fellowship by Examination

Sarah Helen ARMAREGO	NSW
Gail Elizabeth AUGHTERSON	VIC
Ivan James BERGMAN	NZ
Amira BISHAI	NSW
Edward Courtenay BISHOP	SA
Christopher Donald BOWDEN	VIC
Miles Patrick BRODIE	QLD
David Llewellyn BROWN	TAS
Jane Louise BROWN	SA
Christopher John BRYANT	QLD
Richard Stephen BULACH	VIC
CHAI Tsung Yeaw	NSW
CHENG Pui Gee Bonnie	HK
Richard Wee Chee CHIN	VIC
Desmond CHU	NSW
David Yang-Ho CHUNG	QLD
Gabriel Regina CLERY	NSW
Steven Alexander CLULOW	QLD
Julia Clarie COLDREY	SA
Erin Louise CORCORAN	QLD
David Andrew COSTI	SA
Peter McLaren DAVIDSON	NSW
Fergus James DAVIDSON	NSW
Tony Ian DIPROSE	QLD
Suzanne Veronica DOMANSKI	VIC
Aaron Blair Penfold DONALDSON	QLD
Mark Lewis EDWARDS	NZ
Gregory Scott EUSTON	QLD
Nicole Louise FAIRWEATHER	QLD
Tanya Rochelle FARRELL	WA
Christopher Gerard FLYNN	QLD
Jodi Maree GRAHAM	WA
Robert Andrew Gordon GRAY	QLD
Linda GUALANO	VIC
Ian James HARRISON	NZ
Amanda Jane HARVEY	QLD
Christine Anne HUANG	NSW
Donald Francis INNES	NSW
Kim Anne JAMIESON	NZ
Eng Ling Edwin KHOO	NSW
Quentin Gilbert Alan KING	NSW
Jason Weh Meng KOH	NSW
KU Shu Wing	HK
Ian Christopher LACK	VIC
John Jeonghoon LEE	NSW
Keat Chong LEE	NZ
Christine Louise LEE	SA
Sumin LEE	HK
Kevin Andrew LEE	NSW
LIM Soo Ming	WA
Hugh Roland Albert LONGWORTH	NSW
Susan Martha LORD	NSW
Payam MAJEDI	WA
Craig Andrew McCUTCHEON	VIC
James Morgan McLEAN	QLD
Maria Jane MIDDLEMISS	NZ
Lisa MOHANLAL	QLD
Paul Alexander MURPHY	NZ
Yin-Wan Clara NG	NSW
Tracey Janet NIXON	QLD
Helen Louise O'TOOLE	QLD
Johannes OOSTHUIZEN	NZ
Ruari ORME	VIC
POON Ho-Yan	HK
Michael Andrew ROSE	NSW
Karen Ann RYAN	NZ
Sathi SEEVANAYAGA	VIC
Jeremy Alistair SHEARD	NSW
Lukas Iwan TAN	WA
Dan Connie TAO	NSW
TAY Teik Guan	HK
THAM Kok Meng	SA
Ajaypal Singh THIND	NSW
Geoffrey Mark TWEEDDALE	NSW
Nicole Lesley URQUHART	VIC
David Theodore VYSE	NSW
Mark Stuart WADDINGTON	NZ
Adrian Michael WALKER	NSW
Paul Nikolaus WIELAND	NZ
Sean Michael WILLIAMS	NSW
Leigh Karen WINSTON	QLD
Craig Matthew YOUNG	TAS

Admission to Fellowship via OTS Performance Assessment Process

Keith Russell BROWN	QLD
Meher Prasad CHINTHAMUNEEDI	QLD
Werner DE WILZEM	QLD
Michael Beresford HOOPER	QLD
Kurt Heinz KAISER	NSW
Dilip KAPUR	SA
Ralph Kenrick LONGHORN	WA
John Joseph MORRIS	QLD
Gerhard Friedhelm NEUMEISTER	QLD
De Wet POTGIETER	QLD
David Abraham RAPEPORT	WA
Peter Arie SCHENK	NZ
James Edward SCHLIMMER	QLD
Frederick Jacobus STEYN	NZ
Adel TANIOUS	QLD
Jacobus Marinus VAN WESTING	NSW
Niraj VISHNOI	NSW
Lars Peter WANG	WA
Mark Andrew WILLIAMS	WA
Clive Bernard Jonathan WOOLFE	NSW
Yatin YOUNG	NZ

Obituaries

Henri Rene Paul Coutanceau (1921-2004)

FFARACS 1961, FANZCA 1992 - Victoria

Henri was the second son of Maurice and Madeleine Coutanceau, born 5th August 1921 at Ganges, in south-eastern France, where his father was Medical Officer for the French Railway, PLM. His family had a strong connection with the "Church of the New Jerusalem" which came to be known as the "New Church". This was to be Henri's lifetime devotion to his Protestant Christian faith. His first seven years were in France and then the family moved to Mauritius, where he continued his education at his father's old school, the Royal College of Mauritius. Here he performed very creditably at each level of study culminating in him being awarded the "Modern Scholarship" in his final year in 1940. During this time he had the misfortune to contract lobar pneumonia in the years before antibiotics, developing the classical "crisis" then later "lysis" which led to his recovery. The Modern Scholarship was valuable and allowed him to undertake tertiary study in the UK. Henri was initially keen to do Radio Engineering, however, the Second World War interrupted that opportunity, so he followed his elder brother, Maurice, to the UK and joined the RAF. Maurice and Henri were very close as brothers and Henri was devastated when Maurice, then a Pilot Officer in the RAF, was killed in a plane crash in Northern England in 1943.

Henri spent time as an air traffic controller during the latter part of the war, and in 1945, when back in Mauritius, he decided to pursue a medical career but had no success with his application to some medical schools in England. At this time his New Church minister was an Australian, a graduate of the University of Melbourne, who encouraged him to apply there. He was successful and was to commence his year at Mildura Campus in 1947. Because of the subjects he had done in his first year at the college in Mauritius, Henri found the subjects easy in his first year and he obtained Honours in Chemistry and Biology, Second Class Honours in Physics, shared the W H Swanton Exhibition in Biology and obtained the Baldwyn Spencer Prize in Zoology.

His scholarship not only covered his tuition, but he was entitled to take up University College Residence, so on his return to Melbourne he was resident at Queen's College for the remaining years of his medical course, where he first met Noel Cass, who he was later to join as a member of the Melbourne Anaesthetic Group. Henri came to Melbourne suffering not only from being strange to its culture and having English as a second language, but also from having less than optimal skills at articulation. In a word, he was difficult to understand and, on his own admission, whether he was speaking in English or his native tongue! On the other hand, Henri had a winning personality, always a smile, never a sign of malice, and he was liked by virtually everybody. Whilst a medical student, Henri was called to order during a session at the Royal Women's Hospital by his future wife, Paula, who was then a trained Midwife. He graduated in 1952 and returned briefly to Mauritius before travelling to the UK for formal training in anaesthesia at what was then an outstanding institution, the Anaesthetic Departments in Liverpool headed by Professor Cecil Gray and Dr Jackson Rees.

One of us (HN) has known Henri as a medical student at the Royal Melbourne Hospital, and later met him again at the Royal College of Surgeons in London after one of the anaesthetic postgraduate exams in 1958. Henri remained at Liverpool whilst HN spent a year in Philadelphia, USA. They were both to return to Melbourne in early 1960 to full-time positions at the Royal Melbourne Hospital, with Henri as Acting Director and HN as his deputy, whilst the full-time Director went on sabbatical leave. At the end of that year both were invited to join the Melbourne Anaesthetic Group in private practice and they were both appointed half-time to the Royal Victorian Eye and Ear Hospital – life-time appointments for both.

Henri also had appointments at the Royal Melbourne and Prince Henry's Hospital and was favoured and retained by neurosurgeons, ophthalmologists and ENT surgeons – none of whom would have tolerated less than the best. He was a diligent, competent, conscientious anaesthetist, known for his calmness in theatre by the registrars with whom he worked.

He was a devoted husband to Paula and father to four accomplished children – Suzanne, Maurice, Denise and Annette. Maurice followed his father's example in graduating in medicine then a postgraduate course in anaesthesia and Annette also qualified as a Registered Nurse with special skills as a PACU Nurse. With his family he continued in faith to contribute to his church, which remained an important feature in his social as well as his religious life. With Paula he provided a loving family environment. The family, including the grandchildren, constituted a tightly bonded group of admirable, well-rounded personalities with mutual affection. To the amazement of one of his younger colleagues, Henri was also an intense devotee to cryptic crosswords, at which he had great skill, despite them being not in his own native tongue.

After his retirement in his early seventies, Henri found himself afflicted with progressive physical disabilities. He began to lose his mobility and strength, culminating in a disastrous fall producing quadriplegia. His remarkable partial recovery showed his tenacity and persistence. He also had some visual impairment, hypertension and failing peripheral circulation. Compounding his suffering were the deaths of his beloved Paula, then later the sudden death of his daughter, Denise. Despite the torment of these and of the physical deterioration, he remained intellectually active, learning the skill of the computer and making good use of e-mail to foster his various friendships. Henri would talk of his problems only to inform, not to bemoan or seek unjustified sympathy, rather, he would make light of them. The last months of his life were very sad with his on-going afflictions, yet his spirit barley faltered. As Henri would put it, his earthy life ended on the 4th of January 2004. His son, Maurice, referred to his father, on the occasion of the celebration of his life, as the nicest person he had ever met.

Herbert Newman and Robert Gillies

Margaret (Mona) Innes (1913-2003)

FFARACS 1952, FANZCA 1992 - New Zealand

Dr. Margaret Innes - known to all of us as "Mona" - was born in 1913 in Aberdeen, an only child: her father a businessman, her mother a registered nurse who had nursed members of the royal family in Balmoral. Although expected to become a teacher, she decided to qualify in medicine. At Aberdeen University she revelled in the student life, captaining the women's hockey and tennis teams and, an excellent pianist, accompanied the student capping concerts.

After graduation, she spent her House Surgeon years in Dublin doing obstetrics and A&E in Glasgow, sewing up drunken Scotsmen with the help of police (it was too dangerous for nurses on the night shift!)

She then decided to train in anaesthesia, working in Wolverhampton and elsewhere before moving to London and obtaining her D.A. From 1939 to 1941 she worked at St. James Hospital in Balham. At first she really enjoyed the cultural life - restaurants, plays, concerts, friends but soon became involved in the London blitz, working long hours with poor light, no heating, poor food and restriction of any absence from the hospital even in time off. As a pianist she suffered these difficulties with the consolation of access to a grand piano relocated from the home of a senior doctor whose family had been evacuated to the country. Here she met Barclay Innes, the young red-headed surgeon from New Zealand. They married in 1941.

Early in 1942 they moved back to Aberdeen, where Barclay became Surgical Registrar, doing the work of two or three men in the shortage of wartime hospital staff. Mona, in the next four years, raised two children, David and John. In 1944 she suffered an attack of poliomyelitis which fortunately left her with no ill effects.

The family then immigrated to New Zealand, Barclay preceding them and taking over the job of Surgical Registrar at Auckland Hospital. They shared a house in the hospital grounds with Pat Dunn and his family. Mona found the change daunting, with no domestic help, no culture to speak of, no friends and no concerts. However, she did adjust, making many new close friends. The Anaesthetic Department. (Dr. Hudson) was keen for her to work in the hospital, so she applied. However, the Hospital Board refused her application on the grounds that as her husband was already on the surgical staff they may well have to work on the same patient together! I don't know what collusion they could have got up to. This result was devastating and a real blow. There was a general outcry, so much so that the Herald published a cartoon by Minhinnick the next day, of a surgeon and anaesthetist throwing knives at each other over a recumbent patient!

She eventually did work for the public hospital in the Eye and ENT theatres and at the old National Women's Hospital and was later involved in the heady days of early cardiothoracic work at Green Lane. Student teaching was also part of the job. However she did not appreciate the morning lists going on to 2.30pm, as house surgeons were left to finish too long a list. She then gave up public hospital work, deciding to work in private only, as by then she was well known as a reliable and trustworthy anaesthetist. She made many good friends and was much happier when they moved to their new home in Omahu Road, which she furnished with taste and skill. She then completed her family with a daughter, Margaret, born in 1950.

She continued to give anaesthetics until 1979 and then worked as a medical officer for the Blood Transfusion Service. This she enjoyed, travelling over the countryside with a friendly group of staff. She finally retired in the late 1980's.

Always musical, she kept up her pianistic skills with friends but then, stimulated by her sons' violin lessons, decided to learn herself. This she did, to her and others' great pleasure. The frequent trio sessions of Baroque music, usually two violins and piano, and sometimes cello (with lunch) were great fun. She also joined the Mozart Orchestra where Dr Nalden's martinet conducting stimulated all the players. Concerts were always her delight.

Where possible she would travel, especially in Europe, visiting new and old places and revisiting family and friends. She was always welcome, with her gentle wit and sense of humour. She also enjoyed gardening and bush walking with the family on holidays on Egmont.

In summary she was a professional anaesthetist, creator of a loving home environment, a skilled musician and a very good friend. We shall all miss her greatly!

Patricia McDonald

Carl Theodorus Moller (1943-2004)

FANZCA 1995 - Tasmania

Born and educated in South Africa, Carl worked in the field of cardiothoracic anaesthesia and intensive care at Green Lane Hospital, Auckland for many years before moving to Hobart in 1991 to create, with David Hill, the Tasmanian Cardiothoracic Unit at the Royal Hobart Hospital.

As the Director of Cardiac Anaesthesia and Perfusion he was responsible for the development and implementation of the high standard of cardiothoracic anaesthesia, perfusion and postoperative intensive care practice in Tasmania, a legacy he leaves behind. Carl was well known for his rigorous application of modern quality assurance practices, with extensive data collection of all facets of outcome relating to cardiac surgery in Tasmania including presentations at our national CME meetings, with his championing the cause of patients on surgical waiting lists creating welcome media attention.

Carl played a prominent role in the clinical education of many anaesthetic trainees, also intensive care nursing staff, and will be remembered fondly for his wisdom and erudition. He enjoyed lecturing to physiology students at the University of Tasmania and encouraging their attendance in the operating theatre for some real life demonstration. He was elected to Fellowship of ANZCA in 1995.

Carl was good company and an enthusiast in everything he undertook, from computer programming to growing hydroponic plants. He was an avid reader, a very talented craftsman in wood, and enjoyed walking and camping with his family.

Carl died in Hobart in early January 2004 after a prolonged battle with bowel cancer, which he bore with characteristic determination, undergoing treatment while continuing to work fulltime until he decided to retire in June 2003. Carl is survived by his wife, Margy and two adult children.

Peter Peres

Honours and Appointments

Mr Michael Gorton (VIC, Hon Fellow) - Member in the Order of Australia (AM)

Dr Dianne Stephens (NT) - Medal of the Order of Australia (OAM) for services in the aftermath of the Bali bombing

Dr Peter Sharley (SA) - Medal of the Order of Australia (OAM) for services in the aftermath of the Bali bombing

Lt Col Susan Winter (NT) – Conspicuous Service Cross (CSC) for services in the aftermath of the Bali bombing

A/Prof Tony Quail (NSW) – Associate Professor of Anaesthesia, University of Newcastle

Deaths

Dr Henri Rene Paul Coutanceau (Vic) - FFARACS 1961, FANZCA 1992
Dr Carl Theodorus Moller (Tas) - FANZCA 1995
Dr Maureen Joan Peskett (NZ) - FFARACS 1977, FANZCA 1992

International Association for the Study of Pain

11th World Congress on Pain

21st – 26th August, 2005
Sydney Convention Centre, Darling Harbour

The above congress is sponsored by the International Association for the Study of Pain (IASP). The IASP is the pre-eminent, multidisciplinary, world body concerned with advances in all aspects of the diagnosis and treatment of pain, fostering the latest research agendas in both basic and clinical science and particularly the interaction between these areas resulting in the rapid integration of research findings into clinical practice as well as educational initiatives (at both undergraduate and postgraduate levels). It also provides appropriate support of National Pain Societies to Governments to increase the availability of pain relieving options at the local level.

The IASP has around 6750 members from 107 countries and approximately 60 of these countries have formed national Pain Societies (for example, the Australian Pain Society) and the IASP works very closely with these national bodies.

While the IASP has many educational initiatives, its two main areas are to publish the prestigious journal *PAIN* (which has the highest impact rating for all pain and anaesthesia journals) and to run a triennial World Pain Congress.

The next World Pain Congress will be held in Sydney in August 2005 at the Darling Harbour Convention Centre. Previous Congresses have been held in San Diego (2002), Vienna (1999), Vancouver (1996), Paris (1993), Adelaide (1990), Hamburg (1987), Seattle (1984), Edinburgh (1981), Montreal (1978) and the first World Congress was held in 1975 in Florence.

Closer examination of the sites for the World Congresses reveals that the 2005 Sydney Meeting will be only the second occasion in the long history of the IASP (founded in 1973) that a World Congress will be held anywhere in the Southern Hemisphere. Moreover, there will be a 15 year gap between this Meeting and the previous Congress held in the region (Adelaide). It is immediately apparent that there is likely to be a substantial time period after the Sydney Congress before the IASP selects a site that will combine efficiencies in terms of time, finance and convenience for Australian delegates - thus, the 2005 Sydney World Pain Congress does represent the unique opportunity in the foreseeable future for all professionals with an interest in pain to conveniently participate in this pre-eminent triennial meeting. Further, it does also represent a particular opportunity for trainees in any health discipline that concerns the diagnosis and / or treatment of pain to obtain the latest information.

The six day World Congress will comprise plenary lectures (approximately 20 by the leading scientists and clinicians presenting on a wide variety of pain topics), workshops (approximately 80), posters on every conceivable pain topic (over 1500 at the last World Congress in San Diego), Refresher Courses, extensive trade display and a number of Associated Symposium (run in the evenings by various pharmaceutical or equipment companies).

There will also be a number of satellite meetings (nine have been approved) at various locations with the majority in Australia and four actually in Sydney either before or after the World Congress.

The best location for further information on this important Meeting can be obtained from the IASP website at www.iasp-pain.org (click on the XIth World Congress on Pain on the home page - this site will be continually updated with valuable information including the programme when it is finalised). The Local Arrangements Committee (LAC) expects there will be over 4000 registrants for the Sydney Congress. The IASP and the LAC extend the warmest invitation to all professionals with an interest in pain to attend the XIth World Congress on Pain in the knowledge it will provide the best opportunity for professionals to obtain or update knowledge in every conceivable pain area along with the convenience of attending a World Congress in the wonderful facilities of Darling Harbour in the premier convention destination of Sydney. The LAC hopes that Fellows will use the information above to widely publicise the World Pain Congress and to that end, electronic copies can be obtained from Geoff Gourlay:-
(geoff.gourlay@flinders.edu.au)

Faculty of Pain Medicine Board

Back row: Ms M Benjamin (Executive Officer), Profs M J Cousins AM, R D Helme, Drs R S Henderson, G I Rice, J A Fleming
Front row: Drs P A Briscoe, D Jones, A/Profs R L Atkinson (Dean), M L Cohen (Vice-Dean), Dr C R Goucke
(Absent: Dr B Kinloch)

Queensland Regional Committee

Australian and New Zealand College of Anaesthetists

ANNUAL REGISTRARS' MEETING

Once again the Tess Cramond Prize was awarded at the Annual Registrar's Meeting held on 25 October at College House, Spring Hill.

Adjudicators with Professor Cramond were Dr Kersi Taraporewalla, Dr Sean McManus and Dr Anthony Coorey who unanimously voted to award the Prize to Dr Lisa Mohanlal for her presentation "*The incidence and severity of aortic stenosis in patients undergoing hip fracture surgery*".

With 20 presentations and 65 people in attendance the day was a great success.

Dean's Message

Neil Matthews

May will see the culmination of planning for the two Annual Scientific Meetings of RACP and ANZCA in Canberra and Perth respectively. Importantly for the first time, our new Fellows will be presented at the RACP ceremony, an important occasion to mark the acknowledgement of the Joint Faculty's parent bodies, previous presentations having only been at ANZCA ASM's. I very much look forward to presenting our new Fellows in Canberra and meeting as many Fellows as possible at both meetings. In addition, I am excited about the first Joint Faculty Scientific Meeting in Sydney in June 2005. Don't forget to place it in your calendar. It is important to recognise that the Joint Faculty will continue to have important input into future ANZCA and RACP Scientific Meetings.

Professor Tony Bell has stepped down from the Board, and a large number of other administrative commitments. Tony is a major contributor to the Australian and Tasmanian intensive care scene, and I very much valued Tony's input and advice on Board matters. We will miss you Tony, and wish you well. It is sobering to recognise the effort and dedication of those who represent our Specialty, and who are charged with maintaining training, standards and a focussed Fellowship and Intensive Care community. However the rewards are especially fulfilling. There are three vacancies on the Board, with nominations now called for, and an election process to be followed so that the new Board members are installed at the June Board meeting. I very much look forward to the outcomes of the election and to working with the new Board members.

Major discussions are being held with Federal Government agencies regarding workforce issues through the Committee of Presidents of Medical Colleges on which we are directly represented. These discussions relate to ease of access for Overseas Trained Graduates and Specialists. Government wants ease of access to relieve medical officer and specialist shortages, while bodies responsible for training and standards want assurances of quality outcomes. The discussions are ongoing.

I look forward to seeing you at the ASM's.

Cheers,

Neil Matthews
Dean

Items of Interest

FROM THE FEBRUARY 2004 BOARD MEETING

Honour

The Board extended its congratulations to Mr Michael Gorton, Honorary Solicitor for his recent award of the Order of Australia, Member in the General Division, recognising his service to the community.

Liaison with the CMO

The Chief Medical Officer for the Commonwealth, Professor John Horvath met with the Board to brief members on health priorities. Formal links are being established between Colleges and Government on strategic issues and the Joint Faculty will be asked to provide input at short notice. The Government will also liaise with Colleges to seek quicker pathways to allow overseas trained doctors to practice in Areas on Need.

Survey of Supervisors of Training

Following discussion on how the Joint Faculty may better support its Supervisors of Training, it has been agreed to seek input from individual Supervisors in the form of a survey.

Trainee Committee

The first meeting of the Trainee Committee was held in December 2003. This Committee was formed to enable input from trainees, and the Chairperson elected by the Committee is a member of the Education Committee. Details of trainee representatives in each region are detailed elsewhere in the Joint Faculty section of the Bulletin. Trainees are encouraged to contact their local representative to raise any issues or provide input regarding the training program or other educational matters.

Pro-rata Payment of Subscriptions

Upon admission, Fellows pay either a full or half subscription, depending upon when they are admitted, be it in the first half, or second half of the year. The Board resolved that pro-rata payment of subscriptions should be implemented for new Fellows.

Readmission to Fellowship

The Board resolved that Fellows choosing to resign from Fellowship but who later seek to be readmitted will be required to pay all subscriptions for the period of suspension of Fellowship, and undertake a period of retraining depending on the period of suspension of Fellowship, as determined by the Board at the time of application for reinstatement.

Board Elections 2004

A call for nominations for three vacancies on the Board of Faculty will be circulated and an election held in June.

Election of Dean-elect

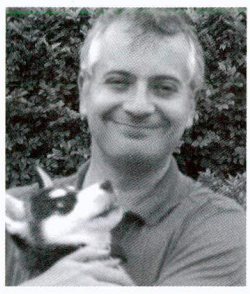
Dr Neil Matthews will resign from the office of Dean in June. A/Professor Jack Havill was elected Dean-elect.

Representatives to New Fellows Conference 2004

Dr Claudia Schneider, New Zealand will be attending the New Fellows Conference in Perth in May as the Joint Faculty's representative.

G A (DON) HARRISON MEDAL 2003

The joint winners of the G A Don Harrison medal for 2003 were Dr Jeremy Cohen (Qld) and Dr David J R Morgan (WA)



Dr Jeremy Cohen (Qld)

Dr David Morgan (WA)

2004 ANNUAL SCIENTIFIC MEETING PERTH

1 to 2 May 2004

The Intensive Care component of the forthcoming Combined Annual Scientific Meeting aims to lure an audience from all disciplines.

New approaches to old chestnuts in Intensive Care Medicine will vie for time with topics as broad as the use of steroids in a life-saving manner, murder and cure by oxygen, genetic predisposition to and diagnosis of infection, nitric oxide, the latest ventilatory tactics and directions in Intensive Care research.

The human face of Intensive Care research will be headed up by Professor Ian Roberts, our Foundation Speaker, as well known for his work on social aspects of head injury prevention as he is with leading the Cochrane Institution's foray into the use of steroids in head injury.

A/Professor Myburgh and Dr Blythe will report on the ANZICS Clinical Trials Group's activities, including the much anticipated result of the SAFE study.

Two overseas visitors, Professor Meisner from Germany and Professor Linton from Israel, will add an international flavour as well as their sub-specialty knowledge to the conference, while eminent speakers locally and from around Australia will present the latest in their areas of research.

The meeting runs hard and fast for just the two days of the week-end, ending at the Perth Mint with the Faculty's Intensive Care dinner.

Registrations have exceeded expectations, and we're looking forward to an exciting meeting.

Hope to see you there!

David Simes
Scientific Convenor
Joint Faculty of Intensive Care Medicine

Faculty Foundation Visitor
Professor Ian Roberts

Invited Speaker
A/Professor David Linton

Invited Speaker
Dr Michael Meisner

Admission to Fellowship of the Joint Faculty of Intensive Care Medicine

The following have completed all requirements for admission to Fellowship by examination:

Paul Brian Goldrick	Qld
Iain George Johnston	Qld
Manoj Krishan Saxena	NSW
Martin John McNamara	Qld

MOPS UPDATE

Participants in the Joint Faculty's Maintenance of Professional Standards Program will have received the updated Manual in early January. News of the new online diary and how to register were also advised.

Program changes

With regard to the program itself, some minor amendments were made for 2004:

- Change 'Practice Peer Review' for 'Professional Practice Review'
- Minor changes to credit points allocation, but all codes remain the same
- 'Other activities' include sabbaticals and overseas aid trips
- Removal of reference to HELP modules
- New code has been included for Simulators and Interactive workshops and seminars

Online Diary

The online diary service is now available. This allows members to view the Manual, access their 2004 diary via the website, and armed with a Medeserv Intouch User Password, input their points as accrued, from their desktop. At the end of the year, with the touch of a button, the annual return is automatically forwarded to the Joint Faculty. Information regarding all of these changes is available in the Members section of the Website, at http://www.jficm.anzca.edu.au/members/mops/index.htm.

In order to register participants need to obtain a Medeserv Intouch User password, then contact the Faculty office to become a registered user of the online service. This takes 1-2 days to process.

A Paper Diary is still available for those who prefer that format.

Members should contact Ms Megan Freeth at the Joint Faculty office to order one. Those utilizing a Paper Diary may also choose to submit their Annual Return electronically via the Website if preferred.

Annual Returns for 2003

Please note that your Annual Return for 2003 should be forwarded no later than the end of February 2004. The Online Service applies for participation from 2004 only.

If you have any queries or problems, please contact Miss Megan Freeth on +61 3 9530 2861 or email mfreeth@anzca.edu.au.

Audit 2004

It is proposed to conduct an audit during 2004. This will involve a random selection of 5% of participants to verify the accuracy of their returns and the relevance of activities claimed. Those contacted will be required to provide documentation verifying their returns, and then an analysis will be made of the types of activities.

J. GILLIS
MOPS Officer

JFICM TRAINEE COMMITTEE

A Trainee Committee has been established by the Joint Faculty as a mechanism for input to the Board and its committees on issues affecting trainees. The Chairperson is a member of the Education Committee.

The following trainee representatives have been nominated by Regional/National Committees, however it is intended that an election will be held in 2004. Trainees are encouraged to contact the following members of the Committee:

Dr Stuart Baker, Western Australia
Email: discostu@westnet.com.au

Dr Amy Bertinelli, New Zealand
Email: amybertinelli@hotmail.com

Dr Celia Bradford, New South Wales
Email: celiabradford@telstra.com

Dr Leo Nunnink, Queensland
Email: leonunnink@optusnet.com.au

Dr Matthew Piercy, Victoria
Email: mepiercy@idx.com.au

Dr Peter Rogers, Tasmania
Email: rogers_p50@hotmail.com

Dr Stephan Lam
Email: stevelamski@hotmail.com

Appointments

SUPERVISOR OF TRAINING IN INTENSIVE CARE MEDICINE

At the recent meeting of the Board, the following appointments were ratified:

Dr Michael Gillham	Green Lane Hospital, New Zealand
Dr Ramesh Nagappan	Frankston Hospital, Victoria

Joint Faculty of Intensive Care Medicine

ABN 82 055 042 852

POLICY DOCUMENTS

IC-1	(2003)	Minimum Standards for Intensive Care Units *Bulletin August 2003, pg 69*
IC-2	(2000)	The Duties of an Intensive Care Specialist in Hospitals with Approved Training Posts *Bulletin November 2000, pg 53*
IC-3	(2003)	Guidelines for Intensive Care Units Seeking Accreditation for Training in Intensive Care Medicine *Bulletin November 2003, pg 61*
IC-4	(2000)	The Supervision of Vocational Trainees in Intensive Care *Bulletin March 2000, pg 57*
IC-5	(1995)	Duties of Regional Education Officers in Intensive Care *Bulletin November 1995, pg 50*
IC-6	(2002)	The Role of Supervisors of Training in Intensive Care Medicine *Bulletin September 2002, pg 36*
IC-7	(2000)	Secretarial Services to Intensive Care Units *Bulletin March 2000, pg 58*
IC-8	(2000)	Quality Assurance *Bulletin November 2000, pg 55*
IC-9	(1997)	Statement on the Ethical Practice of Intensive Care Medicine *Bulletin November 2002, pg 57*
IC-10	(2003)	Minimum Standards for Transport of Critically Ill Patients *Bulletin March 2003, pg 29*
IC-11	(2003)	Guidelines for the In-Training Assessment of Trainees in Intensive Care Medicine *Bulletin November 2003, pg 64*
IC-12	(2001)	Examination Candidates Suffering from Illness, Accident or Disability *Bulletin November 2001, pg 63*
IC-13	(2002)	Recommendation on Standards for High Dependency Units Seeking Accreditation for Training in Intensive Care Medicine *Bulletin June 2002, pg 68*
PS38	(1999)	Statement Relating to the Relief of Pain and Suffering and End of Life Decisions *Bulletin June 1999, pg 93*
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*
PS45	(2001)	Statement of Patient's Rights to Pain Management *Bulletin March 2002, pg 72*
PS48	(2003)	Statement on Clinical Principles for Procedural Sedation *Bulletin March 2003, pg 73*
PS49	(2003)	Guidelines on the Health of Specialists and Trainees *Bulletin August 2003, pg 88*

Dean's Message

Leigh Atkinson

A Visit from the Chief Medical Officer

On 12th February Professor John Horvath A.M., the Chief Medical Officer of the Australian Department of Health and Ageing, attended and addressed the Faculty Board Meeting. This was valuable for the Faculty to gain an understanding of the medico-political process in Canberra. John Horvath has promised us that we will be included in his "small pink book of contact numbers" for issues relating to pain medicine. John Horvath's visit underlined the point that the CMO is often more accessible than his state counterparts.

Most would agree that success has much to do with timing. I asked John Horvath that in view of our frustrations in developing a higher profile for pain medicine, did he think that the birth and the infant years of the Faculty were premature? He did not think the Faculty was premature. "Were we in tune with the community needs"? He gave a positive "yes". He added a disappointing comment that pain is not politically "sexy". He suggested that we need a prominent public advocacy support group such as the disease depression has with "Beyond Blue".

There is no doubt that the communities in Australia and New Zealand are seeking better pain management. Articles in the journals of other Colleges, groups such as the National Institute of Clinical Studies and also the United States Government, have all sensed this change. With our submission to the Australian Medical Council we hope to press the need for national recognition.

John Horvath indicated that there is little discretionary money at a state public hospital level for pain medicine at present. Entrenched specialists such as cardiac surgeons gather in these funds and we have few champions. Still it was reassuring to hear the CMO strongly support the multidisciplinary emphasis of the delivery of pain medicine in our countries.

The visit by John Horvath brings me to the close of my period as Dean. I wish to sincerely thank the Board and the Fellowship for this opportunity over the past two years. Again our Board has enjoyed a period of harmony. With the election of Julia Fleming and Robert Helme the membership of the Board has turned over in a healthy way. On 12th February we did have a productive strategy meeting to set in motion a Business Plan for the next two years based on improved communications with our sister colleges, improved resources within the College and more definite succession plan for our Board and Committees.

I am delighted to report that the multidisciplinary approach of the Faculty continues with the election of Assoc Professor Milton Cohen as the Dean as from the conclusion of the May Annual Scientific Meeting. Each of the specialities brings new visions to the delivery of pain medicine to our patients.

The last two years have passed all too quickly and the achievements in retrospect have been disappointing.

Congratulations to the Dean-Elect, Milton Cohen. Many thanks to the Board Members and the Executive Officer, Margaret Benjamin. Many thanks to the President, Richard Willis and the CEO, Joan Sheales, for their generous advice and support.

I look forward to seeing as many of you as possible at our Annual Refresher Course Day and Dinner in May.

Leigh Atkinson
Dean

Highlights from the Board Meeting

HELD ON NOVEMBER 20, 2003

Professor Sanchia Aranda, CEO, and Dr Ruth Cornish, Pain Management Project Manager, National Institute of Clinical Studies, were visitors to the Board Meeting.

Recognition of Pain Medicine as a Specialty

The Faculty's submission was posted on the AMC and FPM websites with a call for responses. There were 42 responses, most were supportive. Two that were against were from Professor N Bogduk and the Australasian Faculty of Musculoskeletal Medicine (AFMM). The AMC has forwarded a list of 23 questions to the FPM with a deadline to respond by November 24.

The AMC Recognition Review Group will be meeting with members of the Faculty Board on December 1 at ANZCA House. Following this meeting, the AMC Group will also meet representatives from the RACGP and the AFMM. They will also visit the Pain Units at Geelong Hospital and Prince of Wales Hospital.

The AMC will provide a draft document to the FPM by early January for comments.

Finance

The Board resolved that Fellows who are fully retired from practice receive 100% concession on their subscription fees from 2004 onwards, effective immediately. This brings the Faculty into line with the College concession fee for retired Fellows.

Subscription Fees. It was agreed that the 2004 subscription fee remain at A$700 plus GST.

Education

The main issues on the Education Committee agenda at present are:

- Pain Orientated Physical Examination (POPE). Discussions are continuing with CSL regarding support for the production of this CD.
- Supervisor of Training Manual. A working party has commenced work on this document for the Faculty.

A face to face meeting will be held in early 2004.

Research

R Helme reported on his attendance at meetings of The Australian Association of Neurologists (AAN) Clinical Trials in Pain. The National Neurosciences facility is based in Melbourne and $1m has been allocated to the Clinical Neurosciencies Trial Platform. One of the neuroscience trials will be related to pain. M Cousins agreed there was not a conflict of interest with the ANZCA Clinical Trials Group.

Examination

2003:

P Briscoe reported that the 2003 examination was held at Royal Brisbane Hospital on October 28 and 29 with an Examiners' workshop held on October 27. Professor Cramond was acknowledged for her hard work in preparing for the examination including selecting all the patients. Seven candidates in total presented from anaesthesia, neurosurgery and psychiatry and all were successful.

2004:

It was agreed that the 2004 examination will be held in Melbourne.

Barbara Walker Prize for Excellence in Pain Management

It was agreed that the Barbara Walker Prize will not be awarded in 2003. This Prize is to only be awarded when the top candidate achieves at least 70%.

Hospital Accreditation

Flinders Medical Centre Pain Unit, SA

The Board approved Flinders Medical Centre Pain Unit for training for a further two years from the commencement of 2004.

Annual Scientific Meetings

2004 Perth

The scientific program has been finalised.

Refresher Course Day, April 30

The FPM will be combining with the Australasian Faculty of Rehabilitation Medicine (AFRM) and the Australian Society for Geriatric Medicine (ASGM) for its meeting at The Esplanade Hotel, Fremantle. The theme for the day will be on Post Stroke Pain. Speakers will include Professor Ralf Baron, the FPM Foundation Speaker and Professor Peter Langhorne from Glasgow Royal Infirmary.

Annual Dinner

This is to be held at the Old Swan Brewery, Perth on April 30

Admission to Fellowship of the Faculty of Pain Medicine

By training and examination:		*By election:*	
Dr Pradeepa Gunawardane	SA/NZ	Dr Dilip Kapur	SA
		Dr Slav Kostov	SA

Application to the Australian Medical Council for Recognition of Pain Medicine as a Specialty

The Faculty's response to the AMC questions was submitted by the deadline. The AMC Recognition Review Team visited the Pain Units at The Geelong Hospital and the Prince of Wales Hospital and we would like to thank all those involved for their contribution. We are now waiting on the initial report from the AMC.

Court of Examiners

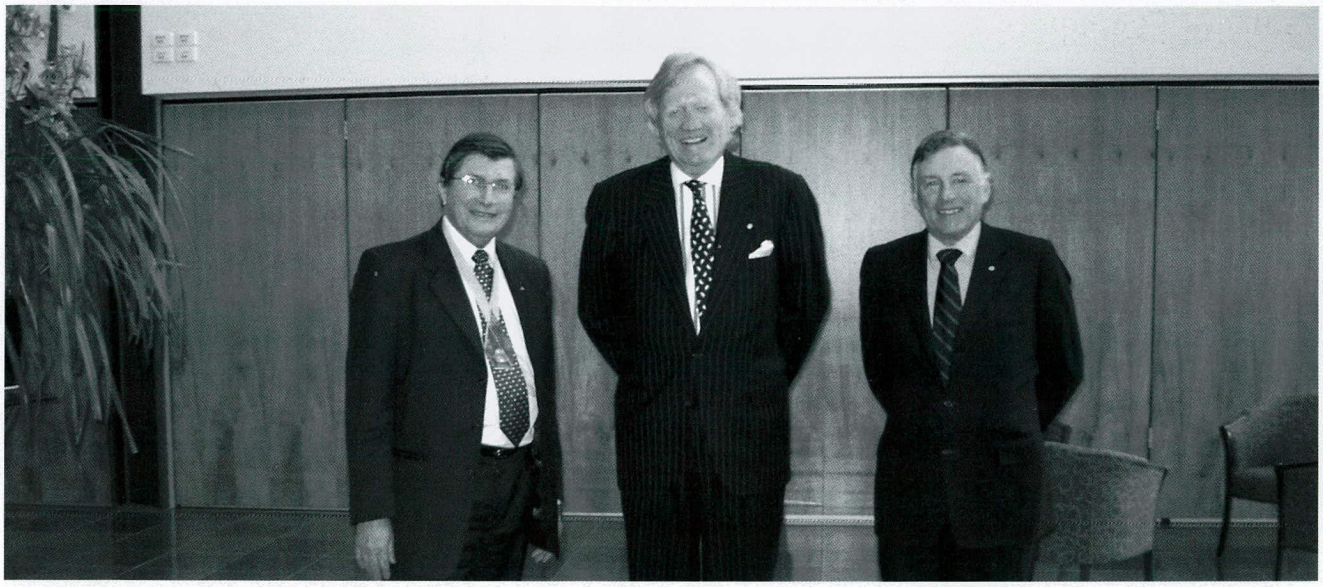
Prof Leigh Atkinson, Dr Carolyn Arnold, Prof Robert Helme, Drs Ray Garrick, Bruce Rounsefell, Frank New, Prof George Mendelson, Dr Lindy Roberts and Dr Bronwyn Williams (who assisted at the examination)
Front L to R: Dr Penny Briscoe (Chair, Court of Examiners) and Prof Tess Cramond (who assisted at the examination)

Successful Candidates at the 2003 Examination

Back L to R: Drs Mohammad Tipu, Gavin Pattullo, Kieran Davis
Front L to R: Drs Bernard Lee, Pauline Waites, Susan Lord, Joseph Azzopardi

Dr Lindy Roberts, Dr Mohammad Tipu and A/Prof Leigh Atkinson

Dr Pauline Waites with Dr Penny Briscoe



Mr Ronald Walker with the Dean, A/Prof Leigh Atkinson, and Prof Michael Cousins. Mr Walker recently attended a Faculty Board Meeting at the College.

Maintenance of Professional Standards

At the May 1, 2003 Board Meeting a decision was made that MOPS become mandatory for all Fellows of the Faculty of Pain Medicine effective from 2004.

While Fellows in New Zealand and New South Wales already have mandatory MOPS as a requirement of their continued registration with their respective Medical Boards, it was felt appropriate to introduce this requirement for all Fellows.

Pain Medicine is a young specialty with many recent developments in the Basic Sciences, clinical practice and standards of care. The Faculty's commitment to continuing medical education and maintenance of professional standards will be shown by the participation of Fellows in its various programmes.

Fellows can complete the MOPS Program of either their primary specialty College and/or the ANZCA MOPS Program.

For those Fellows practising Pain Medicine in any form, the Board would like to see participation in the ANZCA MOPS programme although any MOPS programme will be acceptable. For those Fellows who elect to participate in two MOPS programmes (ie that of their primary specialty and the ANZCA one) 'double dipping' ie the process of submitting **relevant** MOPS details to both programmes is quite acceptable.

As a number of Pain Medicine practitioners are now participating in the ANZCA MOPS Program, a new Practice Type has been introduced. In addition to the existing City, Rural and Overseas, we have added the Practice Type 'Pain Med'.

'Practice Type' is one of the criteria used in creating the Individual Comparison Reports, the feedback report sent to participants mid-way through the year. This report also compares your activities with all participants as well as those in your region (i.e. state, country).

For details regarding MOPS, please contact either your primary specialty College or Juliette Mullumby at ANZCA MOPS Office cme@anzca.edu.au or phone 61 3 9510 6299.

Faculty of Pain Medicine

ABN 82 055 042 852

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
PM3	(2002)	Lumbar Epidural Administration of Corticosteroids
PS3	(2003)	Guidelines for the Management of Major Regional Analgesia
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	(1998)	The Pre-Anaesthesia Consultation (Adopted February 2001)
PS8	(1998)	The Assistant for the Anaesthetist (Adopted February 2001)
PS9	(2001)	Guidelines on Conscious Sedation for Diagnostic, Interventional Medical and Surgical Procedures (May 2002)
PS10	(1999)	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)

Australian and New Zealand College of Anaesthetists

ABN 82 055 042 852

Review PS27 (2004)

GUIDELINES FOR FELLOWS WHO PRACTISE MAJOR EXTRACORPOREAL PERFUSION

1. INTRODUCTION

Major extracorporeal perfusion (ECP) involves the diversion of patient blood through an artificial circuit incorporating a pumping device for the purpose of assisting the circulation, and usually achieving gas exchange for oxygen and carbon dioxide. The circuit will usually include an oxygenator and a heat exchanger and various pressure and flow monitoring devices for major cardiopulmonary bypass. This process is used for partial or total body perfusion as a life support system during cardiac and major vascular surgery and in profound heart or lung failure. The practice includes management and monitoring of procedures such as whole body perfusion, isolated limb perfusion, temperature control, specific organ protection or perfusion, blood coagulation control and blood conservation.

These guidelines are the recommended requirements for appropriate patient care.

2. TRAINING AND MAINTENANCE OF STANDARDS

2.1 Specific Perfusion Training for Specialist Anaesthetists (or Fellows of ANZCA)

2.1.1 This training should include at least 12 months of regularly supervised experience in the practice of perfusion, covering all practical aspects of perfusion, including circuit set-up, priming and direct management of perfusion.

2.1.2 Training should result in a detailed knowledge of all medical aspects of management of patients undergoing major ECP. This includes managing the anaesthetised patient with cardiopulmonary bypass and drug and medication requirements. Management and knowledge of cardiovascular variables, gas exchange, acid base homeostasis, glucose and electrolyte homeostasis, coagulation and transfusion of blood and blood products, are essential components of perfusion management.

2.2 Education and Quality Assurance

All Fellows who practise major ECP should participate in:

2.2.1 A Continuing Education and Quality Assurance Program,

2.2.2 Auditing and data collection on all patients, with periodic review of data and all incidents occurring during or associated with major ECP.

3. PRE-OPERATIVE PATIENT ASSESSMENT

3.1 The Fellow who practises major ECP must assess the patient preoperatively, as advised in the College Professional Document PS27 *Recommendations on the Pre-Anaesthesia Consultation*.

3.2 The Fellow who practises major ECP must inform the patient of the planned procedure and the anaesthesia, as outlined in the College Professional Document PS26 *Guidelines on Providing Information about the Services of an Anaesthetist*.

4. CLINICAL MANAGEMENT OF MAJOR ECP

4.1 Major ECP Circuit Assembly and Priming.

4.1.1 Prior to application, the major ECP circuit must be assembled, checked and primed according to written protocols developed by each institution. These protocols must encompass standards for handling of sterile equipment, consistence with manufacturers' recommendations, appropriate selection of priming solutions and a procedure for checking the circuit.

4.1.2 A written pre-bypass checklist for the assembled and primed circuit and all

components of the major ECP machine must be completed and signed and kept on record.

4.1.3 Drugs added to the major ECP circuit must be checked and signed for according to protocols.

4.2 Initiation of Extracorporeal Perfusion

4.2.1 Prior to the initiation of extracorporeal perfusion, the Fellow who is conducting the perfusion must relieve himself/herself of any conflicting responsibility.

4.2.2 The anticoagulation status of the patient must be confirmed as appropriate for the procedure, and noted on the perfusion record.

4.3 Maintenance of Extracorporeal Perfusion

4.3.1 During maintenance of major ECP, continuous and vigilant assessment and management is required of all patient monitored physiological parameters and monitored machine parameters and anticoagulation. A clear display of monitored parameters is essential.

4.3.2 Medical management includes responsibility for all drugs administered and the maintenance of cardiovascular flows and perfusion pressures and of acid base homeostasis and gas exchange. Consideration of co-morbid medical conditions such as diabetes and renal failure is essential at this time.

4.3.3 Continuous communication with the surgeon, anaesthetist, and technical assistants is essential during perfusion.

4.4 Cessation of Major ECP

4.4.1 Weaning from major ECP and resumption of adequate cardiac and pulmonary function requires particular care and skill as difficulties may occur at this time. As in all stages of major ECP, close cooperation and communication between the perfusionist, anaesthetist and surgeon is essential.

4.4.2 The major ECP circuit must be kept in a functional state until it is agreed by all medical carers that it is no longer required.

4.5 Protocols for Management of Major ECP

Basic clinical management protocols for extracorporeal perfusion and anticoagulation should be established in consultation with perfusion, anaesthesia, and surgical staff and be regularly reviewed.

Protocols for management of critical events should be distributed and regularly practised by all perfusion staff.

Such protocols must cover gas leaks or failure, blood circuit leaks or rupture, pump failure, oxygenator, filter or heat exchanger malfunction and the detection of clots in the circuit.

5. PATIENT RECORDS OF MAJOR ECP

A contemporaneous record of the conduct of extracorporeal perfusion must be made on a form appropriate for retention in the medical records of the patient. The record should include:

5.1 Patient details, operative procedure and relevant pre-operative clinical information.

5.2 Names of medical and technical perfusion staff.

5.3 Equipment and circuit details, including prime constituents, administered drugs and fluids.

5.4 Monitored physiological parameters.

5.5 Monitored machine parameters.

5.6 Notations of relevant events during extracorporeal perfusion

5.7 Notation of administration of cardioplegia.

5.8 A completed and signed pre-bypass check list.

6. ORGANISATION OF THE MAJOR ECP SERVICE

Fellows who practise major extracorporeal perfusion should be part of an organized hospital based service that is staffed with an appropriate number of trained and qualified personnel.

6.1 Staffing

6.1.1 The Head of the major ECP Service is responsible for all aspects of the administration and quality in delivery of the service as detailed in this document. He/she will be responsible for decisions relating to equipment selection and ordering.

6.1.2 The Head of the Service should ensure that the extracorporeal perfusion service is staffed at all times with appropriately trained staff to cover in hours and out-of-hours requirements, including emergencies.

6.1.3 Other staff will include appropriately trained personnel to support the service.

6.2 Facilities and Equipment

The Head of the Service should ensure that the extracorporeal perfusion service has appropriate staffing, facilities and equipment, and that members of the service are designated to:

6.2.1 Maintain and regularly review an

inventory of all hardware equipment, including records of maintenance and repairs and preventative maintenance. All equipment must meet current standards in electrical safety for cardiac protection.

6.2.2 Maintain an inventory of orders, receipts and supplies of all disposable equipment.

6.2.3 Provide on-going assessment of the efficacy and cost-benefit of currently used and potentially available equipment.

6.3 Physical Facilities

The Major ECP Service requires adequate dedicated space in close proximity and with easy access to the operating theatre and postoperative recovery/intensive care unit for:

6.3.1 Storage of hardware items

6.3.2 Storage of adequate supplies of disposable equipment in appropriate areas, with respect to lighting and protection from humidity, moisture and temperature extremes.

6.3.3 A clean area, in accordance with standards applicable and relevant to assembly of circuits, for use during extracorporeal perfusion.

6.3.4 Storage of patient perfusion records and other data used for quality assurance, research and other activities, including the performance of all devices used during the conduct of extracorporeal perfusion.

6.3.5 Offices and secretarial assistance for the Head of the Service and other members of the Service.

COLLEGE PROFESSIONAL DOCUMENTS

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T *Technical*

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Promulgated: 1994

Reviewed: 2001

Date of current document: Feb 2004

College Website: http://www.anzca.edu.au/

Australian and New Zealand College of Anaesthetists

ABN 82 055 042 852

Review PS37 (2004)

STATEMENT ON LOCAL ANAESTHESIA AND ALLIED HEALTH PRACTITIONERS

1. The College acknowledges that local anaesthetic agents may be administered to patients by allied health practitioners to perform procedures for which they are legally qualified. Such health practitioners may include Dentists, certain Registered Nurses and Podiatrists.
2. Health practitioners who may administer local anaesthetic agents must be appropriately trained in the use of local anaesthetic agents and relevant local anaesthesia techniques. It is desirable for ANZCA Fellows to be involved in the design and implementation of such training.
3. The course of instruction should include the detailed pharmacology of the drugs used with emphasis on the complications due to the drugs or injections. Training and certified competence in cardiopulmonary resuscitation is essential.
4. Patients undergoing procedures performed by allied health practitioners should not be denied the benefits of general anaesthesia when clearly indicated.
5. Arrangements must be made for the continuing medical management of such patients if required.

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This document is intended to apply wherever anaesthesia is administered.

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College Website: http://www.anzca.edu.au/

Australian and New Zealand College of Anaesthetists

ABN 82 055 042 852

Review PS46 (2004)

RECOMMENDATIONS FOR TRAINING AND PRACTICE OF DIAGNOSTIC PERIOPERATIVE TRANSOESOPHAGEAL ECHOCARDIOGRAPHY IN ADULTS

INTRODUCTION

Transoesophageal echocardiography (TOE) is a complex monitoring and diagnostic modality requiring specific cognitive and technical skills. Indications for TOE in the perioperative period have been clearly stated by the Task Force of the American Society of Anesthesiologists and the Society of Cardiovascular Anesthesiologists (Task Force 1996). Information derived from a diagnostic TOE examination is made available to other medical practitioners and may be used to guide or assist their management decisions.

1. THE TRANSOESOPHAGEAL ECHOCARDIOGRAPHY EXAMINATION

A diagnostic TOE examination comprises:

1.1 A full diagnostic study including spectral and colour Doppler analysis (Shanewise, Cheung et al. 1999), unless this is not achievable in a specific clinical situation.

1.2 Pre and post bypass studies in those cases involving cardiopulmonary bypass.

1.3 Video-taping, or equivalent, of key elements of the investigation and archival storage of all study recordings.

1.4 A formal written report with patient identification and including the name of the person conducting the examination, with one copy archived and one copy in the patient records.

1.5 A mechanism for peer review of study recordings.

2. TRAINING

Appropriate training for the use of transoesophageal echocardiography in the peri-operative setting is essential. (Cahalan and Foster 1995; Savage, Licina et al. 1995) Training guidelines have been published by other organisations (Intercollegiate Consensus Statement; Cardiac Society of Australia and New Zealand; Cahalan, Abel et al. 2002)

2.1 Training should be under the direct supervision of experienced practitioners, who shall have met standards equivalent to those outlined in this document. Such training should include both performance and interpretation of TOE examinations with no concurrent clinical responsibilities for the trainee.

2.2 The period of training should be at least the equivalent of 50 days full-time (based on Intercollegiate Consensus Statement) over a minimum period of ten weeks to a maximum period of two years. An initial two week period of full-time training is strongly recommended.

2.3 During the period of training, the trainee should perform:

2.3.1 Initially, a number of supervised TOE procedures to achieve and demonstrate competence to perform and report complete diagnostic TOE examinations. This would usually be expected to require 50 complete TOE examinations.

2.3.2 At least 50 unsupervised TOE examinations that have been reviewed with a supervisor.

2.3.3 At least 100 additional supervised reviews and reports of pre-recorded TOE examinations.

The trainee must be exposed to a wide range of cardiovascular pathology and at least 50% of TOE examinations should be undertaken in the operating theatre.

2.4 Prior to completion of TOE training, practitioners are encouraged to use TOE in a clinical environment to further develop their skills. In such circumstances, diagnostic information should only be used with caution to guide anaesthetic management. Information gained from the TOE examination should only be used to guide or assist other medical practitioners in their management decisions in consultation with an experienced practitioner.

2.5 Attendance and participation in post-graduate courses (e.g. Postgraduate Diploma in Perioperative and Critical Care Echocardiography, University of Melbourne), workshops and continuing medical education programs dedicated to peri-operative TOE is strongly recommended during the training period and thereafter.

3. DOCUMENTATION OF TRAINING

3.1 A log book (or equivalent database) must be maintained during the training period to record:

3.1.1 the number and case-mix of TOE examinations performed and/or reviewed.

3.1.2 training courses attended.

3.2 The logbook should be available for review by a supervisor both during and on completion of the training period.

4. SAFETY

4.1 TOE is a semi-invasive procedure and appropriate skill and judgement is required when placing and manipulating the probe to reduce the risk of injury to the patient or damage to the probe.

4.2 If intraoperative TOE is performed by the patient's anaesthetist, an experienced assistant may be required to assist in monitoring patient parameters. This is particularly the case when there is the combination of a very unstable clinical situation and particularly complex TOE interpretation issues.

4.3 TOE must always be used in an environment where there are adequate facilities and staff to decontaminate and clean the TOE probe after use. There must be a documented protocol for cleaning the probe and a log to record compliance.

5. SUPERVISORS

Where trainees must be supervised and their reports reviewed by an "experienced practitioner", then such a practitioner must have documented training equivalent to that described in 2.1 to 2.5 or in 5.1 to 5.3. Supervisors must comply with Maintenance of Standards as specified in 6.

5.1 Medical practitioners who can demonstrate by log book or other verifiable means, 100 completed diagnostic TOE studies and have obtained the Postgraduate Diploma in Perioperative and Critical Care Echocardiography from the University of Melbourne, or passed the Perioperative Transesophageal Echocardiography Examination (PTEeXAM) which is administered by the National Board of Echocardiography in the USA.

5.2 Practitioners who have satisfied the requirements of the Australian Society of Ultrasound in Medicine (Intercollegiate Consensus Statement 1995) and are regular practitioners of TOE in a tertiary medical institution.

5.3 Practitioners who have satisfied the requirements of the Cardiac Society of Australia and New Zealand for training in echocardiography.

6. MAINTENANCE OF STANDARDS

After appropriate training in transoesophageal echocardiography has been undertaken, practitioners must maintain appropriate standards of proficiency in TOE examinations. This should include:

6.1 Performance of at least 30 TOE examinations every year.

6.2 Reviews of at least 50 TOE study recordings with qualified colleagues every year.

6.3 Attendance and participation in post-graduate courses, workshops and continuing medical education programs on peri-operative TOE and related subjects.

REFERENCES

Task Force on Transesophageal Echocardiography. (1996) Practice guidelines for perioperative transesophageal echocardiography. A report by the American Society of Anesthesiologists and the Society of Cardiovascular Anesthesiologists. Anesthesiology 84(4): 986-1006

Shanewise, J.S., Cheung, A.T. et al. (1999) "ASE/SCA guidelines for performing a comprehensive intraoperative multiplane transesophageal echocardiography examination: recommendations of the American Society of Echocardiography Council for Intraoperative Echocardiography and the Society of Cardiovascular Anesthesiologists Task Force for Certification in Perioperative Transesophageal Echocardiography." Anesth Analg 89(4): 870-84.

Cahalan, M.K. and Foster, E. (1995). "Training in transesophageal echocardiography: in the lab or on the job?" Anesth Analg 81(2): 217-8

Savage, R.M., Licina, M.G. et al. (1995). "Educational program for intraoperative transesophageal echocardiography." Anesth Analg 81(2): 399-403.

Intercollegiate Consensus Statement (1995). Guidelines for Medical Practitioners Performing and Interpreting Diagnostic Ultrasound. Australian Society of Ultrasound Medicine Newsletter , October 1995 Vol 18:1.

Cardiac Society of Australia and New Zealand Standards For Training In Adult Echocardiography
Website -
http://www.csanz.edu.au/guidelines/training/echo_stan.cfm

Cahalan MK, Abel M, Goldman M et al. (2002). "American Society Of Echocardiography and Society of Cardiovascular Anesthesiologists Task Force Guidelines for Training in Perioperative Echocardiography." Anesth Analg 94:1384-8.
(Website - http://www.scahq.org/sca3/tee_guidelines.pdf)

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Promulgated: 2002

Date of current document: Feb 2004

College Website: http://www.anzca.edu.au/

Professional Documents Under Review

In line with College policy, the following Professional Documents are due for review in 2004:

TE7 *Secretarial and Support Services to Departments of Anaesthesia*
TE9 *Quality Assurance*
PS10 *Handover of Responsibility During an Anaesthetic*
PS26 *Guidelines on Providing Information about the Services of an Anaesthetist*
PS38 *Statement Relating to the Relief of Pain and Suffering and End of Life Decisions*

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

Australian and New Zealand
College of Anaesthetists

ABN 82 055 042 852

Review PS50 (2004)

RECOMMENDATIONS ON PRACTICE RE-ENTRY FOR A SPECIALIST ANAESTHETIST

1. Introduction

There are some anaesthetists who wish to upgrade their knowledge and clinical skills voluntarily before returning to clinical anaesthesia practice after a prolonged period of absence. This may have been due to a variety of reasons (such as family commitments, practice in another area of medicine, practice overseas in a volunteer capacity, or a long period of illness.)

ANZCA considers that in such circumstances, the anaesthetist should be advised to follow an agreed "retraining" or "refreshment of knowledge and skills" program before re-entering independent specialist clinical practice.

2 ANZCA Practice Re-Entry Program

2.1 This program is an educational service by ANZCA for Anaesthetists to re-enter specialist anaesthesia practice after an absence of more than 12 months from practising clinical anaesthesia. It involves participation in a program that offers a renewal of experience in current anaesthesia practice.

2.2 The program requires supervised experience in clinical anaesthesia in a hospital or practice for a duration that is appropriate for the participant. This duration would usually be at least four weeks for every year of absence from clinical practice, up to a maximum period to be determined by the supervisor in 2.3.3.

2.3 The participant must submit an individual program for prospective approval by the College. The program must:

2.3.1 nominate the hospital department or anaesthesia practice in which the anaesthetist wishes to undertake the Practice Re-Entry Program; and

2.3.2 provide details of the clinical experience to be undertaken, and

2.3.3 enclose an endorsement of the program and its duration by the Director of the nominated Department or a senior specialist anaesthetist in the nominated practice.

2.4 At the completion of the program, the Director of Department or specialist anaesthetist designated in 2.3.3 will confirm to the College in writing that the participant has satisfactorily completed the program. ANZCA will then endorse the participant as having satisfactorily completed a retraining program.

3. ANZCA recognises that the circumstances of each Anaesthetist wishing to follow this process will vary, and that the program should be tailored to the individual.

4. The process described above is distinct from the Professional Practice Review component of the Maintenance of Professional Standards Program, and distinct from any process involving assessment of an anaesthetist's practice at the request of a Medical Board, Council or Health Authority.

This document should be read in conjunction with the following College Professional Documents:

TE6 *Guidelines on the Duties of an Anaesthetist*

TE9 *Guidelines on Quality Assurance*

PS16 *Statement on the Standards of Practice of a Specialist Anaesthetist*

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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*
P28	(1995)	Policy on Infection Control in Anaesthesia *Bulletin March 1995, pg 38*
PS29	(2002)	Statement on Anaesthesia Care of Children in Healthcare Facilities without Dedicated Paediatric Facilities *Bulletin November 2002, pg 80*
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	(1999)	Statement Relating to the Relief of Pain and Suffering and End of Life Decisions *Bulletin June 1999, pg 93*
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*

February 2004

Australian And New Zealand College Of Anaesthetists

ABN 82 055 042 852

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 Supervisor *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	(1999)	Secretarial and Support Services to Departments of Anaesthesia *Bulletin November 1999, pg 69*
TE8	(2003)	Guidelines for the Learning Portfolio for Trainees in Anaesthesia *Despatched with August 2003 Bulletin*
TE9	(1999)	Quality Assurance *Bulletin June 1999, pg 94*
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	(1999)	The Handover of Responsibility During an Anaesthetic *Bulletin November 1999, pg 62*
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*
P21	(2003)	Guidelines on Conscious Sedation for Dental Procedures *Bulletin June 2003, pg 93*
P24	(1997)	Sedation for Endoscopy *Bulletin May 1997, pg 78*