Australian and New Zealand College of Anaesthetists

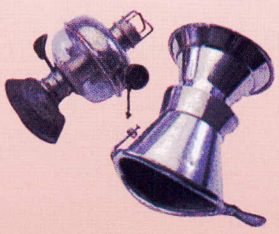
ABN 82 055 042 852

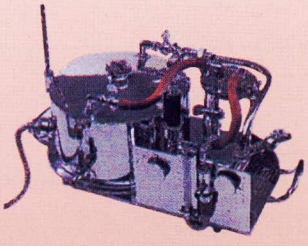
Joint Faculty of Intensive Care Medicine
Faculty of Pain Medicine

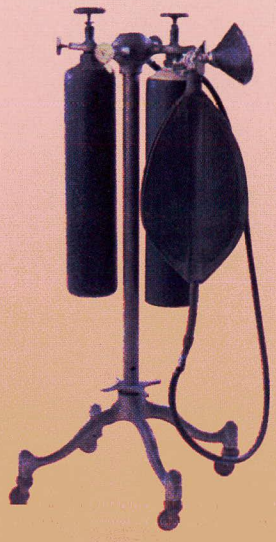
Bulletin

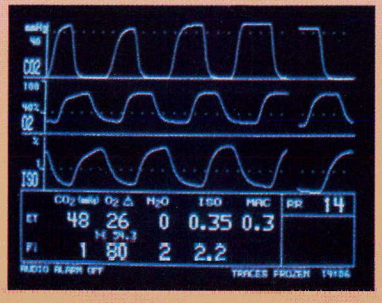
'To serve the community by fostering safety and quality patient care in anaesthesia, intensive care and pain medicine'

Inside ....









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Editorial

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

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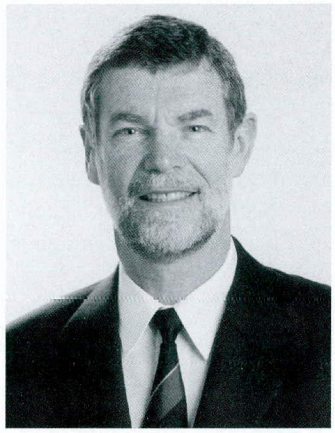


President's Message

Richard J Willis, ANZCA

Accreditation of the College by the Australian Medical Council is well underway with most site visits to training hospitals now completed. The whole process should be finished by the time this Bulletin is published but the final report will not be available for several weeks. Many College processes and documents have been either developed or upgraded to enable the College to address the requirements for medical education in the new millennium. A key document in this regard is the report from the Royal College of Physicians and Surgeons of Canada's Canadian Medical Education Directions for Specialists 2000 Project (CanMEDS 2000 Project). Seven roles of a specialist doctor are described. These are: medical expert/clinical decision-maker, communicator, collaborator, manager, health advocate, scholar and professional. Under each of these roles, a series of competencies are outlined. In this 'Message' I want to refer to just one of these roles, the important one of communicator.

In the CanMEDS document, the major focus is on listening and communicating with patients. Do we do this well? Some would cynically suggest that the reason we become anaesthetists is to avoid too much discussion with patients. Perhaps this has been true in the past, but with the increasing use of pre-anaesthesia clinics, the need to offer more than a cursory consent discussion and the use of acute pain services, the importance of appropriate communication with our patients both before and after surgery becomes obvious. In the event of a complication or adverse outcome, frank discussion with the patient is a fundamental principle of risk management. In addition, each patient visit provides a unique opportunity to explain to an interested person what we are and what we do. The current revision of our FANZCA training program will require appropriate skills and attitudes in communication as components of an essential Module in the first two years of training.

Important as this is, there is much more to communication than that. One of the College Objectives is 'Establishing communications with Fellows and Trainees of the College and Faculties'. Many efforts have been made in recent years to improve communication between the College headquarters in Melbourne and its Fellows, particularly those in more distant regions. Communication within large Departments of Anaesthesia is difficult, so it is not surprising that communication across large countries is even more challenging. However, there are exciting new opportunities. During the development of the new building in Melbourne, state-of-the-art video-conferencing facilities have been installed in the auditorium. Our professional advisor in this project now has an office in the building. Video-conferencing for general and CME meetings is now a reality and is available at an acceptable cost. This facility has recently attracted the attention of the Commonwealth Department of Health and Aged Care for its application in tele-medicine. Communication via the College web-site continues to be available and MOPS data can now be easily transmitted on-line. For those who have been reluctant to embrace the new technology, please try it. If you need advice, please contact the College staff who will be happy to assist.

In order to facilitate communication with Fellows, the College Council members have endeavored to make themselves more available in areas outside of Melbourne. Monthly Executive Committee meetings have been held in conjunction with Regional and National committee meetings and CME meetings in most national and state capital cities. The most recent of these was held in Wellington where the opportunity to experience the different medico-political climate in New Zealand was revealing for those Councillors present and conversely College support for NZ affairs was also appreciated by the

local Fellows. Social meetings with Fellows during these visits have met with mixed success but will continue. Perhaps these could have been better advertised. State and National Chairpersons attend Council meetings on a rotational basis to help them more easily understand the multiplicity of issues that are under discussion. There are therefore many opportunities to speak with senior College officers, often in your own region. Please take advantage of these occasions to get your point of view across to those who may be able to help.

For myself, I intend to visit as many areas of Australia and New Zealand as possible during my term as President and listen to the opinions and suggestions of Fellows and trainees. I am happy to discuss any matter relevant to College activities. Industrial and remuneration issues are of course off-limits. In particular, I would like the opportunity to visit some of the more distant and isolated areas where our Fellows are working. If any Fellows or groups of Fellows have any matters that are of particular concern or have suggestions for improvement, I can be contacted via the Melbourne office. I would welcome the chance for a face to face meeting where possible.

Finally, on a different tack but still related to communication, I would like to draw attention to a group of largely unheralded Fellows who do an extraordinary job in maintaining the College training programs. The Supervisors of Training in our hospitals provide the backbone for our programs and deserve our recognition. Thankyou!

Maintenance of professional standards, professional practice review and confidentiality

REPORT, JULY 2002

The Maintenance of Professional Standards (MOPS) Program is open to all Fellows, and to non-Fellows in Australia and New Zealand. The principal role of MOPS is to foster continuing scholarship in order to maintain a high standard of clinical practice. It has a number of components, one of which is Quality Assurance (QA), another Professional Practice Review (PPR). In order to encourage participation in MOPS QA and PPR, the College has guaranteed that all data will be held in strict confidence. To this end, MOPS and PPR have been declared under the following Acts:

- New Zealand Medical Practitioners Act 1995
- Health Insurance Act 1973 (Commonwealth)
- South Australian Health Commission Act 1976
- Western Australia Health Services (Quality Improvement) Act 1994
- Australian Capital Territory Health Act 1993
- Queensland Health Services Act 1991
- Tasmanian Health Act 1997
- Health Administration Act 1982 (NSW)

Individual State and Territory declarations in Australia were required because Federal legislation does not override that of individual States or Territories. The Northern Territory has no separate Act, and relies upon Commonwealth legislation in this area. A new application has been made for declaration under the Victorian Health Services Act 1988.

Each legislation requires ANZCA to follow the conditions laid down in the particular legislation, all of which vary.

To meet the permutations of the legislation, the College has a MOPS Officer, who is Chairman of a three person MOPS Committee. The Committee currently comprises: Dr Leona Wilson (MOPS Officer and Chairman), Professor Teik Oh and Professor Garry Phillips.

The MOPS Committee prepares annual reports for Council, for publication in the Bulletin, and for the relevant Ministers. All of these reports are required to describe the activities of MOPS in general terms, report findings of the Committee in general terms and specify recommendations, strategies for their implementation and results of any action taken. All of these must have all information de-identified, and must not identify any patient or clinician.

To date, the main activities of the Committee have been to refine and update the MOPS Program, now in its third edition, based on feedback to the previous programs, and to provide feedback to participants.

The online diary was introduced in March 2002 and revised Program Manuals and Paper Diaries were distributed at the same time. The Program Manual contains several new activities and changes to some code and point allocations.

Initial response to the introduction of the online diary has been positive. The number of Fellows applying to join the MOPS Program has increased as a result of the manual and letter from the MOPS Officer sent to all non participating Fellows.

The following information is reported, as required by legislation.

STATISTICAL REPORTS FOR 2001

PARTICIPATION RATES

Region	Fellows			Non Fellows	
	Active	Registered	Returns Submitted	Active	Returns Submitted
NZ	350	282	257	62	58
ACT	40	23	15	0	-
NSW	743	490	324	22	17
NT	12	7	5	0	-
QLD	410	221	144	10	8
SA	209	96	68	2	1
VIC	575	275	204	12	9
WA	210	77	61	4	4
TAS	55	22	16	2	2
HK	133	40	29	-	-
SIN	46	1	1	-	-
MAL	48	4	3	-	-
Other	145	20	16	-	-
Total	2976	1558	1143	114	99

ACTIVITIES CLAIMED

Activity Type	Mean of all Participants
Continuing Medical Education	
Major CME Meetings	2.0 meetings
Local CME Meetings	10.2 hours
Remote Group Learning	0.1 hours
HELP Modules, Submitted	0.6 returns
Self Directed Learning Activities	16.6 hours
Learning Projects	0.1 projects
CME Committee Work	0.5 hours
Quality Assurance	
Clinical Audits	0.5 projects
Major QA Meetings	0.4 meetings
Local QA Meetings	7.5 hours
Hospital Accreditation Reviews	0.1 days
QA Committee Work	1.8 hours
Reporting to Mortality Committees	0.3 reports
Training, Teaching and Research	
Teaching	8.2 hours
Examiner in Approved Exams	0.2 days
Setting Questions/Marking Papers	1.1 hours
Publications	0.4 publications
Presentations	0.3 presentations
TTR Committee Work	0.6 hours
Professional Practice Review	
Practice Review, Participant	0 reviews
Practice Review, Reviewer	0 reviews
Hospital Attachments	
One-week Attachment, Participant	0.02 attachments
Short Attachment, Participant	0.08 attachments
One-week Attachment, Preceptor	0 attachments
Simulator and Skills Laboratory Courses	
Simulator/Skills Courses	0.19 courses
Other Activities	
Other Activities	0.2 activities

PROFESSIONAL PRACTICE REVIEW

This is a review of participants' practice, on site at the practice, by a peer nominated by the Regional/National Committee and endorsed by the MOPS Officer. Recent experience with PPR indicates that this has been a valuable experience for both participants and reviewers. It has not only provided feedback on appropriate professional practice, but also identified areas of practice in need of review.

AUDIT REPORT FOR 2000

1. 20 participants were randomly selected for auditing. All returned the documentation supporting their Returns. The participants audited came from QLD (5), VIC (5), NSW (5), NZ (4) and SA (1), which reflects the participation in MOPS across the Fellowship.
2. The members of the Continuing Education & Quality Assurance Committee, who are also Councillors performed the audit.
3. The Returns were audited according to the criteria set out in the Program Manual, that is accuracy of returns and relevance of activities.
4. Results:
   - 11 returns had either no errors, or minor errors,
   - 8 returns had errors in documentation.

However, none of the errors identified changed the compliance with the minimum points requirement.

5. Errors noted:

   - Professional Practice Review (PPR) was claimed inappropriately by 11 people. PPR is a formal on site review of a participant's practice, requires prior approval by the MOPS Office, and is not the same as credentialling (or granting of privileges) by the institution,
   - Training, Teaching and Research (TTR): 3.1 should be used for all activities related to teaching examination techniques; 3.2 should only be used by examiners involved in formal examinations, such as Primary FANZCA, or those preparing HELP Module questions.

6. Recommendations:

   - Documentation required for attendance at major meetings should be reviewed; "registration receipt and copy of the programme", or attendance certificate, suggested.
   - Documentation of attendance at local CME and QA meetings should be improved; recommended that an Attendance Register is kept for such meetings, and if possible, annual statements of attendance issued,
   - Documentation required for self directed learning activities should be reviewed, with emphasis on recording the date and material read,
   - Instructions to indicate that either the hours or the days column be filled in, but not both for the one activity,
   - That the same format and timetable be used for 2001. Selected Councillor members of CE & QA will be asked to perform the audit of 30 randomly selected Returns.

AUDIT REPORT 2001

1. 30 participants were randomly selected for auditing. 26 returned the documentation supporting their Returns. Returns from the other 4 are still awaited. The participants audited came from QLD (4), VIC (4), NSW (11), NZ (4), SA (1), WA (1) and TAS (1).
2. The members of the CE & QA Committee, who are also Councillors, performed the audit.
3. The Returns were audited according to the criteria set out in the Program Manual, that is, accuracy of Returns and relevance of activities.
4. Results:

   - 12 returns had no errors,
   - 12 returns had minor errors,
   - 2 returns had errors in documentation.

However, none of the errors identified changed the compliance with the minimum points requirement.

5. The Auditors were pleased to see that some participants, when reviewing their documentation, recognised errors made in their returns, and submitted an amended return and explanatory letter.
6. Errors noted:

   - Some participants included documentation for 2002, not 2001,
   - Some participants claimed hours/days for CME and QA activities in excess of their supporting documentation,
   - Some participants claimed attendance at Major QA Meetings, when such meetings more properly should have been counted as Major CME Meetings,
   - There were discrepancies between the participants' claims for HELP Modules submitted (code 141), and those modules actually received. 20 points per issue can only be claimed for those modules that were submitted.
   - Evidence of attendance at hospital / practice CME (code 1.2) and QA Meetings (code 2.3) was variable in quality, as was evidence of involvement in teaching activities under code 311,
   - Code 2.4 Hospital Accreditation Reviews should only be claimed by those selected by the College as inspectors, not those in the hospital that is the subject of the inspection,
   - Claims for reports to Mortality Committees under code 252 should be supported by an acknowledgement from that Committee,
   - Code 5.2 Short Hospital Attachment requires a note of attendance by the receiving Department's Chairman as supporting documentation.

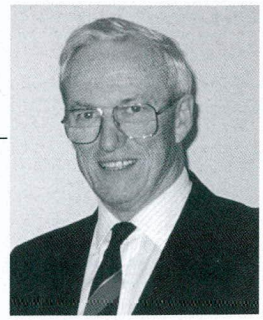
7. The Auditors considered that the activities that the participants recorded were relevant to their practice.
8. Recommendations (many of these are repeated from the 1999 and 2000 audits):

   - Participants claiming attendance at Major QA Meetings should ensure that the meeting does meet the definition of Major QA meetings in the MOPS Manual, if prior points assignment has not been made,
   - The documentation of attendance at Local CME and QA Meetings should be improved; I would recommend that an Attendance Register is kept for such meetings, and if possible, annual statements of attendance issued,
   - The documentation for teaching activities (code 311) should be improved, so that rosters or timetables are available,
   - The same format and timetable should be used for next year. Selected Councillor members of CE & QA will be asked to perform the audit of 40 randomly selected Returns.

LEONA WILSON
QA/MOPS Officer

Tracking the Colleges: AMWAC, MTRP and ANZCA

PROFESSOR GARRY D PHILLIPS



The Australian Medical Workforce Advisory Committee (AMWAC) produced its first report "Australian Medical Workforce Benchmarks" (jointly with the Australian Institute of Health and Welfare (AIHW)) in 1996.

It has produced between five and eight reports per year since then, including "The Anaesthetic Workforce in Australia" in 1996, and "The Specialist Anaesthesia Workforce in Australia – An Update" in 2001. In between, there have been a number of reports relevant to ANZCA:

"Female Participation in the Australian Medical Workforce" (jointly with AIHW) in 1996;

"The Medical Workforce in Rural and Remote Australia" in 1996;

"Influences on Participation in the Australian Medical Workforce" in 1998;

"Sustainable Specialist Services – A Compendium of Requirements" in 1998; and

"Medical Workforce Supply and Demand in Australia – A Discussion Paper" (jointly with AIHW) in 1998.

AMWAC is a Committee of the Australian Health Ministers Advisory Council (AHMAC). The Chairman is currently Professor John Horvath, and members are nominated by the AHMAC, AIHW, AMA, AMC, CPMC, RACGP, the Australian Vice Chancellor's Committee, the Commonwealth Department of Education, Science and Training, and the Department of Immigration and Multicultural Affairs.

Each working party has a Chairman appointed by AMWAC, and in the case of the latest Anaesthesia Report, the Working Party had as member's nominees of the ASA, ANZCA, State and Territory Health Departments (Anaesthetists) with a consumer nominee.

In interpreting AMWAC data, it is important to appreciate that the data sources include ANZCA, the ASA, AIHW, Medicare, the Australian Bureau of Statistics, with input from State and Territory Health Departments and Professional Organisations.

Key assumptions in projecting Anaesthesia supply and requirements included:

- That there will be no significant change in existing national health structures;
- That the current length of the Anaesthesia Training Program will remain unchanged;
- That the candidates will complete the program within the prescribed time frame;
- That the basis for projection of future work trends is provided by the pattern of workforce participations and service delivery of the current workforce.

The Medical Training Review Panel (MTRP) was originally established in 1996 as a result of the Health Insurance Act (No 2) 1996. It has produced an annual report since 1997, and serves to monitor and report on postgraduate medical training.

MTRP has a large membership, with representatives from each State and Territory health administration, nine Colleges, the AMA (including Doctors-in-Training), ASMOF, the NSW PSA, the Australian Medical Students Association (AMSA) and the Committee of Deans of Australian Medical Schools.

The reports of MTRP provide details supplied by all the Colleges, with assistance from AMWAC.

Data provided by ANZCA to MTRP for inclusion in their 2002 report include:

Total Year 1-4 Training Posts	478
Rural/Remote Training Posts	32
Female Vocational Trainees	177
New Fellows in 2001	123
Female New Fellows in 2001	40
Pass Rate in Final Exam (95 out of 115)	83%
Pass rate in Primary Exam (211 out of 342)	62%

Data provided by ANZCA to AMWAC for their 2001 review included:

Training Positions	478
Number of Fellows	2103
Anaesthetists per 100,000 Population	1:9176

The main changes that have occurred between 1996 and 2001 have been:

- An increase in the size of the Fellowship and in the number of trainees, consistent with the recommendations of the 1996 AMWAC report
- A slight increase in the number of female Fellows, but a significant increase in the number of female trainees.

The AMWAC Working Party looked at the likely projection of requirements and supply of anaesthetists to 2011.

Based on the data provided, it was projected that there would be an increase in the total population, with ageing of the population; that there would be an increase in the numbers of Medicare services performed by anaesthetists, and an increase in hospital separations for principal diagnoses implying anaesthesia.

On the supply side, factors considered included entrants and departures from the workforce, effect of increased number of female anaesthetists, likely number of overseas trained anaesthetists.

Using AMWAC projection modelling, the recommendations were that ANZCA should increase its Year 1-4 training positions from 478 to 512 by 2003, with the aim of graduating 128 Fellows per year.

Clearly there are many factors which will change between 2001 and 2011 which will affect supply and demand for anaesthesia. These will include changes in policies of various bodies, industrial changes, changes to lifestyle among others. However, the projections of 1995, based on data from 1993 and 1994 were remarkably accurate. They did not, however, allow for increasing out of theatre activities of anaesthetists, changes in lifestyle, influences causing early retirement by some, and influences on choices relating to type of practice.

All reports can be found at:

- http://amwac.health.nsw.gov.au
- http://www.health.gov.au/workforce/mtrp/5thr.htm

References:

- Theile D, Brennan P, Gavel P, Harding J, Horvath J (1998) "Methodology for the study and projection of surgical and anaesthetic workforce" ANZJ Surg 68: 481-492
- Yang H, Byrick R, Doren N (2000) "Analysis of anaesthesia physician resources: projected Ontario deficit in 2005" Anaesthesia 47: 179-184

Professor Garry D Phillips
Director of Professional Affairs

Overseas Trained Specialists Performance Assessment

The following candidates have completed the requirements of the Overseas Trained Specialists Assessment Process and have been admitted to Fellowship:

Mark Bannister	WA	Berthold Franz Weitkamp	VIC
Johanna Kathe Gesine Somfleth	SA	Godfrey Andrew Wright	TAS

Prize Winners

Gilbert Brown Prize 2002

Gilbert Brown Prize 2002: Dr Richard French (NZ)
– Work of breathing with paediatric anaesthetic circuits

Formal Project Prize 2002

Formal Project Prize 2002: Dr Naresh Ramakrishnan (NSW)
– Intra – abdominal venous pressure accurately reflects central venous pressure in critically ill patients

Honours and Appointments

Council congratulated the following:

Professor Michael Cousins, AM (NSW) – Carl Koller Gold Medal, European Society of Regional Anaesthesia

Professor Barry Baker (NSW) – Fellowship, Wood Library – Museum of Anesthesiology

Dr Jose Carlos Almeida Carvalho (Brazil) – 2002 Distinguished Service Award, ASRA

Dr Simon Towler (WA) – Admitted to AMA Roll of Fellows

Professor Garry Phillips (SA) – Emeritus Professor, Flinders University of South Australia

Professor John Russell (SA) – Clinical Professor, Department of Anaesthesia and Intensive Care, Adelaide University

Professor Alan Merry (NZ) – Professor of Anaesthesia, Auckland School of Medicine, University of Auckland

Professor Jamie Sleigh (NZ) – Professor of Anaesthesia, Waikato School of Medicine, University of Auckland

Associate Professor Geoff Gordon (Qld) – Associate Professor of Medicine, James Cook University, The Townsville Hospital

Dr Richard J Willis (SA) – Fellowship, Academy of Medicine, Singapore

Deaths

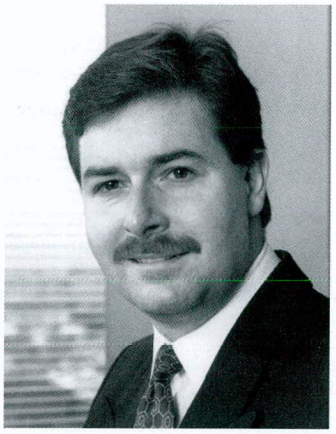
Council noted with regret the death of the following Fellows:

Dr Anna Karolina Havlin (Vic) – FFARACS 1986, FANZCA 1992
Dr John William Langley Kemp (UK) – FFARACS 1975, FANZCA 1992
Dr Norman Robert Sherwood (Qld) – FFARACS 1972, FANZCA 1992
Dr Thomas Cecil Dixon (SA) – FFARACS 1966, FANZCA 1992
Dr Kenneth William MacLeod (NSW) – FFARACS 1956, FANZCA 1992

Admission to Fellowship by Election under regulation 6.3.1 (b)

The following were invited to accept Fellowship by Election.

Dr Anthony Mark Alford (NZ)
Dr Andrew William Winter (QLD)



Law Report

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

'Legal issues for Medical Audit in Australia'

Audit (whether self-audit or in groups) is a welcome quality assurance activity – to monitor and improve medical competence, and to inform the debate on medical standards.

It is important that doctors are encouraged to participate in these activities, given the benefits for the individual, and the profession as a whole.

Whilst the profession generally is in favour of open and positive participation in quality assurance activities, some may be discouraged for fear that:

- information generated by the activity may be used in medical negligence litigation;
- disclosure of the information may cause embarrassment or adverse impact on their practice;
- legal action may arise from third party review of other practices.

Many doctors will be concerned that information obtained during the audit, particularly identifying information, may be adverse to the doctor and his or her practice. Additionally, care should be taken to avoid patient identifying information. Even information which identified particular hospitals, if adverse, would be a matter of some concern. Accordingly, surgeons will be reassured if some privilege or confidentiality applies to the process.

QUALIFIED PRIVILEGE

There are various statutory schemes available to provide protection to medical professionals for protection of information obtained through audit and quality assurance activities.

The Commonwealth Qualified Privilege Scheme is established under sections dealing with quality assurance and confidentiality in the *Health Insurance Act 1973 (Cth)*.

Quality assurance projects, medical audits and credentialling processes can be registered under the Scheme. Application is made to the Minister for Health for a declaration in relation to the activity or project.

Once an activity is declared under the legislation, all participants must comply with the confidentiality requirements contained in the legislation. This means that any person (including a participant) who acquires information which identifies individuals or entities, which is information known solely as a result of participation in the activity, must not disclose or make a record of that information. A breach of the confidentiality provisions is a criminal offence to which sanctions apply.

The information cannot be disclosed in court, unless it involves a serious criminal offence, and then only with the specific written approval of the Minister.

Registration under the Commonwealth legislation provides two important protections:

- Confidentiality of information that identifies individuals or entities, which is known as a result of participation in the activity or project.
- Protection from civil proceedings for members of committees that assess or evaluate the quality of health services provided by others (Credentialling activities).

States and Territories also have legislation to provide protection for quality assurance activities. However, the legislation in some States does not provide as strong protection as the Commonwealth legislation and, in some cases, information thought to have been protected by State

legislation has been ordered to be produced publicly by courts and tribunals. The legislation in some States is similar to the Federal legislation and, accordingly, the choice of registration (either under State or Federal law) will vary from state to state.

I believe that registration under the Commonwealth legislation affords professionals, and doctors in particular, with adequate and strong protection of confidentiality and removes the fear of unprotected disclosure of adverse identifying information.

PATIENT CONFIDENTIALITY

Some activities, including medical audit, might necessarily involve the disclosure of patient identifying information.

Patient confidentiality is, of course, a general duty attaching to all medical professionals.

Identifying patient information and patient records should not be used without patient consent.

In many circumstances, in hospitals, consent is given as part of the general hospital consent form, signed by all patients on admission.

However, in the context of private practice, patient consent should be sought for all release or use of patient identifying information or patient records for quality assurance, medical audit, or research purposes.

The material below in relation to privacy legislation also deals with these issues.

CREDENTIALLING

Audit sometimes takes place within a credentialling environment. In other words, it can affect the reputation and practising rights of individual doctors.

Credentialling procedures must be very carefully established and properly implemented. Credentialling processes can also be registered as a qualified privilege scheme under the Commonwealth legislation, and thus have confidentiality protected. However, the credentialling scheme must ensure that it has appropriate rules of procedural fairness and "natural justice".

The general principles underlining "natural justice" are as follows:

Appropriate Notice

The individual should have notice of any hearing and have the opportunity to put their views. This right is one of the fundamental principles underlining "natural justice".

Sufficient notice should be given to the individual to enable consideration of the material and preparation of submissions. The individual may wish to obtain legal advice and representation.

Obviously, the more damaging or important the allegations, or the more severe the consequences, the more detail will be required of the allegations.

Irrelevant material should not be considered, and where irrelevant material is presented, it should be made clear that it is not being considered or relied upon in any way.

Bias

The committee must be free of bias. That is, the membership of the committee should not include any person who has taken part in any substantive decision affecting the individual, and should not have any relationship with the individual (whether family or otherwise), which would preclude them dealing with the matter with an open mind.

Pre-Judgment

Similar to the question of bias, is the question of whether the committee, or any member of the committee, has previously made a decision about the individual, which would suggest that they have already pre-judged the issue. For example, a committee member who has carried out an investigation of an individual and may have prepared an investigative report and given a recommendation to the committee, could then not sit as a committee member to determine the committee's view of the matter.

Procedure

Credentials Committees are formal bodies and the meetings should be conducted in a formal manner, including taking scrupulous notes of the proceedings. It is important for each committee to decide on the criteria for a decision before proceeding with deliberations. Committee members should make themselves aware of any requirements, rules or regulations, applicable criteria or guidelines from the institution.

Rules of Evidence

Committees are not bound by formal legal rules of evidence, unlike courts. They are entitled to hear material from any source, and determine what weight to place on the material (subject to such material being relevant).

Committees should avoid giving too much emphasis to information from anonymous parties, or information that is second or third hand. Similarly, opinions should be regarded merely as such, unless the person forming the opinion is entirely qualified to have their opinion respected.

Defamation

Normally, in relation to such processes, the parties directly involved will not be subject to the ordinary laws relating to defamation. It is said that the protection of "privilege" against defamation applies to these proceedings. This would also extend to material prepared prior to, and for the committee's deliberations, such as statements of witnesses and report providers.

However, statements made by individuals that go beyond what is strictly necessary for the proceedings, may lose protection from defamation, particularly if comment is mischievous or malicious.

PRIVACY LAWS

Recent legislative changes dealing with privacy issues impact on the way audit, credentialling and medical research is conducted in Australia.

The *Commonwealth's Privacy Act* commenced in December 2001 and regulates the way that information is collected, used and protected. It particularly restricts disclosure.

Private sector organisations are required to comply with a set of privacy principles (National Privacy Principles – NPP) that set a base line standard for the protection of personal information. Reference has been made in other articles to requirements under Privacy legislation.

Medical organisations in particular deal with sensitive health information which will be regulated by the privacy legislation. In addition, some States have their own legislation dealing with these issues in a similar, but not necessarily identical, way. (For example, the Victorian Health Records Act, which will commence in July 2002.)

Health Information

Health information includes information or an opinion about the physical, mental or psychological health of a person. It includes information about a disability, and an individual's wishes about future health services. It includes information relating to the health services provided.

Collecting Health Information

Generally speaking, health information now collected will need individual consent. This need not be written, but should be clear, either from the express wishes of the individual, or arising from the conduct or circumstances.

Information collected can only be used for the general purposes for which it was collected. In the main, this will relate to the treatment and health services to be provided to the patient or individual. It can include secondary purposes for which a doctor may need to use or disclose health information, including for research, management of health services, quality assurance, follow up with individuals or consulting with other doctors.

Research

Health information forms a special category of information which is highly sensitive. In general terms, it can only be collected and used under the privacy legislation with consent. However, the NPP provide an exemption allowing for the collection, use and disclosure of health information, which is necessary for research, that is, "relevant to public health" under particular conditions. These include circumstances where it is impracticable for the organisation conducting research to seek the individual's consent first. For example, there may be no current address for a person whose health information is being used in the research, or insufficient information to allow follow up or identification. There may be administrative and practical reasons why an individual consent in each case is difficult to obtain. Some research projects allow patients to "opt out" of a trial or data collection project, rather than require a specific consent to participate.

However, to utilise this exemption:

- it must be shown that the research cannot be served by "de-identified information" – where the identity of the individual cannot be ascertained, and
- the research must take place in accordance with guidelines issued by the Privacy Commissioner.

The Privacy Commissioner may approve guidelines issued by the NHMRC, and draft guidelines have been issued for comment. The guidelines require that general ethical principles be applied to all research involving humans, as well as guidelines on specific research, participant groups and other issues.

A fundamental of the guidelines is a requirement for a Human Research Ethics Committee to review research proposals. The HREC must consider a number of matters, including whether the research proposal has sufficient expertise and understanding of the privacy issues involved, and whether or not the public interest in carrying out the research activity substantially outweighs the public interest in the protection of privacy.

Nonetheless, other National Privacy Principles should also be borne in mind when conducting research, even if approval has been received from an HREC:

- reasonable steps must be taken to ensure that, where health information has been collected without consent, it is de-identified before it is disclosed;
- reasonable steps must be taken to protect personal information from mis-use, loss, unauthorised access, modification or disclosure;
- reasonable steps must be taken to destroy and de-identify personal information when no longer required;
- reasonable steps must be taken to let any person who asks, to be advised of the personal information held, for what purpose, and how the information is collected, held and used.

Other Legislation

State based legislation does, in the main, reflect the same requirements. For example, in Victoria, the Health Records Act 2001 establishes its own health privacy principles (HPP), which similarly govern the collection, use, disclosure and handling of health information. The Health Services Commissioner in Victoria has also issued statutory guidelines on research reflecting similar requirements to those under the Federal legislation:

- research must be in the public interest if it is not practicable to seek consent from patients;
- research information should be de-identified as much as possible;
- research should be reviewed by a Human Research Ethics Committee.

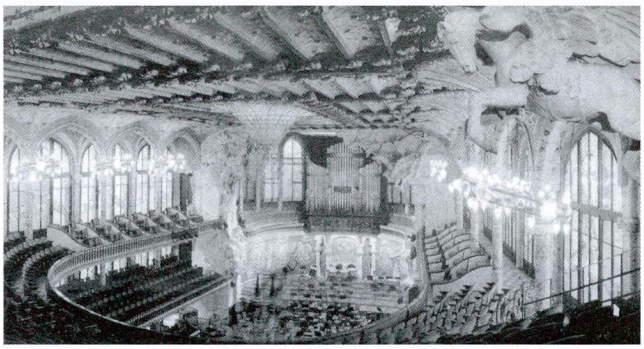
Carl Koller Award

MICHAEL J. COUSINS, AM

At the 1st World Congress on Regional Anaesthesia and Pain Medicine in Barcelona, Spain (May 29-June 1, 2002) The Regional Anaesthesia Societies, ESRA, ASRA, LASRA and AOSRA combined to post a World Congress which attracted registrants from many countries. At this Congress ESRA took the opportunity to present its Annual Carl Koller Award in honour of the discovery of the local anaesthetic properties of cocaine in 1884. Dr. Koller was an Ophthalmologist doing research with the illustrious psychiatrist Sigmund Freud. (picture to be inserted).

ESRA initiated the award of the Carl Koller Gold Medal with the financial support of Astra Zeneca. In presenting the Medal, Professor Dag Selander commented "if he were alive today, I am sure that Carl Koller would be amazed at the growth in regional anaesthesia and pain medicine that has arisen from his simple discovery of the local anaesthetic properties of cocaine".

The Carl Koller Gold Medal was presented at a colourful Opening Ceremony held in the extraordinarily beautiful Palau de la Musica, Catalonia in the centre of Barcelona. The current President of ESRA and President of the Congress, Professor Andre van Zundert made the following comments in his introduction of the 2002 Carl Koller Awardee "Who could be a more appropriate person to receive this golden award than Michael Cousins, from Sydney, Australia." At the Opening Ceremony of the Congress, Professor Cousins made a brief presentation on the subject of "Pain Relief: A basic human right?" Subsequently in the Main Congress his Carl Koller Lecture was entitled **"The spinal route of analgesia: Current & future options"**. A substantial component of this presentation dealt with the current evidence for the efficacy of "combination spinal analgesic therapy" which is addressed in a systematic review of the literature in collaboration with Dr. Suellen Walker from the Pain Management & Research Centre, Royal North Shore Hospital and Drs. Daniel Carr and Leo Goudas from the New England Medical Center and Tufts University, Boston. (in press **Anesthesia & Analgesia** 2002).



The list of previous Carl Koller Awardees makes interesting reading and in essence charts the more recent history of the field of regional anaesthesia and pain medicine.

Year	Annual Congress	Country	Carl Koller Recipient
1984	Vienna	Austria	Alfred Lee
1985	Rome	Italy	John Bonica
1986	Malmo	Sweden	Torsten Gordh
1987	Paris	France	Luc Lecron
1988	Mainz	Germany	Robert McIntosh
1989	Lisbon	Portugal	Phillip Bromage
1990	Bern	Switzerland	Bruce Scott
1991	Athens	Greece	Ben Covino
1992	Brussels	Belgium	Nicholas Greene
1993	Dublin	Ireland	James Moore
1994	Barcelona	Spain	Fidel Pages
1995	Prague	Czech Republic	Daniel Moore
1996	Nice	France	J. Bertil Lofstrom
1997	London	UK	Alon Winnie
1998	Geneva	Switzerland	Hans Nolte
1999	Istanbul	Turkey	Albert Van Steenberge
2000	Rome	Italy	Phulchand Prithvi Raj
2001	Warsaw	Poland	Poul Buckhoj
2002	Barcelona	Spain	Michael J. Cousins

Highlights of Council

FROM THE JUNE 2002 COUNCIL MEETING

WELCOME

Dr Willis welcomed Dr Kate Leslie and Dr Kerry Brandis to their first meeting as elected Councillors and Dr Peter McCall and Dr Sharon King, representing the Victorian Regional Committee and the New Zealand National Committee respectively.

EDUCATION AND TRAINING

Effective Management of Anaesthetic Crises Courses

Council resolved that:

- The College accredit Simulator Centres, not instructors, to run EMAC.
- The criteria for accreditation be developed to include the type of simulator, available space, other facilities and personnel.

Minimum Requirements for Patient Simulators for Running Scenarios in EMAC

Council approved the document "Minimum Requirements for Patient Simulators for Running Scenarios in the EMAC Course". A copy of this is available from the College Executive Officer.

Accreditation of Courses by the Courses Sub-Committee

Council approved the document "Accreditation of Courses by the Courses Sub Committee", which is available from the College Executive Officer.

Courses Sub-Committee

Council resolved that the Courses Sub-Committee will deal with "those approved courses, the successful completion of which is required for the awarding of the Fellowship". These courses will be a requirement of training for ANZCA trainees. Currently these are the EMST and EMAC Courses. In the future other courses may be stipulated and they may be accorded mandatory or optional status as stipulated from time to time by the ANZCA Training Program. Whilst these courses are, or may be primarily directed at trainees, that does not preclude them being used by Fellows for their continuous professional development.

Following the request at the May Council Meeting for additional nominees to Courses Sub-Committee, Council approved the nominations of Dr Michele Joseph, Dr Ed Loughman and Dr Kersi Taraporewalla.

New FANZCA Program

An Assessment Working Party was established to further consider the development of assessment procedures with the following membership:

Dr Leona Wilson (Chair)
Dr Wally Thompson
Dr Annette Turley
Professor John Gibbs
Dr Steuart Henderson
Dr Richard Lee (Joint Faculty of Intensive Care Medicine Representative)

The Education Unit to provide input and materials.

ANZCA Clinical Tutors' Course Working Party

The ANZCA Clinical Tutors' Course Working Party was established to further develop the course concept and report back to the Education and Training Committee. Membership will include:

Professor John Gibbs (Chair)
Dr Ed Loughman
Dr Tim McCulloch

Associate Professor Jack Havill (Joint Faculty of Intensive Care Medicine Representative)

INTERNAL AFFAIRS

Certificates Committee – Terms of Reference

The Certificates Committee will deal with "those approved courses for which ANZCA has agreed to issue a certificate following successful completion of the course".

The courses will each cover a defined area of knowledge and expertise which is not currently part of the core requirements for FANZCA. These courses have:

- A defined curriculum.
- A defined period of instruction.
- A defined period of training and practical experience which is generally greater than 12 months.
- A formal assessment process and examination.

CERTIFICATES IN SPECIAL AREAS

Certificate of Completion for Anaesthesia Assistants

Council resolved that:

- The College support the "National Training Schemes for Anaesthesia Assistants in Australia and New Zealand."
- The College should review the Guideline for Anaesthesia Assistants and from that develop the minimum training for core educational requirements/ curriculum that would be acceptable to ANZCA.
- That accredited programs for Anaesthesia Assistants may note ANZCA approval.

Museum

Council supported the recommendation for a Museum display in the foyer of ANZCA House on the understanding that the display will incorporate both contemporary and historical issues relating to the College and the profession.

Council also resolved that a curator of the Geoffrey Kaye Museum of Anaesthetic History be appointed to catalogue and cull the collection. Council noted that in the process of culling, some duplicated pieces may be exchanged with other interested parties.

Application for Election to Fellowship – Pursuant to Article 23

Council has approved amendment to Regulation 6.3 with regard to eligibility for application for Admission to Fellowship of the College by Election, a copy of which is appended to this report.

Community Representative For College

Council has appointed Ms Helen Maxwell-Wright as a Community Representative for College Committees and activities as required. Ms Maxwell-Wright's background is in marketing consultancy for advertising and communication services. She is a Board Member and advisor to a number of community and welfare organisations.

College Appeals Process

Council approved the revised College Appeals Process for dealing with Appeals resulting from decisions of the College. A copy of this document may be obtained from the Chief Executive Officer.

South Australian and Northern Territory Regional Committee

In view of the small number of Fellows in the Northern Territory and the fact that the South Australian Regional Committee co-opts a Fellow from the Northern Territory to that Committee, Council has agreed to change the Regional Committee name to reflect Northern Territory involvement. In future, the South Australian Regional Committee will be known as the South Australian and Northern Territory Regional Committee

Global Telehealth

The College has formalised an association with Global Telehealth, which organisation provides videoconferencing facilities for medical and associated organisations from ANZCA House. These facilities are available for any CME or committee meetings currently being held at ANZCA House. It is planned that a videoconferencing facility will also be established in the New South Regional Committee Office at Crows Nest in Sydney.

FINANCE

Subscription Concessions – Elected Fellows

Council resolved that the subscription concessions applying to Fellows who have dual Fellowship of the College and Joint Faculty of Intensive Care Medicine, be applied to Fellows in a similar position being admitted to Fellowship by Election.

MOPS Program

Council accepted the recommendation that:

- Non-FANZCA holders of JFICM and FFPMANZCA are eligible to participate in the College MOPS Program.
- Participation in the College MOPS Progam for such individuals should not attract an Annual MOPS Fee.

CONTINUING EDUCATION AND QUALITY ASSURANCE

MOPS Program Manual Eligibility Statement

Council accepted the MOPS Eligibility Statement as follows:

I certify that, for the period covered by this MOPS Return, I have been (please tick):

- ❑ *Continuously registered as a medical practitioner with a Medical Board/Council*
- ❑ *Free from chemical dependence*
- ❑ *Unaware of any illness which would prevent me from safely practising anaesthesia and related disciplines*
- ❑ *I am willing to provide evidence of compliance with the MOPS Program if requested by ANZCA*

ANAESTHESIA CONTINUING EDUCATION COORDINATING COMMITTEE

SIG Constitution

Council accepted the following amendments to the SIG Constitution:

That Item 5.3 be amended to read:

> "An Annual General Meeting of the SIG shall be held once in every calendar year at such time and place as determined by the SIG Executive. Members of the SIG shall receive at least two months notice of such meeting".

That Item 5.5 be amended to read:

> "The Executive Committee shall have the power to co-opt up to two other members. Co-opted members of the Executive Committee will be non-voting members and may serve in this capacity for a maximum aggregate of three years".

That Item 5.6 be amended to read:

> "At its first meeting following the AGM of the Special Interest Group, the SIG Executive Committee shall elect:

- The amount of the Grant be determined by Council during its Budget process annually.
- Allocated funds be accumulated to allow multiple awards if appropriate.

PROFESSIONAL

Nurse Anaesthetists

A Working Party has been established to consider the issue of Nurse Anaesthetists, the membership of which is:

Professor Michael Cousins (NSW), Chairman
Dr Sharon King (NZ)
Dr Steuart Henderson (NZ)
Professor Garry Phillips (SA)
Dr Rob Burrell (NZ)

Health Services to the Community

Concern has been expressed from provincial areas with regard to services available in these centres. Council has agreed to prepare a document outlining the requirements for a viable health unit that would encompass minimum standards for an Anaesthetic Department within a small hospital.

Health Assessment Panel – Asylum Seekers

Council supported the role of the CPMC's involvement with the Health Assessment Panel in relation to the care of asylum seekers in detention.

COLLEGE AWARDS AND ELECTION

Awards

Council awarded the following:

ANZCA Medal

Dr Ian Rechtman (Vic)

ANZCA Council Citations

Dr Malcolm Futter (NZ)
Dr Ian Rechtman (Vic)
Dr Peter Roessler (Vic)

Rural, Remote and Metropolitan Areas Classification

The Commonwealth Departments of Health and Aged Care and Primary Industries and Energy, Rural, Remote and Metropolitan Areas classification, has been used to classify the geographic location of the job of responding medical practitioners in the following seven categories.

Metropolitan Areas:

1. *Capital cities* consist of the State and Territory capital cities of Sydney, Melbourne, Brisbane, Perth, Adelaide, Hobart, Darwin and Canberra.
2. *Other metropolitan centres* consist of one or more statistical subdivisions which have an urban centre of population of 100,000 or more in size. These centres are: Newcastle, Wollongong, Queanbeyan (part of Canberra-Queanbeyan), Geelong, Gold Coast-Tweed Heads, Townsville-Thuringowa.

Rural zones:

3. *Large rural centres* are statistical local areas where most of the population reside in urban centres of population of 25,000 to 99,999. These centres are: Albury-Wodonga, Dubbo, Lismore, Orange, Port Macquarie, Tamworth, Wagga Wagga (NSW); Ballarat, Bendigo, Shepparton-Mooroopna (Vic); Bundaberg, Cairns, Mackay, Maroochydore-Mooloolaba, Rockhampton, Toowoomba (QLD); Whyalla (SA); and Launceston (Tas).
4. *Small rural centres* are statistical local areas in rural zones containing urban centres of population between 10,000 and 24,999. These centres are: Armidale, Ballina, Bathurst, Broken Hill, Casino, Coffs Harbour, Forster-Tuncurry, Goulburn, Grafton, Griffith, Lithgow, Moree Plains, Muswellbrook, Nowra-Bombaderry, Singleton, Taree (NSW); Bairnsdale, Colac, Echuca-Moama, Horsham, Mildura, Moe-Yallourn, Morwell, Ocean Grove-Barwon Heads, Portland, Sale, Traralgon, Wangaratta, Warrnambool (Vic); Caloundra, Gladstone, Gympie, Hervey Bay, Maryborough, Tewantin-Noosa, Warwick (QLD); Mount Gambier, Murray Bridge, Port Augusta, Port Lincoln, Port Pirie (SA); Albany, Bunbury, Geraldton, Mandurah (WA); Burnie-Somerset, Devonport (Tas).
5. *Other rural areas* are the remaining statistical areas within the rural zone. Examples are Cowra Shire, Temora Shire, Guyra Shire (NSW); Ararat Shire, Cobram Shire (Vic); Cardwell Shire, Whitsunday Shire (QLD); Barossa, Pinnaroo (SA); Moora Shire, York Shire (WA); George Town, Ross (Tas); Coomalie, Litchfield (NT).

Remote zones:

These are generally less densely populated than rural statistical local areas and hundreds of kilometres from a major urban centre.

6. *Remote centres* are statistical local areas in the remote zone containing urban centres of population of 5,000 or more. These centres are: Blackwater, Bowen, Emerald, Mareeba, Moranbah, Mount Isa, Roma (QLD); Broome, Carnarvon, East Pilbara, Esperance, Kalgoorlie/Boulder, Port Hedland, Karratha (WA); Alice Springs, Katherine (NT).
7. *Other remote areas* are the remaining areas within the remote zone. Examples are: Balranald, Bourke, Cobar, Lord Howe Island (NSW); French Island, Orbost, Walpeup (Vic); Aurukun, Longreach, Quilpie (QLD); Coober Pedy, Murat Bay, Roxby Downs (SA); Coolgardie, Exmouth, Laverton, Shark Bay (WA); King Island, Strahan (Tas); Daly, Jabiru, Nhulunbuy (NT).

Special Interest Groups
Critical Care in Unusual Environments SIG

ASM BRISBANE 2002

The SIG examined the conserving of cylinder oxygen on transfers of long duration, by using an electric ventilator and semi-closed circle circuit with CO2 absorber.

Dr John Orton FANZCA, the Medical Director of Auckland's Pacific Air Ambulance retrieval service, outlined to the meeting the uniformly favourable experience of PAA in using this IPPV technique for about 50 transoceanic cases across the world.

Most of those PAA cases used the electrically powered Portable Lifecare Ventilator (model PLV-102; Lifecare, Lafayette, Colorado). Although reliably capable of IMV, the PLV-102 cannot deliver Pressure Support Ventilation (PSV) + CPAP and weighs 11 kg. Recently Dr. Orton's service began using a Swedish device, the Breas PV 403, which does allow PSV + CPAP, has a built-in bag-in-bottle and weighs only 5.5 kg.

The ventilators can be powered by 240 V AC, or by 12 V DC source. PAA uses gel-cell 12-volt batteries about the size of a car battery, each of which can provide power for these ventilators for approximately 12 hours. Airline operators accept the batteries.

Assisted by the respective distributors, the SIG session assessed three electrically-powered portable ICU ventilators: the Breas PV 403 (Air Liquide), Newport HT 50 (Parker HealthCare) and Pulmonetics LTV 1000 (Tag Medical).

Each ventilator is TGA-approved, has an internal battery and can operate on a range of externally-sourced DC and AC currents. Each can use ambient air to drive a bag-in bottle and a Circle circuit, leaving cylinder oxygen for little more than metabolic uptake.

We had a Parker HealthCare Australia Circle circuit to ventilate a test lung with oxygen. That circuit is supplied complete with T-piece, soft reservoir bag for manual IPPV and disposable flexible concertinable hoses 65 cms long compressed and 230 cms extended.

Our Miden Medical (Melbourne) reuseable CO2 absorber is the one PAA uses. It has a polycarbonate case, silicone valves, manual APL valve and standard connections, but no over-pressure valve, a deficiency resolved by placing a re-useable adjustable pressure-relief valve (from ULCO or Drager) in the patient circuit. As well as providing continuous protection from barotrauma, this valve enables pressure-limited IPPV of patients from adults to infants of about 5 kg.

Clinical and instrumented monitoring at the contemporary standard is assumed.

Of the three ventilators, only the Breas PV 403 has an integral bag-in-bottle and hence is the only one to allow PEEP during IMV without placing an in-line PEEP valve between the endotracheal tube and the Circle. During weaning a CPAP valve can be attached to the Breas bag-in-bottle's easily accessible spill valve, but not to the spill valve of the generic bag-in-bottle (ULCO) available to us.

The participants in this enjoyable and interesting session gratefully acknowledge the assistance of Dr. Orton, the three ventilator distributors, ULCO Medical and Dr. Sean Beehan FANZCA the Acting Chair of the Critical Care in Unusual Environments SIG.

George Merridew FANZCA FFPMANZCA

Apology

ERRATA

Apologies for the following errors appearing in the June Edition of the Bulletin

THE TASMANIAN REGIONAL COMMITTEE ANNUAL REPORT.

Remote Area Anaesthesia course –

The correct report should have read:

"The highly successful "Remote Area Anaesthesia Course" was convened in Launceston in April 2002. It was organized by Dr George Merridew, whose continuing work and commitment is greatly appreciated by all concerned."

CECIL GRAY PRIZE

We misprinted the Cecil Gray Prize award winners in the June edition of the Bulletin:

The photograph on the left should have read:

"Dr Mark Lewis EDWARDS receiving his award, September 2001", (not Dr COWIE): and the photograph on the right should have read:

"Dr Brian Shaune COWIE, May 2001.

Dr Cowie was also awarded the Renton Prize at the September 1998 Primary Examinations", (not Dr EDWARDS).

Obstetric Anaesthesia Annual Report 2001-2002

Executive

At the 2001 SIG Annual General Meeting, held at the October meeting of the ASA in Canberra, the elected Executive Committee was ratified. The representatives are Drs Alison Lilley and Andrew Ross (Melbourne), Dr Scott Simmons (Adelaide), Drs David Elliot and Stephen Katz (Sydney), Dr Graham Sharpe (Wellington), Dr Richard French (Christchurch); Associate Professor Warwick Ngan-Kee (Hong Kong) and Clinical Associate Professor Michael Paech (Perth)(Chairman). Drs David Crooke and Stephen Gatt (Sydney) were co-opted. Dr Richard French resigned in May 2002 and has been replaced by Dr Genevieve Goulding (Brisbane).

Continuing Education

Continuing education has continued to be a prominent initiative of the SIG this year and an enjoyable and successful plenary session was held at the 2002 ANZCA ASM in Brisbane in May. We were most fortunate that Professor Joanne Douglas from Vancouver, Canada had been invited by ANZCA and her contributions to the session and conference were greatly appreciated. My thanks also to colleagues involved in these sessions. The SIG has made a firm commitment to the organisation of a SIG plenary session at the May 2003 Hobart ANZCA Annual Scientific Meeting. In addition, Dr Graham Sharpe has offered to convene a conference for the SIG, probably in November 2004, in New Zealand. He is currently actively involved in preliminary organisation.

2002 Annual General Meeting

This was held in Brisbane at the ANZCA ASM and Minutes have been circulated. Items considered included the training of registrars and the new modular ANZCA curriculum; the ASEAN-OASOA congress and links to other organisations; resuscitation guidelines (NZ); and representation on the NHMRC Maternal Morbidity and Mortality Committee (Australia). The Chairman has now written to the Chairman of the latter about this matter. The results of the members' survey, which achieved a very low response rate, were formally tabled. Thanks to Dr Scott Simmons for organising this.

Other

Matters to be determined in the future include cost of associate membership of the SIG and journal and other society affiliation. A newsletter, an initiative identified as popular by the members'survey, has been produced and recently distributed.

I would like to thank Helen Morris of ANZCA for her invaluable help with administrative matters and again would welcome comment from members as to future directions of the group.

Michael Paech
Chairman

Admission to Fellowship by Examination

Kevin Dean Arthur	NZ	Fiona Elizabeth Russell	NZ
Putli Keiku Bhabha	QLD	David Robert Sandford	NSW
Maria Hondrondicola	NSW	Christopher Wout Smit	NZ
Richard Ardron Jones	VIC	James William Tomlinson	VIC
Jacqueline Wen-Yee Kuh	NZ	Gordon Tin Chun Wong	NSW
James Tek-En Lai	NSW	Laura Lee-Anne Burgoyne	SA
Maurice Kong Lim Lee	NZ	Alicia Therese Dennis	VIC
Eamonn Michael Mathieson	VIC	Matthew Ian Robert McGill	NZ
Alastair Duncan McGeorge	NZ	Jason Richard Hollard	NSW
Neil Patrick McKinley	QLD	Lisa Jayne Horrell	NZ
Joanne Elizabeth Ritchie	NZ	Patrick Liston	NSW
Jonathon Mark Rothwell	NSW	Martin Peter Shaw	NSW

Primary Examination

AUGUST/SEPTEMBER 2002

The written section of the examination was held in all capital cities in Australia, Launceston, Newcastle, Townsville, Auckland, Dunedin, Hamilton, Hong Kong, Kuala Lumpur, Singapore and Wellington.

The Viva Examination was held at College Headquarters, Melbourne.

SUCCESSFUL CANDIDATES

M W K Acheson	VIC	E J Freihaut	NSW	M A Minehan	NZ
S J Allen	NZ	K M Fry	SA	T S Morgan	NSW
M L Andrews	NSW	D S Gradstein	VIC	A E Murdoch	QLD
D Arumugam	MAL	J D Griffiths	VIC	M Narayanaswamy	NSW
L J Bannon	QLD	N Gupta	NSW	J M P Nayagam	NZ
K Barker	SA	I D Ha	QLD	Ng Yuen Chong	HK
L A Beckmann	QLD	G L Hounsell	NZ	E D O'Connor	QLD
D N Bell	WA	R Hui	VIC	L S Partridge	SA
S M Berrill	NZ	N A Jansen	VIC	A R O Phillips	NSW
D M Bertholini	QLD	S Kabir	NSW	F D Phillips	QLD
D F Brown	NSW	M J Keane	SA	A Ratnavadivel	NZ
D M Brown	QLD	L P Y Khoo	WA	T J Rawdanowicz	VIC
F F Buchanan	VIC	J N King	NZ	A H Rehak	VIC
M L Buenaventura	NSW	R Kishen	MAL	J Rotherham	NZ
J T Butler	WA	J F Knuckey	WA	M L-C Soh	VIC
Louisa Yuk Li Chan	MAL	M O Krumrey	NZ	J M M Tan	NSW
W Y C Cheng	SA	Lam Kar Yee Katherine	HK	Wen Tien James Tan	SIN
Cheung Suk Yan Olivia	HK	P Z Laverty	VIC	Tang Kong Choong	SIN
A B Chisholm	NZ	A I Leavy	NSW	Alvin Teo Yeng Hok	SIN
A H H Chuan	NSW	A N H Lee	WA	M P Thompson	QLD
M M Conroy	VIC	T C Lee	VIC	D L Trappett	QLD
N M Courtney	QLD	Lee Yuk Ming Sunny	HK	A E Tse	NZ
D J Cox	NSW	S X Li	NSW	D R Tsui	QLD
A L Craig	NZ	K S Lim	NSW	P Vats	VIC
A G Crowther	NZ	G S-Y Liu	QLD	J R Vieusseux	NSW
R Dabars	VIC	P F Lockington	NZ	Wai Chor Keung	HK
E L Darbar	NSW	B Manasiev	NSW	E M Weeks	QLD
K Davenport	NZ	J E McArthur	WA	I Y Y Wong	HK
A E Donaldson	QLD	C McGrath	VIC	Wong Chak Man	HK
S M Doneley	QLD	S M McKenzie	WA	P W Wright	NZ
M L Dreux	NSW	J E McLennan	QLD	Wu Wai San Janet	HK
W J Egerton	ACT	C M McNally	VIC		
B A Fraser	VIC	A G Millard	WA		

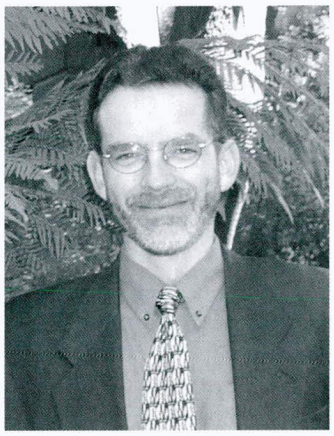
Renton Prize

The Renton Prize for the period ending 30th December 2002 was awarded to Dr. James Nicholas King of New Zealand.

Merit List

In line with the Council's decision to recognise candidates who have achieved excellence in their examination results, the following candidates were awarded a Merit Certificate for their performance at the September 2002 Primary Examination.

K. Davenport	NZ	J. E. McArthur	WA
G. L. Hounsell	NZ	S. M. McKenzie	WA
G. S-Y. Liu	QLD	Ng Yuen Chong	HK



Education Report

RUSSELL W. JONES, Director of Education, ANZCA

A great deal of current educational activity within the College is focused upon writing various guidelines for instruction. Many of these guidelines can be lengthy, for example a syllabus or curriculum, whereas others are comparatively brief, for example an educational goal, objective or outcome. Some confusion surrounds the use of these terms and they may be defined as:

Syllabus:

An outline of the main points of a course of study.

Curriculum:

A comprehensive overview including: planned activities, scope of content, sequence of materials, interpretation and balance of subject matter, and motivational, instructional and assessment techniques to be used.

Goal:

A broad statement of intent.

Objective:

An intended outcome of a course or program of study (tends to be more specific than a goal).

Outcome:

The result or product of learning.[1]

For example, a goal might be to understand the postanaesthesia recovery process. An associated objective could be to list all criteria to be achieved prior to discharge from the recovery room or day care unit. The outcome would be the extent to which a trainee could list these criteria.

The two definitions that cause greatest angst are 'objective' and 'outcome'. The journal Medical Education published an article by Professor David Prideaux[2] that provides a worthy and informative historical overview of the development of objectives and outcomes. Within education there has been much heated debate about these two terms. In particular over the past decade as outcomes-based education has gained greater influence. However, it is perhaps most constructive for those interested in education to focus on the broader picture rather than become enmeshed in the minutiae of definitions. This is because objectives and outcomes both serve useful functions and should be the products of careful considered thought about the educational process. They allow educators to prepare guidelines for instruction that, in the words of Professor Prideaux, consider the following sorts of questions:

- What are the significant and enduring outcomes of medical education?
- How can we ensure that such outcomes are included in curricula?
- How can we ensure that the complex and difficult to define outcomes are included along with those that are easily discerned?
- How can we ensure that learning experiences that lead to the stated outcomes are selected and used? (p.169).

As educational guidelines are written, it is these types of questions that must be considered.

1 Wheeler, P & Haertel, G Resource handbook on performance assessment and measurement. Owl Press, Berkeley, 1993.

2 Prideaux, D. The emperor's new clothes: from objectives to outcomes. *Med Educ* 2000; **34**:168-9.

Victorian Regional Committee

Annual Combined ANZCA/ASA CME Meeting

The 23rd Annual Combined CME of the Victorian Section of the Australian Society of Anaesthetists and the Victorian Regional Committee-ANZCA was held on Saturday 20th July 2002 at the Sofitel Hotel. The meeting "Welfare of the Anaesthetist" attracted a large number of registrants and was well patronised by the Health Care Industry, Medical Insurance and Financial Services Industries. The feedback from those who attended has been very enthusiastic and a great day was enjoyed. Dr Peter McCall awarded ANZCA Citations to Dr Ian Rechtman and Dr Peter Roessler for their contributions to Anaesthesia over many years. The CME Organising Committee and Ms Corinne Millane, VRC Administrative Officer is to be congratulated on a fine effort!

A limited supply of surplus copies of the Meeting abstract book remains and can be obtained by contacting the Victorian Regional Committee at the College.

Dr Simon Reilly
Convenor

Dr Peter Roessler, Dr Ian Rechtman, Dr Peter McCall

Sharon Hall, Kelly Phillips, Kate Silverback

Victorian Regional Committee

Annual Registrars' Scientific Meeting

The 2002 Annual Registrars' Scientific Meeting was held on 19th July in the Auditorium of "ANZCA House". The standard of registrar presentations was commendable and once again the Meeting was very well attended attracting a record number of delegates in excess of 128 Registrars, Fellows and Exhibitors. Dr David Canty, Department of Anaesthesia and Pain Management, Royal Melbourne Hospital was awarded the $500 prize donated by Anaequip (Vic) Pty Ltd for his presentation "Superior Laryngeal Nerve Block in Human Cadavers – an anatomical study comparing two techniques".

Thanks to our Administrative Officer, Ms Corinne Millane, Dr David Bain, Formal Projects Officer, and College Staff for their assistance and organisation of the Meeting.

Dr Mark Buckland
Convenor

Dr Mark Buckland presents Dr David Canty with the Annual Prize

A/Prof Kate Leslie, Dr David Canty, Prize Winner, Dr Mark Buckland, Convenor, and Dr David Bain

Testing for susceptibility to Malignant Hyperthermia

Malignant Hyperthermia (MH) is a pharmacogenetic disorder, which becomes manifest almost exclusively under general anaesthesia (there is inconclusive evidence that exercise-induced episodes may occur). It was first reported by Denborough in 1960, and two years later as a genetic disorder with autosomal dominant inheritance. It tends to affect all ages but the majority of reactions have been described in younger individuals. The mean age of all reported cases is 18.3 years and MH has been responsible for a significant number of fatalities in otherwise fit, young individuals. However advanced monitoring, increased anaesthetic staff awareness, and in particular the introduction of dantrolene sodium in the early 1980s resulted in a decline in mortality from 80% to less than 5% worldwide at present.

Two tests are available for testing for MH susceptibility, In Vitro Contracture (IVC) testing of excised fascicles from lateral quadriceps muscle, regarded as the 'gold standard' test and in a limited number of families, DNA testing. IVC testing is a day stay procedure with minimal long-term morbidity.

The development of newer anaesthetic drugs such as propofol, rocuronium and remifentanil have provided safer methods of anaesthesia in individuals susceptible to MH.

Testing for MH susceptibility however, continues to have advantages - testing confirms a clinical reaction, identifies individuals within families who are susceptible or not susceptible, and therefore limits an increasing pool of individuals with a possible-only diagnosis, and at present IVC testing is necessary to confirm a negative DNA test. It can be used to determine MH susceptibility in patients with central core disease. Parameters of the test are set to eliminate false negative results.

There are social advantages in testing – travel in under-developed countries where newer anaesthetic drugs are not available, absence of need to wear medic alert bracelets in individuals with negative test results, work discrimination and perhaps insurance discrimination.

In New Zealand and Australia there are four centres which undertake testing of individuals suspected of malignant hyperthermia susceptibility.

New Zealand

Palmerston North Hospital,
Palmerston North,
New Zealand
contact:- Dr N Pollock, Dr R Whitta
Ph: (06) 3569169
Fax: (06) 3508566
E-mail: neil.pollock@midcentral.co.nz

Sydney

IVCT:

Stud and Track Malignant Hyperthermia Testing Unit
The Children's Hospital at Westmead
Locked Bag 4001
Westmead NSW 2145
Contact:-Dr Neil Street, Dr David Baines, Dr Mark Lovell
Ph: 02 9845 0000, 9845 2367
Fax: 02 9845 3959
E-mail: neils@chw.edu.zu, davidb@chw.edu.au

Melbourne

Dept of Anaesthesia and Pain Management
Royal Melbourne Hospital
Grattan St
Parkville 3050
Contact:-Dr Robyn Gillies
E-mail: robyn.gillies@mh.org.au
Ph: 9342 7540

Perth

Dept of Anaesthesia and Pain Medicine
Royal Perth Hospital
Contact: Dr David Perlman, Dr Mark Davis
Ph: 0802241037
Fax: 0892241111
E-mail: david.perlman@health.wa.gov.au

Dean's Message

Felicity Hawker

Shortly, the Joint Faculty of Intensive Care Medicine will be reviewed by the Australian Medical Council (AMC), the national assessment and standards body for medical education and training.

In addition to its better known roles in the accreditation of Australian and New Zealand medical schools and medical courses, and assessment for admission to practice of overseas medical practitioners, the AMC now also advises the Commonwealth and states on the recognition of medical specialties, and reviews and accredits specialist education programs.

Last year, the AMC tested the review process with the assistance of the Royal Australian and New Zealand College of Radiologists and the Royal Australasian College of Surgeons. The Australian and New Zealand College of Anaesthetists is the first College to be reviewed through the new process, which will include the Joint Faculty of Intensive Care Medicine and the Faculty of Pain Medicine.

The Joint Faculty submission was prepared by Professor Garry Phillips over a period of many months. It is written as a 51 page narrative with the various policy documents and references as appendices, and is available on the Joint Faculty web site. Since its submission in April, we have been asked to clarify several matters and the documentation was resubmitted last month. The next phase involves visits by the team conducting the review to Regions and hospitals with Intensive Care Units approved for training to hold discussions with groups associated with intensive care training. These include intensive care specialists who contribute to training assessment and mentorship of trainees, nurses, senior executive staff of the hospital and other relevant groups.

Finally the team will meet Board Members responsible for education, hospital accreditation, overseas trained specialists and the Fellowship Examination as well as the Dean and Censor. Subsequently the team will complete its review and prepare a report that identifies what the team perceives as the strengths and weaknesses of the Faculty's processes, and make recommendations on areas requiring attention. The AMC will then make a decision concerning accreditation on the basis of the report.

Clearly the timing of this review has not been ideal for the Joint Faculty, coming only six months after its formation when major changes are either underway or imminent. It has also stretched our administrative resources already taxed by the extra work involved in the formation of the new body, and the record number of trainee enquiries. Nevertheless the AMC review is one of the most important events in which the Joint Faculty will be involved for some time to come. Accreditation of the education, training and assessment programs depend upon the outcome, as will the credibility of our Faculty and the specialty of intensive care medicine. Most importantly, it is clear that this review will lay the groundwork for the recognition of intensive care medicine as an independent specialty. I am confident the outcome will be positive.

Admission to Fellowship of the Joint Faculty of Intensive Care Medicine ANZCA and RACP

The following have completed all requirements for admission to Fellowship of the Joint Faculty of Intensive Care Medicine, ANZCA and RACP, by examination and were admitted by the Board:

Troy Stuart Browne	NZ
Anthony Peter Delaney	NSW
Peter Maxwell Garrett	Qld
John Francis Lambert	NSW
Robert Plant	Ireland
Alan Bruce Rouse	Tas
Benjamin Robert Turner	VIC

Paediatric Intensive Care

Michael Peter Clifford	VIC

The following were admitted to Fellowship of the Joint Faculty of Intensive Care Medicine, ANZCA and RACP, by election:

Under Regulation 5.2	Bernard Clarke	Vic
Under Regulation 5.3	Peter John Stow	Vic

The following were admitted to Fellowship of the Joint Faculty of Intensive Care Medicine, ANZCA and RACP, by election, having met the criteria for Foundation Fellowship:

David Langton	Vic
Donald Stewart	NSW
Craig Stewart Walker	Vic
John William Arnold Mulder	Vic
Ross McL Wilson	NSW
Stuart Russell Green	Qld
Derek Lai Ki Chu	Qld

As at June 2002, the Joint Faculty has a total of:

423 Fellows

262 Registered Trainees

Items of Interest

FROM THE JUNE BOARD MEETING

EDUCATION AND TRAINING

Representation of Trainees in Joint Faculty Affairs

The Board is eager to improve communications with and representation of trainees in Joint Faculty affairs. An electronic mailing list which will allow trainees to interact with each other and representatives of the Board is being established. This will allow for rapid and constructive communication between trainees of matters of common interest and allow early feedback to the Joint Faculty of concerns and issues related to training.

Supervisors of Training

The following appointments as Supervisors of Training in Intensive Care were ratified by the Board:

Dr J. Awad, Sydney Children's Hospital
Dr B. Ihle, Epworth Hospital
Dr J. Gillis, The Children's Hospital at Westmead

A draft Support Kit for Supervisors of Training is in preparation and will be circulated shortly The kit covers issues such as duties of Supervisors, the training program, exams, in-training assessment (ITA), mentoring, trainees with difficulties and education resources and modules.

The Board revised the policy document "The Role of Supervisors of Training in Intensive Care Medicine" to expand the requirements for appointment and emphasise the importance of the role of Supervisor of training. This document is reproduced elsewhere in the Bulletin.

In-Training Assessment – Goals Form

The Board approved a form to be used as a voluntary tool for documenting short-term goals, for trainees to complete during the formative assessment together with the Supervisor at the commencement of training terms. The form outlines future employment and training positions, acquiring skills, attendance at courses and conferences and examinations.

Examination Dates for 2003

Examination dates for 2003 were approved and details of these dates appear elsewhere in the Joint Faculty Section of the Bulletin.

Survey regarding the Role of the Senior Registrar

A survey of Directors of Units regarding the "role of the senior registrar" will be carried out in order to assess the responsibilities and duties of the SR in the current training environment with a view to defining and formalising the SR position in Intensive Care training.

Role of Regional Education Officers (REO's)

Following discussion as to the value of this role in light of the increased importance of the Supervisor of training (SOT) role, the Board will seek the view of Regional Committees to ascertain whether this position should be removed from the administrative structure of the Joint Faculty. Many of the current duties of the REO are now carried out by the SOT who reports directly to the Joint Faculty office.

PROFESSIONAL

Assessment of Overseas Trained Intensive Care Specialists

The Board approved a new streamlined process for assessment of Overseas Trained Specialists, which will be available on the Joint Faculty Website.

Accreditation of Overseas Intensive Care Units

The Board is exploring a mechanism for approving overseas units for training. This will require prospective approval, and fulfilment of the requirements for accreditation as currently required for Australasian hospitals. Trainees wishing to undertake part of their training in overseas posts should ensure that the hospital in question has applied for and been granted approval as an overseas training hospital prior to commencing training. The possibility of accrediting training undertaken in Singapore is also under consideration.

Policy Document

The following document was approved and appears elsewhere in the Bulletin:

IC-6 "The Role of Supervisors of Training in Intensive Care Medicine"

Australian Medical Council (AMC) Accreditation of the Joint Faculty of Intensive Care Medicine

The review of the Joint Faculty by the AMC is well underway, with site visits of accredited hospitals and interviews with Faculty representatives due to take place in August/September.

FELLOWSHIP AFFAIRS

Annual Scientific Meeting

The format for future Annual Scientific Meetings is being considered. Options include retaining the status quo (i.e. a joint ASM with the ANZCA and the FPM), a stand-alone meeting, or joint meetings with ANZICS or the RACP. A survey has been circulated to Fellows.

Honours and Appointments

The Board noted the following Honours and Appointments:

Professor Garry Phillips (SA) – Emeritus Professor, Flinders University of South Australia

Professor Barry Baker (NSW) – Fellowship, Wood Library – Museum of Anesthesiology

Professor Jamie Sleigh (NZ) – Professor of Anaesthesia and Intensive Care, Waikato School of Medicine, University of Auckland

Dr Simon Towler (WA) – AMA Roll of Fellows

A Financial Strategy for the Joint Faculty

The Board is developing a financial strategy for consideration by the Councils of ANZCA and the RACP. This will include a staged plan for financial independence of the Joint Faculty, accrual of funds and disbursement of funds for research and CME activities.

Election to Fellowship – revised process

The Board revised its process for election to Fellowship of those persons who have made a notable contribution to the science and practice of intensive care medicine. The assessment is structured and based on contributions to education and training, research and publications and administrative and professional affairs.

Communications with Fellows

A survey of Fellows has been undertaken with regard to an electronic mailing list for Fellows. A dedicated electronic newsletter instead of a Joint Faculty section in the Bulletin is also under consideration.

INTERNAL AFFAIRS

Constitution of the Board

In noting the results of the election, the Board agreed that in accordance with the Regulations, as there is no elected member from Queensland, a representative from that state should be appointed. It was also agreed to revise the Regulations to reduce the minimum of Fellows required for representation of a state to 7, to allow a representative from Tasmania to be co-opted to the Board. The Regulation pertaining to the constitution of the Board to include eight FFICANZCA and two FRACP Fellows will be removed now that the Joint Faculty has been established.

Appointment of Office-bearers

Details of the appointment of office-bearers of the Board are detailed elsewhere in the Bulletin. Congratulations to Dr Neil Matthews who was elected Dean-elect.

Staff Appointment

Ms Megan Freeth has been appointed as Administrative Assistant. Mr Andrew Coghill has taken on the role of Administrative Officer (Training and Examinations).

Proposal for a new JFICM Training Program

A Working Party has been established to review the existing training program. The Board has supported a number of new principles, which will now be circulated for further consideration by Regional Committees and Supervisors of Training.

- The program will be divided into 3 Basic Training Years (BTYs) and 3 Advanced Training Years (ATYs). The BTY1 may be the same as Postgraduate Year (PGY) 2. Registration with the JFICM, the RACP, the RACS, ANZCA or the Australasian College for Emergency Medicine (ACEM) must occur within 3 months of the start of BTY2. Retrospective recognition may be allowed for BTY1. The prescribed supervision for the above programs (i.e. RACS, ACEM, RACP, ANZCA) will be accepted by the Joint Faculty for its trainees in the BTY's.
- The minimum elements of the total program would be:

  -24 months of core intensive care medicine training as an advanced trainee.

  -12 months clinical anaesthesia in either BTYs or the non-core (elective) ATY year, at least 6 months of which must have been undertaken in a registrar position.

  -12 months clinical medicine in either BTYs or the non-core (elective) ATY year, at least 6 months of which must have been undertaken in a registrar position.
- The ANZCA Primary, FRACP Written/Clinical, FACEM Primary or the FRACS Primary Examinations would be accepted as appropriate prerequisites to entry into the ATYs of the FJFICM program. The Examination must be passed during the BTYs or ATY1 before training progression (if the examination is attempted during ATY1, retrospective approval for ATY1 is not guaranteed and can only be considered after successful candidacy of the Examination). Prospective approval will nevertheless be required.
- At the discretion of the Censor and the Training Committee, trainees who have undertaken Specialist training overseas may be exempted from some or all of the elements of basic training. Exemption will depend on an assessment of equivalence of training and / or examination.
- All trainees must spend at least 2 years of the total training program (BTYs and ATYs) in Australia, New Zealand or Hong Kong. At least one of the ATYs has to be spent as a continuous core year in an intensive care unit in Australia, New Zealand or Hong Kong, accredited as C24. All ATYs would be prospectively approved.
- Basic Training requirements for a dedicated Intensive Care Training Program would need to be identified. It is considered 2 of the 3 years in any combination of Intensive Care medicine, Anaesthesia, Internal medicine (general or specialities), Emergency medicine and Surgery would be appropriate. Basic training must be undertaken in hospitals with accreditation by relevant training Colleges. The Supervisor of Training in ICM in the hospital where the trainee works, will be responsible for the overall supervision of the trainee as soon as they register with the JFICM, but may ask for assessments from the SOTs in the particular discipline where the training is taking place. The Primary or FRACP Written/Clinical Examination should be undertaken during BTYs.

A draft document will be widely disseminated to ensure full consideration prior to finalisation at the October meeting of the Board. It is anticipated that the program will be introduced in 2004. Comments are welcome and should be addressed to the Education Officer, c/- Joint Faculty office.

Fellowship Affairs

Annual Scientific Meeting

The format for future Annual Scientific Meetings is being considered. Options include retaining the status quo (i.e. a joint ASM with the ANZCA and the FPM), a stand alone meeting, or joint meetings with ANZICS or the RACP. A survey has been circulated to Fellows.

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Annual General Meeting

JUNE 2002

The Inaugural Annual General Meeting of the JFICM was held at Ulimaroa in Melbourne on Thursday 27th June 2002. The Dean presented Dr Ranald Pascoe with a token of appreciation for his service to the Board of FICANZCA, and Interim Board of JFICM.

From left: A/Professor Jack Havill and Drs Richard Lee, Ranald Pascoe and Ray Raper.

From left, foreground: Drs Peter Thomas, Felicity Hawker, Gill Bishop, Jonathan Gillis and Richard Lee
From left, rear, Drs Richard Willis, Craig French, Neil Matthews, Sathyajith VK, Ray Raper, Vernon van Heerden, Ranald Pascoe, John Myburgh, and A/Professor Jack Havill.

Results of Board Election

Elected members:	
F.H. Hawker	Dean
N.T. Matthews	Vice-Dean and Censor, Dean-elect
J.H. Havill	Education Officer
P.D. Thomas	Treasurer
R.P. Lee	Assistant Censor, Chairman OTS Committee
R.F. Raper	Co-ordinator of Advanced Training and Chairman Hospital Accreditation Committee
G.F. Bishop	Chairman, Rural Focus Group
J. Gillis	MOPS Officer
J. Myburgh	ASM Officer
P.V. van Heerden	Asst Treasurer, Communications Officer
Co-opted Members:	
P.T. Morley	Chairman, Fellowship Examinations Committee
R.J. Willis	President, ANZCA
N. Thomson	President, Adult Medicine Division, RACP

POLICY DOCUMENT

Joint Faculty of Intensive Care Medicine

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS
ROYAL AUSTRALASIAN COLLEGE OF PHYSICIANS

ABN 82 055 042 852

Review IC-6 (2002)

THE ROLE OF SUPERVISORS OF TRAINING IN INTENSIVE CARE MEDICINE

The Supervisor of Training is the Faculty's representative on training in accredited units. The role is an important one, and the Supervisor must have a broad understanding of Faculty affairs. The Supervisor provides liaison between trainees and the hospital authorities (in respect of matters related to training) as well as with the Joint Faculty of Intensive Care Medicine (JFICM). The role of the Supervisor is assuming increased importance, and takes considerable time and training if he/she is to be effective. Support from administration must be available to provide adequate time for trainee assessments, and provision for attendance at Supervisor's training workshops.

The primary role of the Supervisor is to provide formative assessment (feedback on performance). In order to do this, the Supervisor should have regular meetings with the trainee, and organise assessments based on general observation of the trainee's clinical practice.

The Supervisor also has the responsibility to provide summative assessment (formal determination of competency). This involves completion of the in-training assessment form at the end of each 6 month period of training.

The Supervisor will often also have a mentor role. This might involve discussion with the trainee regarding their future training and employment. It might also involve assisting the trainee to recognise and deal with personal problems including aspects of inadequate performance.

1. APPOINTMENT

1.1 The Supervisor of Training will be nominated by the Director of Intensive Care who will be responsible for notifying the Board of the recommendation. The Supervisor will be appointed by the Board and both the Director and Hospital Administration will be advised of the appointment.

1.2 The appointee is required to hold the Diploma of FJFICM or an equivalent qualification acceptable to the Board, and should not be a candidate for any examination.

1.3 It is preferable but not mandatory that the Supervisor of Training be an intensive care specialist other than the Director of the Unit, and to have held the Diploma of FJFICM or equivalent for at least three years.

1.4 Nomination from the Director of Intensive Care must be accompanied by:

a) The curriculum vitae of the Fellow nominated.

b) An explanation of reasons for nominating the Fellow, including particular attributes which make the individual suitable.

c) If the nominated Fellow is less than 3 years post Fellowship, the Director should explain how support will be offered to help him/her. Some oversight from an experienced Fellow for 1 year is acceptable.

d) An indication of support for the new Supervisor to attend a Supervisor's Workshop within one year of starting the role.

e) An indication of the non-clinical time allowed for the Supervisor to perform their role.

2. DUTIES OF SUPERVISORS

2.1 Responsibilities to Trainees

2.1.1 To be familiar with the Joint Faculty's Administrative Instructions on Training and Examinations.

2.1.2 To advise potential and current trainees on their training, registration requirements, fee payments, examination dates and dates of closure for entries.

2.1.3 To be aware of dates and other matters relevant to appropriate courses and to ensure that trainees receive this information.

2.1.4 To monitor supervision, experience and fair allocation of duties for trainees and if necessary, to facilitate changes.

2.1.5 To liaise with the Director of the Department with respect to trainee duties, supervision, working hours and study time and release for approved courses.

2.1.6 To ensure an adequate orientation program is available for trainees.

2.1.7 To ensure that there is a structured educational program for trainees.

2.1.8 To provide advice, supervision and support for trainees planning, executing and presenting the Formal Project. The Supervisor also has a responsibility to critically review the final manuscript to ensure its suitability for submission.

2.1.9 To advise and assist candidates regarding the Fellowship Examination by providing or organising tutorials and trial examinations. After the Examination, to provide feedback from the Chairman of Examinations to the failed candidate and advise on future planning.

2.1.10 To undertake in-training assessments in accordance with Policy Document IC-11 'In-Training Assessment of Trainees in Intensive Care Medicine'.

2.1.11 To undertake in-training assessments for trainees, who are working in the intensive care unit on training programs other than the JFICM program. Documentation may need to be on forms specific to that particular training program.

2.1.12 To assist in the identification and counselling of trainees with difficulties, and to initiate remedial action.

2.2 Responsibilities to the Joint Faculty

2.2.1 To establish and maintain liaison with other Supervisors of Training.

2.2.2 To refer any difficulties in respect of training or trainees to the Executive Officer.

2.2.3 To ensure the Board is aware of any senior staffing or other changes in the unit likely to impact on training.

2.2.4 To attend any regional meetings or Workshops for Supervisors of Training.

Related Documents:

IC-3 *"Guidelines for Intensive Care Units seeking Accreditation for Training in Intensive Care Medicine"*

IC-4 *"The Supervision of Vocational Trainees in Intensive Care"*

IC-11 *"Guidelines for the In-Training Assessment of Trainees in Intensive Care Medicine"*

This policy document has been prepared having regard to general circumstances, and it is the responsibility of the practitioner to have express regard to the particular circumstances of each case, and the application of this policy document in each case.

Policy documents are reviewed from time to time, and it is the responsibility of the practitioner to ensure that the practitioner has obtained the current version. Policy documents have been prepared having regard to the information available at the time of their preparation, and the practitioner should therefore have regard to any information, research or material which may have been published or become available subsequently.

Whilst the Joint Faculty endeavours to ensure that policy documents are as current as possible at the time of their preparation, it takes no responsibility for matters arising from changed circumstances or information or material which may have become available subsequently.

Promulgated:	*February 1994*
Reviewed:	**1995**
Reviewed:	**2001**
Date of current document:	**June 2002**

Faculty Website: http://www.jficm.anzca.edu.au/

Joint Faculty of Intensive Care Medicine

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS
ROYAL AUSTRALASIAN COLLEGE OF PHYSICIANS

ABN 82 055 042 852

POLICY DOCUMENTS

IC-1	(1997)	Minimum Standards for Intensive Care Units *Bulletin August 1994, pg 44*
IC-2	(2000)	The Duties of an Intensive Care Specialist in Hospitals with Approved Training Posts *Bulletin November 2000, pg 53*
IC-3	(2002)	Guidelines for Intensive Care Units seeking Accreditation for Training in Intensive Care Medicine *Bulletin June 2002, pg 63*
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	(2001)	The Role of Supervisors of Training in Intensive Care Medine *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 Ethics and Patients' Rights and Responsibilities *Bulletin November 1997, pg 68*
IC-10	(1996)	Minimum Standards for Transport of the Critically Ill *Bulletin March 1996, pg 42*
IC-11	(2002)	Guidelines for the In-Training Assessment of Trainees in Intensive Care Medicine *Bulletin June 2002, pg 66*
IC-12	(2001)	Examination Candidates Suffering from Illness, Accident or Disability *Bulletin November 2001, pg*
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	(2000)	Intrahospital Transport of Critically Ill Patients *Bulletin July 2000, pg 84*
PS40	(2000)	Guidelines for the Relationship Between Fellows and the Healthcare Industry *Bulletin March 2000, pg 55*

ATTENTION – INTENSIVE CARE SPECIALISTS AND TRAINEES AND ANAESTHETISTS WITH AN INTEREST IN INTENSIVE CARE

MEDICAL ADAPT WORKSHOPS have been developed for intensive care medical staff, to provide training and continuing education in communicating with and caring for the families of dying patients and potential organ and tissue donors.

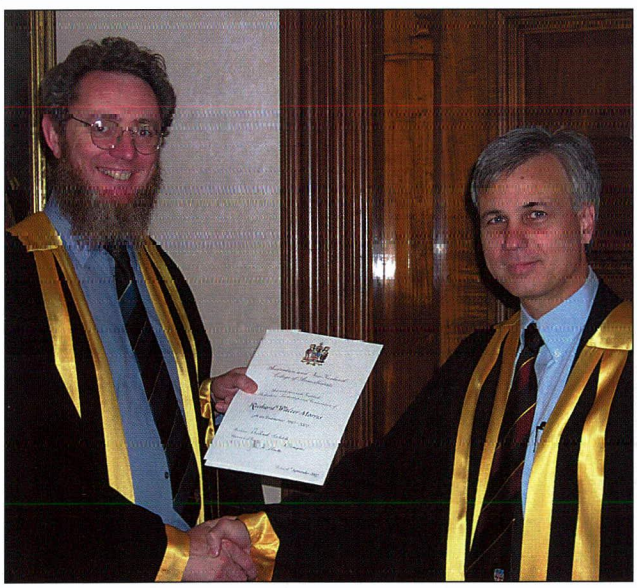
The one-day workshops receive excellent appraisals from both intensive care trainees and experienced specialists alike. Participants particularly value the 'excellent format – very good discussion of important points in an open forum style', 'interaction with colleagues', 'learning a lot more about the donation and retrieval process', and a 'better understanding of and approach to bereaved families'. Both the Board of the Joint Faculty of Intensive Care Medicine and the Australian and New Zealand Intensive Care Society highly recommended Medical ADAPT Workshops.

During the workshop, an intensive care specialist reviews brain death and brain death testing (what is standard practice, what are areas of controversy?), and the physiological management of potential donors. Mal McKissock – one of Australia's leading bereavement counsellors – explores the different needs of families at the time of sudden death (what's normal, what can you expect?), strategies for "breaking bad news" to relatives, and ways in which families can be approached about organ and tissue donation.

Medical ADAPT workshops are held throughout Australia and New Zealand, with further workshops planned for this year in Melbourne on November 12 (contact Dr Bill Silvester), Sydney on November 14 (contact Dr Ray Raper) and Perth on November 29 (contact Dr Alan Duncan or Dr Geoff Dobb).

For further information about Medical ADAPT Workshops, please contact Dr Bill Silvester on 03 9496 3422, or Ms Jennifer Gillott, ADAPT Project Manager on 02 9229 4429.

Front: Drs Tim Short, Michael Cleary, Gill Bishop, Neville Gibbs (Chairman), Assoc. Prof. K. Leslie, Dr Graig Noonan
Back: Drs Steuart Henderson, David Cottee, Stephen Barratt, Mark Finnis, Prof. Jamie Sleigh, Drs Richard Morris, Tony Plowman, David Story



Retiring Examiner Dr Richard Morris with Dr Neville Gibbs, Chairman, Primary Examination Committee

Retiring Examiner Dr Steuart Henderson with Dr Neville Gibbs, Chairman, Primary Examination Committee

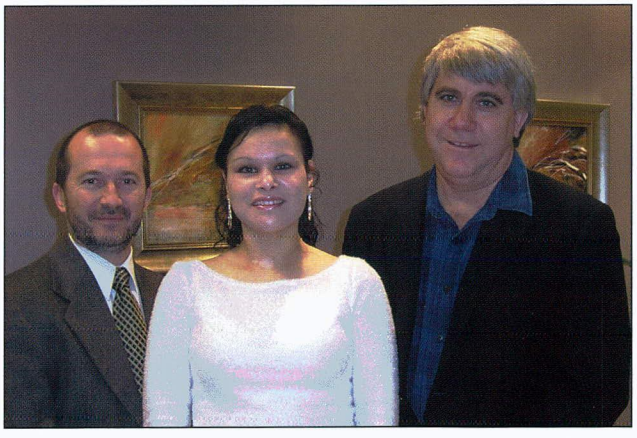
The Honourable, Dr Kay Patterson, Minister for Health and Ageing with Dr Willis (ANZCA President) (centre) and Dr Mark Yates Clinical Director of Aged Care, Rehabilitation of Medicine, Ballarat Health Services. The Minister opened the National Demonstration Hospitals Videoconferencing Program from the ANZCA House Auditorium.

Background – left to right
Dr Richard Willis (ANZCA), Dr James Gardiner (College of Anaesthetists, RCSI, Professor Mike James and Dr Clive Daniel (College of Anaesthetists, College of Medicine South Africa), Mr David Bowman (RCA).

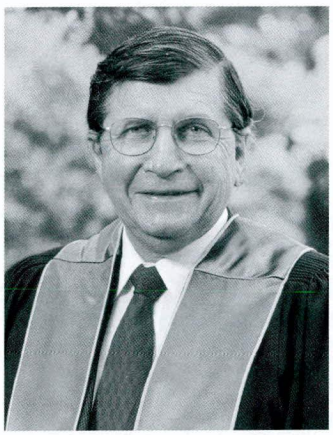
Front Row – left to right
Mrs Joan Sheales (ANZCA), Professor Anthony Cunningham (College of Anaesthetists, RCSI), Dr Paul Cartwright (RCA).

Dr Richard Willis, Presenting Professor Anthony Cunningham (College of Anaesthetists, Royal College of Surgeons in Ireland) with a gift on behalf of ANZCA.

Professor Michael Cousins, Dr Graham Rice, Professor Kim Burchiel (Foundation Visitor), Professor Leigh Atkinson.



Dr Grant Turner, Dr Tandra Paul and Dr Ken Williams recipient of the ANZCA/ASA Gilbert Troup Prize.



Dean's Message

Leigh Atkinson

On May 12th I had the privilege of becoming the Dean of the Faculty of Pain Medicine. The pendulum had swung. From 1989 to 1994 I had been a Board Member of the Faculty of Anaesthetists within the Royal Australasian College of Surgeons and now I am a neurosurgeon within the Australian and New Zealand College of Anaesthetists.

On behalf of our Fellows I would like to congratulate Richard Willis on his election as President. I look forward to building on our special relationships within the College. Our Faculty appreciates the initiative of the College in providing staff, accommodation and financial support for this important pioneering experiment in improving pain management in Australia and New Zealand.

While many fine minds have contributed to the Faculty, I must congratulate our College Vice-President and retiring Dean, Michael Cousins, for his crusade over three decades. While many of us in the past recognised our failures in pain management Michael Cousins, backed by mentors and research, built a pain unit at the Flinders Medical Centre and became the Founding President of the Australian Pain Society in 1979. He became the President of the International Association for the Study of Pain in 1987 and, with the backing of the College, guided the formative years of our Faculty as Dean. He laid the foundations for an innovative multidisciplinary specialty.

During that time neurosurgeons have also made a notable contribution to pain management around the world including the late William Sweet in Boston, the late William Noordenbos in Amsterdam, John Miles in Liverpool, John Loeser in Seattle and Kim Burchiel in Portland. As a neurosurgeon I look forward to working with our new Vice Dean and rheumatologist, Milton Cohen, to maintain the pace set by Michael Cousins.

Your Board has developed a business plan for the next twelve months. Education is our core business. Penny Briscoe will present a two-day course for advanced trainees in Adelaide. Milton Cohen will introduce our one-day update for Fellows which is to be held in Hobart prior to the Annual Scientific Meeting. Structured educational modules will be developed to present to advanced trainees in the participating Colleges of Anaesthesia, Medicine, Surgery, Psychiatry and Rehabilitation. In November our annual examination will be held in Perth. We plan to expand the training program by five trainees and we will seek government support for this. Your Board recognises the need to develop evidence-based guidelines and four papers should be available by June 2002. Lastly, we plan to expand the website to carry increased information and educational material.

The persistent pain patient and the cancer patient present a complex clinical picture. The neuropathic pain and cancer pain are ensheathed in a cloak of frustration, helplessness, hopelessness, grief and suffering. The patient's unspoken words, like Picasso's picture "Guernica", sets the scene of pain. Should this patient be managed by a multidisciplinary group or by an independent pain specialist? Should we be developing a type of professional mutation that borrows D.N.A. from the chromosomes of the participating Colleges of Anaesthetists, Medicine, Psychiatry, Surgery and Rehabilitation?

Our embryonic Faculty and our Board are committed to the multidisciplinary delivery of care to the pain patient. Our Fellowship Diploma is signed by Board Members representing the five Colleges. Our accredited pain clinics have set the gold standard for the multidisciplinary approach to pain patients. Earlier this year Professor Kim Burchiel suggested that financial restrictions in health

budgets would probably limit the numbers of new pain clinics. Maybe in public and private practice we have to develop more flexible models of multidisciplinary pain management.

While our Faculty remains small, we must ensure that the green trimmed gown and the framed Diploma do not franchise a new professional species of "Lone Rangers with long needles". John Bonica had earlier identified that the pain patient could be a clinical trap for the individual clinician. The individual skills of Fellows trained with speciality programs of Anaesthesia, Psychiatry, Medicine, Surgery and Rehabilitation are all required. The day when the individual surgeon could promise pain cures with ablative surgery have receded and should not be replaced with a generation of "needle jockeys". We must protect ourselves from specialists inserting $30,000 pumps and stimulators on an individual whim. The government health departments and our medical peers are still suspicious of our costs and outcomes. Maybe we have to ask the question more frequently, "Is our Faculty about the delivery of evidence-based multidisciplinary pain medicine or about developing a new specialist practising independently across the pain spectrum?"

Leigh Atkinson

Admission to Fellowship

The following have completed all requirements for admission to Fellowship of the Faculty of Pain Medicine, ANZCA, by examination and were admitted by the Board:

Steven George Faux	NSW
Lorna Fox	NZ
Paul Douglas Gray	Qld
Malcolm Noel Hogg	NSW
Alan Melville Howell	ACT
Charlotte Sarah Hope Johnstone	NSW
Diarmuid Gerard Luke McCoy	SA
Brendan Joseph Moore	Qld

Highlights from the Board Meeting

HELD ON MAY 10, 2002

Education

A meeting of the Education Committee was held on July 31 2002. The two main agenda items reviewed the Objectives of Training and Reading List and viewed educational materials to evaluate for teaching purposes. Videos were viewed regarding clinical interview skills, breaking bad news and informed consent.

MOPS

It is envisaged that the requirement would evolve for a Faculty Fellow to satisfy Faculty MOPS requirements in addition to those for their primary specialty. R Goucke agreed to review the MOPS Programs of the participating Colleges/Faculty.

Regional Education Meetings

Board Members agreed to discuss this issue at the Regional Committee Meetings.

Examination

A meeting of the Examination Committee was held on August 2 2002.

Pre-Examination Short Course

P Briscoe confirmed this course will be held at the Royal Adelaide Hospital on September 12 and 13. The program is close to being finalised.

Election to Fellowship

It was agreed that a third pathway for admission to Fellowship by election be developed. This is to cater for those individuals who have not had formal training in Pain Medicine during their primary specialty training and who are not in a position to enrol prospectively in the Faculty training program but who have been actively engaged in Pain Medicine practice since obtaining their primary specialty Fellowship.

It was agreed that a draft document be prepared for discussion at the next meeting of the Board.

Professional Documents

PS3 (2001) *Guidelines for the Conduct of Major Regional Anaesthesia and Analgesia.*

It was agreed that this document be re-written for Faculty purposes.

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

It was agreed that this be adopted as a Faculty document.

Performance Assessment

A modified document for the Faculty was presented to the Board. A few further minor amendments were made and it was agreed to seek legal advice on this document prior to its adoption.

White Papers

Lumbar Epidural Administration of Corticosteroids.

A revised draft document was presented to the Board. Following minor amendment it was agreed that this be forwarded to the Regional/NZ National Committees for comment.

National Institute of Clinical Studies

The Board noted a letter from NICS regarding an initiative aimed at improving pain assessment and management. It was agreed to work with NICS on this initiative.

Annual Scientific Meetings

Brisbane 2002

G Rice commented that it was encouraging with the number of registrants for the Faculty section of the meeting.

The Faculty Dinner at the Queensland Club will also be well attended.

2002 New Fellows Conference

Dr Sarah Lindsay agreed to represent the Faculty at this conference.

Hobart 2003

Hilton Francis has commenced arrangements for this meeting. The Board agreed to work closely with Dr Francis to assist in developing the scientific program.

Refresher Course, Hobart

It was agreed to proceed with a one day refresher course on Friday, May 2 in Hobart and that this course be independent from the scientific meeting. P Briscoe, L Atkinson, M Cohen, H Francis and S Walker will develop the program.

Faculty Dinner, Hobart

It was agreed to hold a Faculty Dinner in Hobart on Friday, May 2 2003.

Composition of the Board

M Cohen presented a draft document proposing changing the composition of the Board. The Board agreed with this concept and it was agreed to draft a Notice of Motion for the next meeting. It was further agreed that comments be

sought from the participating Colleges/Faculty in relation to this proposal.

Dissemination of the Existence of Fellows of the Faculty as a Resource for Other Practitioners

The Board agreed that it is a concern regarding the lack of knowledge about the Faculty amongst other medical practitioners, including general practitioners. It was agreed to develop either a brochure or an information package. This will be discussed further at the next meeting of the Board.

At a meeting of the Board on May 12, 2002 the following Fellows were appointed to Faculty Committees:

Education Committee

Chairman	M L Cohen
Representing ANZCA	P E Macintyre
	J J Trinca
	C R Goucke
	L V Rodrigues
	J A Fleming
Representing RACP	R D Helme
	M J Butler
Representing RANZCP	F R Noore
	F J New
Representing RACS	R L Atkinson
Representing AFRM (RACP)	B M Kinloch
	G C Booth
Chairman, Examination Committee	P A Briscoe

Examination Committee:

Chairman	P A Briscoe
Representing ANZCA	L J Roberts
Representing RACP	R W M Chye
	R Garrick
Representing RANZCP	G Mendelson
Representing RACS	R L Atkinson
Representing AFRM (RACP)	C Arnold
Chairman, Education Committee	M L Cohen

Hospital Accreditation Committee:

Chairman	C R Goucke
	D Jones
	P E Macintyre
	P A Briscoe
	B F Rounsefell
	R L Atkinson
	J E Marosszeky
	G I Rice
Co-Opted Member of Council	R S Henderson

The following mini-review by Dr Eric Parisod, was submitted for assessment as part of his training requirements towards Fellowship of the Faculty. Assessors are asked to assess a treatise as they would for a journal article, enumerate the specific changes required, or fail with suggestions as to how the treatise may be improved. This treatise was assessed as a pass. The Assessors cannot be held responsible for errors or any consequences arising from the use of information contained in this treatise. The views and opinions expressed do not necessarily reflect those of the Assessors or the Faculty.

Management of pain in a patient with Guillain-Barré syndrome.

SUMMARY

A high incidence of pain is present in Guillain-Barré syndrome, which is often regarded as a predominantly motor neuropathy with few sensory changes. Some authors have described a variety of pain syndromes (Pentland and Donald 1994). A better understanding of the mechanisms underlying these different pain syndromes may improve the management of pain. In this patient the multidisciplinary pain team was essential in identifying the multidimensional aspect of the patient's pain and other aspects of suffering. The pain team also helped in dealing with different types of pain medication. This case report illustrates the problems encountered in the pain management of a patient with Guillian-Barré syndrome and discusses the multidisciplinary approach to the pain.

Key words

Pain, Guillain-Barré syndrome, Gabapentin, Ketamine.

INTRODUCTION

Guillain-Barré syndrome (GBS) is an uncommon acute polyneuropathy characterized by demyelination of the peripheral nervous system and rapidly progressive ascending paralysis. It has a good prognosis in most cases. The primary neurological deficit is motor loss with only few sensory disturbances. Pain and paraesthesia are common manifestations of the disease.

This case report aims at illustrating features of pain associated with GBS and summarizing the mechanisms and multidisciplinary approach to the management of this difficult problem.

CASE HISTORY

A 33-year-old female presented to the emergency room with complaints of "pins and needles" in feet, numbness and ache over both legs with feeling of poor coordination and unsteady gait, progressing over two days.

There was no history of viral illness or immunization, bowel and bladder symptoms were absent, but the patient acknowledged exhaustion over last week as a result of inadequate sleep due to the care of her 1 month old baby.

Past medical history

The patient had suffered a non-specific low back pain that was treated conservatively by a chiropractor for many years. She also reported some occasional frontal headaches. She had no known allergies, was a non-smoker and only drank alcohol in social occasions. No relevant family history was noted.

Physical examination

The patient was afebrile, and the cardio-pulmonary examination was normal. The abdomen was soft with normal bowel sounds, but with occasional spontaneous cramp-like pain. She had no sign of meningism, with Kernig's sign negative. Examination of cranial nerves and fundus was normal. No cerebellar signs were found in arms and legs. Gait was unsteady. There was no objective muscle weakness in limbs, although she was unable to walk "heel-toe", reportedly because of feeling unbalanced. The reflexes were normal symmetrically and both plantar reflexes were absent. Straight Leg Raising (SLR) was negative. Sensation to pinprick was diminished over her back, the posterior aspect of calves and soles. Vibration sense and proprioception were normal. The perineal examination revealed a normal anal sphincter tone and a subjective reduced sensation around the perianal area.

Provisional diagnosis

The initial provisional diagnosis based on the clinical findings and supported by the investigations listed below was Guillain-Barré syndrome.

Investigations

Spirometry on admission showed a decreased Lung Functional Vital Capacity (FVC) to 2.7 litres (normal predicted values: 3.69 L).

A lumbar puncture, performed 24 hours post admission, was normal, in particular normal protein level and no white blood cells. Cultures of cerebral spinal fluid were negative.

The first Nerve Conduction study (NCS) 48 hours post admission was normal except for an absent left tibial and peroneal F waves, consistent with a very mild neuropathy.

A second NCS 10 days later showed changes indicative of a severe neuropathy. The absence of fibrillation suggested the process was predominantly demyelinating rather than axonal degeneration.

Arterial Blood Gas (ABG), Forced Vital Capacity (FVC) and Peak Expiratory Flow (PEF) were monitored on a regular basis daily.

A second lumbar puncture performed on the 10th day revealed an elevated protein level at 1.94g/1 (normal range 0.15-0.4)

Psychological and social presentation

The patient had a 1-month-old son and was still breastfeeding him when her condition made it necessary for her to cease breastfeeding. This was a major stress for the patient. Her husband also felt initially overwhelmed by the care of their son but benefited the support of the patient's mother and from advice from the social worker. The patient was very anxious and nurses had difficulty reassuring her. Following admission of the patient to ICU, the patient's husband had counselling, which provided great benefit.

The patient was frightened to be left unattended and potentially in pain. The nursing staff indicated that the patient was aware of the difficulty of achieving adequate pain relief without respiratory depression caused by the opioids. She was also aware of the potential course of the disease and the potential of requiring respiratory assistance, making communication difficult. The social worker organized accommodation for both her husband and her mother close to the hospital and requested that her husband be granted paid work leave to be able to support his wife and care for his child.

The main psychological factors contributing to the intensity of her distress were her inability to care and provide "bonding" for her young son, the fear of being left unattended and to be left in pain, with the loss of autonomy and the potential of inability to communicate.

Pain on presentation

The pain, from the very first day following admission, became a major component of her distress. The first symptoms were pins and needles over toes and numbness over the feet, progressing rapidly over two days into the legs and buttocks, then to the arms. She complained from the time of admission of severe pain over her legs, which was described as aching and cramp-like, and progressed towards low back, then the neck. Pain seemed to be constant, but relieved by postural changes. Mild analgesics did not alleviate the pain, but subcutaneous morphine injections and oral oxycodone initially provided adequate pain control.

Breast pain due to lactation (as she was breastfeeding) was a concern initially and required manual expression and treatment with Bromocriptine. She also from time of admission complained of abdominal discomfort and colicky abdominal pain.

Definitive diagnosis

The definitive diagnosis of Guillain-Barré syndrome was confirmed by the evolution of symptoms and the results of further investigations such as high level of protein in the cerebral spinal fluid. It was consistent with diagnostic criteria recommended by the National Institute of Neurological and Communicative Disorders and Stroke (NINCDS) (Table 1)

Progress

Plasmaphoresis and gamma globulin therapy were instituted 48 hours post admission. On the third day of admission (a week after the onset), the patient was transferred to Intensive Care Unit (ICU) for respiratory failure, progression of muscle weakness with bulbar involvement (hoarse voice, weak cough and loss of gag reflexes). ABG on room air revealed a pH 7.33, pCO_2 46, pO_2 52, Bicarb 24, BE -2, and O_2 Sat 84%. The PEF was 180L/min and FVC was 1.2L. She was intubated on the same day.

Because opioids were withheld due to concerns of respiratory depression, the pain during the day of admission to ICU had been poorly controlled with regular Paracetamol. Low dose of Amitriptyline (25-mg) was initiated but this did not improve the pain control. Following intubation, she was started on continuous intravenous (iv) infusion of Morphine (5 to 14 mg/h) and Midazolam (3 mg/h). As this failed to achieve satisfactory pain control, a Lignocaine (iv) infusion (50 mg/h) was started with some effect noted, but was stopped after 6 hours for no apparent reason.

The patient was referred to the pain team on the third day post intubation regarding pain that was not relieved by intravenous boluses of Morphine in addition to Morphine infusion. She indicated that she had pain in her hips, lower back and shoulders that was worsened by passive movements and positioning in bed. It was impossible to obtain a better description of the pain as the patient was intubated and partially sedated. A Lignocaine (iv) infusion (50 to 100 mg/h) was recommenced in combination with Morphine (iv) infusion (6 mg/h). This initially did not provide acceptable pain control, despite an adequate blood level of lignocaine often above normal range (patient's range 7-30 µmol/L; therapeutic range 6-21 µmol/L). A (iv) continuous infusion of Ketamine (10mg/h) was commenced in addition to the Lignocaine and Morphine infusions and a better control of pain was achieved. She remained on this regimen for the following 2 weeks with the pain well controlled. The Amitriptyline was increased from 25 to 75 mg, effectively improving her sleep.

A tracheotomy was performed (1 week post intubation). The patient, due to her neurological condition, was only able to communicate with eyes movement (meaning "yes") and tongue poked out, although very weak (meaning "no"). Some paroxysmal exacerbations of pain were treated with an increase of Ketamine infusion rate (10- 30mg/h). Some abnormalities of liver function tests were noted, but this was thought to be unrelated to pain medications. An acute bleeding at the tracheotomy site occurred and this required an endo-tracheal intubation for a few days.

The weaning of systemic pain medication started two weeks after the initial intubation, with the introduction of progressively increasing doses of Gabapentin while weaning the Lignocaine infusion over 3 days.

The continuous (iv) infusion of Morphine (5 mg/h) was stopped by the intensivists at the same time and bolus of (iv) Morphine (2.5-5mg) were administered on average twice a day. She was also on a continuous (iv) infusion of Midazolam (3mg/h) and Ketamine (20-40 mg/h). The dose of Gabapentin was progressively increased to a maximum of 2g/day over a period of 3 weeks.

The main complication during the following couple of weeks was pulmonary infection, which was treated with antibiotics and active physiotherapy. Urinary tract infection (UTI) required further antibiotics. There was only minor improvement of her neurological condition with only mild movements of head and continuing complete quadriplegia.

As one of the objectives was to wean all parenteral medication, the ketamine (iv) infusion was stopped at the end of the fourth week. This actually resulted in inadequate pain control and necessitated the addition of Mexiletine to her pain regimen (gradual increment as per protocol). The pain then was mostly in legs and hips, presenting intermittently and lasting 10-15 minutes. Passive manipulation of the patient appeared to trigger or to worsen the pain. A Slow Release formulation of Morphine (Kapanol) was started in order to reduce the use of intermittent Morphine (iv) injections. The pain episodes settled down when the dose of Mexiletine reached 600 mg/day. Some episodic burning feeling in the feet was reported during the eighth week.

The ongoing management concerns included constipation and occasional episodes of insomnia. The relationship of these conditions and pain was difficult to assess. Abdominal pain was reported regularly by the nurses, but was not clearly correlated to constipation and could have been indeed a genuine manifestation of GBS related neuropathic pain. The different potential causes of impaired sleeping pattern were also difficult to identify, but could have been partly due to pain at some stage. Following the removal of the tracheostomy tube on the 69th day of assisted ventilation, the patient reported soreness/tenderness over the four limbs on deep pressure compatible with some degree of hyperalgesia, but no pain at rest. There was neither allodynia nor hyperpathia (prolonged pain following stimulus). She also complained of pins and needles over her hands and mild burning over soles. She also described ache in the muscles during her stretching sessions with physiotherapists. We felt that some of her neuropathic pain had improved, such as the spontaneous and episodic exacerbation of pain, but with some remaining paresthesia. Weaning of Mexiletine was commenced. She was discharged to the rehabilitation hospital on the 83rd day post admission on Gabapentin 2000 mg/day, Mexiletine 300 mg/day, Amitriptyline 100 mg/day and Temazepam 20-mg nocte to.

From a neurological point of view, she had recovered most of the function of arms and bulbar muscles, but was still very weak in the legs at time to discharge.

She benefited from an extensive program of physiotherapy, occupational therapy and hydrotherapy during the 3 months spent in the rehabilitation hospital. She was discharged walking with forearm crutches and largely independent in her activities of daily living, although still having some distal weakness and sensory changes in her legs. She was weaned off her anti-neuropathic medication over the first 6 weeks and remained on weak analgesics (Paracetamol and Codeine formulation) on request for hip pain thought to be secondary to pressure changes in the capsule of the hip joint.

DISCUSSION

Guillain-Barré syndrome

Guillain-Barré syndrome or acute inflammatory polyneuropathy is a relatively uncommon condition with an annual incidence of one or two cases per 100,000 population (Hughes 1990). It is often regarded as a predominantly motor neuropathy with a few sensory features. However pain is a common symptom occurring in up to 72% of cases (Ropper et al. 1984).

Guillain-Barré syndrome described by Guillain, Barré and Strohl (1916) is best regarded as a clinical syndrome rather than a specific disease entity. The diagnosis is essentially clinical, albeit supported by cerebrospinal fluids changes and neurophysiological abnormalities (Table 1). In over one-half of the cases of GBS, there is an antecedent history of infection, most commonly viral. A wide range of specific agents such as Herpes zoster, CMV, Epstein-Barr viruses and Campilobacter jejuni have been associated with the disease although probably acting as non-specific triggering factors (Ropper 1992). Other cases follow vaccination, surgery, anaesthesia and possibly certain drugs such as thrombolytic agents. A small category of GBS occurs in the presence of an underlying disease, most commonly systemic lupus erythematosus, Hodgkin's disease (and less frequently other neoplasms), sarcoidosis or more recently HIV infection (Ropper 1992).

Differential diagnosis

The differential diagnosis depends on the pattern of weakness and the clinical settings, but includes in order of importance, spinal-cord compression, transverse myelitis, myasthenia gravis, basilar-artery occlusion (simulating Fischer's syndrome), neoplastic meningitis, vasculitis neuropathy, polymyositis, metabolic myopathies, paraneoplastic neuropathies, and less frequently, hypophosphatemia, heavy-metal intoxication, neurotoxic fish poisoning, botulism, poliomyelitis, and tic paralysis (Ropper et al. 1991). Of the many variants of GBS, the commonest is Fischer's syndrome, which involves ophthalmoplegia, ataxia, and areflexia with little weakness and accounts for 5% of cases in large series (Ropper et al. 1991).

Table 1. Diagnostic Criteria for typical Guillain-Barré Syndrome (Asburry and Comblath 1990)

Features required for diagnosis
Progressive weakness in both arms and both legs
Areflexia
Features strongly supporting the diagnosis
Progression of symptoms over days to 4 weeks
Relative symmetry of symptoms
Mild sensory symptoms or signs
Cranial-nerve involvement, especially bilateral weakness of facial muscles.
Recovery beginning 2 to 4 weeks after progression ceases
Autonomic dysfunction
Absence of fever at the onset
Elevated concentration of protein in cerebrospinal fluid, with fewer than 10 cells per cubic milliliter
Typical electrodiagnostic features
Features making the diagnosis doubtful
Sensory level
Marked, persistent asymmetry of symptoms or signs
Severe and persistent bladder or bowel dysfunction
More than 50 cells per cubic milliliter in cerebrospinal fluid
Features excluding the diagnosis
Diagnosis of botulism, myasthenia, poliomyelitis, or toxic neuropathy
Abnormal porphyrin metabolism
Recent diphtheria
Purely sensory syndrome, without weakness

Mechanisms

The predominant pathological finding is inflammation of the peripheral nerve and spinal nerve root with lymphocytic and macrophage infiltration and demyelination. The central nervous system is largely spared with the exception of anterior horn cell chromatolysis and posterior column degeneration in a proportion of cases (Hughes 1990). The precise pathogenesis is unclear. Although current work support the concept of a primary lymphocytic T-cell mechanism for the inflammation in GBS, the extent of lymphocytic infiltration is indeed varied among pathological studies, with some clinically typical cases showing virtually none (Honovar et al. 1991). This has led to the hypothesis that an early antibody attack on myelin occurs in some cases and a mainly inflammatory process in others, both leading to a macrophage response that causes myelin destruction (Honovar et al. 1991).

Clinical and laboratory findings

Paraesthesiae in the toes is often the first neurological symptom followed within hours or days by weakness of the legs. The symptoms are usually distal, but can be proximal and characteristically spread to involve upper limbs, trunk and face muscles to a variable extent. In mild cases the patients may retain ability to walk and use arms whereas in severe cases a complete flaccid quadriparesis occurs with 10-30% of all patients requiring mechanical ventilation. Tendon reflexes are absent or severely diminished. Tachycardia and vasomotor symptoms indicative of autonomic disturbance may accompany these features.

An examination of cerebral spinal fluid (CSF) should show normal pressure, few or no cells, and a protein concentration above 0.55-g per litre after the first week of illness. A protein level in CSF above 2.5-g per litre should raise the suspicion of spinal-cord compression, and pleocytosis may signify Lyme disease, neoplasia, human immunodeficiency virus (HIV), sarcoid meningitis, or other diseases.

Abnormalities of nerve conduction reflecting demyelination are the most sensitive and specific laboratory findings in GBS (Ropper et al. 1990). The characteristic finding of early demyelination is conduction block (reduction in the amplitude of the muscle action potential after stimulation of the distal as compared to the proximal nerves or roots). Conduction block in motor nerves causes the weakness in GBS. Spontaneous discharges in demyelinated sensory nerves probably cause the paraesthesia and the pain.

Course and outcome of the condition

The progression of the motor symptoms ceases within 2 weeks in about one-half and by 4 weeks in 90% of cases, with recovery beginning 2-4 weeks after the progression stops (Asburry and Comblath 1990). While recovery over a period of weeks or months is a hallmark of GBS, only about 15% of patients have no residual deficit. Another 65% have persistent minor problems, such as foot-drop or distal numbness that do not impair the conduct of everyday life (Hughes 1990). Permanent disabling weakness, imbalance, or sensory loss occurs in 5 to 10%. Severely reduced amplitudes of muscle action potentials on electromyography consistently predict residual weakness, but older age, the need for ventilation support for more than a month and severe rapidly progressive disease are also prognostic. Pain is mostly not described in the literature as one of the long-term sequelae of GBS.

Rehabilitation requires an organized program with defined end points. Early goals include the prevention of decubitus ulcers, tendon shortening, joint malalignment, and peroneal-nerve compression palsies and the facilitation of pulmonary toilet.

Most patients with GBS require at least observation in hospital for the first few days until stabilization of the symptoms. The patients presenting with respiratory impairment or failure, or cardiovascular instability due to

dysautonomia, are appropriate candidates for observation in the Intensive Care Unit. Apart from the interventions aimed at supporting these organs' failures, the management includes prevention or treatment of nosocomial infection (25% of patients acquire pneumonia and 30% acquire urinary infections (Ropper et al. 1991), prophylaxis for pulmonary embolism, adequate nutrition, physiotherapy and psychological care.

Sensory features and different types of pain

Whereas the most striking feature of Guillain-Barré syndrome is progressive paralysis, less attention has been paid to the incidence and nature of sensory symptoms including pain. Little distinction is often made between paraesthesia and dysaesthesia. The incidence of pain varies among different series depending upon whether pain and paraesthesia are grouped together. A variety of pain syndromes may occur at different stages of the illness, presenting a challenge for the different specialists responsible for the medical management (Pentland and Donald 1994). Although it is impossible to differentiate unequivocally some descriptions of pain as being of one type of another, Pentland and Donald (1994) have described 7 types of pain as listed in Table 2.

Table 2. Pains in Guillain-Barré syndrome

1. Paraesthesia/dysaesthesia
2. Backache/root pain
3. Meningism
4. Muscle pain
5. Joint pain
6. Visceral pain
7. Others

Paraesthesia/dysaesthesia

Paraesthesia generally herald the onset of the disease and are reported as relatively non-painful sensation such as mild tingling, pins and needle and are tolerated fairly well. They can be replaced by stronger and coarser feelings of a deeper, needle-like, burning nature and can cause considerable distress. Such sensations by definition should be called dysaesthesia. Excessive sensibility to painful stimuli is also frequently encountered and should be described as hyperalgesia. Differentiation of these phenomena is difficult and often confused in both clinical and research reports.

In contrast to the high frequency of sensory symptoms, sensory signs are said to be less common (Hughes and Winer 1984). However, in a large prospective series, loss of vibration sense at the ankles was reported in 59%, while there was distal loss of light touch and pinprick sensitivity in 26% and 22%, respectively (Winer et al 1988). The pattern is generally accepted that sensation associated with large-fibre conduction is most affected (Hughes and Winer 1984, Wirier et al 1988, and Ropper et al. 1991).

Ropper has suggested, on the basis of experiments that paraesthesiae result from spontaneous ectopic activity in large sensory nerves (Ropper 1991), whereas others proposed that pain arises from small unmyelinated C fibres and the loss of the inhibitory influence of damaged larger myelinated fibres on the cells of the substantia gelatinosa (Connelly et 1990).

Backache and sciatica

Severe lumbar or interscapular pain is well recognized as a presenting feature of GBS, sometimes preceding weakness by days. Radicular pain, usually in the form of sciatica, may occur at the same time as acute backache or independently. Deep-seated pains in the lumbar, thoracic or cervical regions may be of aching or a sharp stabbing nature. They may be transient or persistent, resulting in considerable distress (Connelly et al. 1990). The origin of back and radicular pains is unclear. The acute pain may relate to inflammation or entrapment of nerve roots while the more chronic varieties may result from abnormal mechanical forces on the axial skeleton as a consequence of weakness of the paraspinal musculature (Pentland and Donald 1994)

Meningism

Apart from neck pain, some authors have specifically referred to meningism as an early feature. More recently, de Jager and Sluiter (1991) noted neck pain associated with meningism in 37% of cases. The suggested mechanism is that local meningeal irritation arises from adjacent swollen nerve roots.

Muscle pains

In a prospective study specifically addressing the question of the nature and frequency of pain in GBS, Ropper and Shahani (1984), reported deep muscular discomfort or pain in the large proximal muscles of the lower limbs, described in term of severe muscle strain or severe cramping pain. The quadriceps, hamstring and buttocks are the most frequent sites. But general muscle soreness has been described consistently (De Jager and Sluiter 1991). These pains may also increase in frequency later in the disease and are often reported as worse at night (Ropper and Shahani, 1984). The same authors found that most of the patients describing this pain had raised serum creatine kinase but could not find a clear correlation between severity of pain and the level of creatine kinase. They concluded that changes in muscle of neurogenic origin were the likeliest cause of muscle pain in GBS.

Joint pains

With the caveat that patients suffering from severe limb pain may not be able to localize it to the muscle or to the joints, there are a number of instances where discomfort appears to originate in the latter. Apart from the vertebral structures, aching in hips and shoulders seems to be the most frequent complaint. Whether this is a primary or secondary phenomenon is unclear although the distribution and nature of the joint involvement is more suggestive of the latter (Soryal et al. 1992).

Visceral pains

Although some early reports of GBS described abdominal pain as one of the early features of the condition (Asbury et al. 1969), it remains an infrequently reported phenomenon. It may arise in some case from peptic ulcers, a recognised complication of GBS (de Jager and Sluiter, 1991). Otherwise autonomic dysfunction is common in GBS and sometimes life threatening; the cardiovascular changes in blood pressure and heart rate may result in chest pains with a tightening sensation in some cases.

Causes of other pain and suffering

Acute GBS is a frightening experience occurring in an otherwise healthy individual. The feeling of utter helplessness and dependence on others to perform the simplest of tasks, such as scratching an itchy nose or removing a dust spec from the eyes can make the patient appear very demanding of their immediate carers. This should not be misinterpreted by assuming that reported pains or discomfort is psychogenic. The procedures of venopunctures, airway lavage and evacuation of the bowels may lead to considerable discomfort and if performed by unskilled, or uncaring, hands may be painful (Bowes D, 1984). Poor positioning can result in pains from pressure sores or pressure neuropathies of the ulnar and peroneal nerves (Hughes et al. 1984).

Pain experienced by our patient

Her condition of GBS was heralded by paraesthesia, such as pins and needles, in feet. This is a common presentation for the syndrome. Some of the neurological symptoms initially reported were compatible with sensory deficits, such as numbness over feet. This is rather unusual, since the syndrome is regarded as a predominantly motor neuropathy, but sensory changes have also been recognized in GBS. The physical examination revealed subjective diminished sensation to pinprick over soles, posterior aspects of calves, and back, without any objective loss in vibration sense and proprioception. Initial muscle weakness was mild. From the very first days, the patient complained of severe cramp-like pain, which progressed toward the lower back and neck area. This pain resembled the muscle pain described by Ropper and Shahani (1984), who postulated a neuropathic pain in muscle area. The same authors found that most of the patients describing this pain had raised serum creatine kinase level, but they could not find a clear correlation between severity of pain and the level serum creatine kinase. Our patient did not show any increase of the serum creatine kinase. The pain responded initially to parenteral morphine, but along the course of the illness the pain became more difficult to control with opioids and required the addition of a Lignocaine and a ketamine infusion. The pain recurring after the interruption of the Ketamine responded to Mexiletine. This suggested a neuropathic component to this pain. Some pain perceived in the legs in GBS has been attributed to nerve root irritation and called sciatica-like pain (Ropper 1992). There was not any sign in favour of nerve root irritation, such as positive SLR, during the physical examination before admission to ICU, although leg pain was already present. This would support the concept of muscle pain rather than sciatica pain in the legs, although still likely of neuropathic origin. Back and neck pains were reported as a progression of the leg pain in our case, but they did not remain as problematic to control as the leg pain. Pentland and Donald (1994) postulated that back pain may be caused by a mixed pattern of inflammation along the nerve roots (neuropathic pain) with some nociceptive component possibly resulting from abnormal mechanical forces on the axial skeleton as a consequence of weakness of the paraspinal musculature. The back and neck pain in our case was prominent only during the first half of the course of the illness and responded well to a combination of Morphine and anti-neuropathic drugs. Visceral pain is an uncommon feature of GBS and, although our patient reported abdominal discomfort, it remained difficult to differentiate it from the condition itself or to the episodes of constipation. She presented signs of autonomic dysfunction with high heart rate and unstable blood pressure, which is a well-recognized feature of GBS. Of interest, the only remaining pain at time of discharge from rehabilitation hospital was hip joint pain thought by the rehabilitationists to be secondary to pressure changes in the joint capsule.

Treatment options for Guillain-Barré syndrome

Some of the treatments directed at the assumed underlying pathogenic process have been reassessed in the medical literature. Two randomized controlled trials, assessing the use of steroids in GBS (Hughes 1978, 1991) found no benefit, and corticosteroids can no longer be considered useful therapy for GBS.

Three large randomized controlled trials that included 500 patients established the benefit of plasma exchange in acute GBS (North American Trial 1984). The time required before patients were able to walk unassisted and the duration of mechanical ventilation were halved by plasma exchange, and in two studies all patients improved without additional morbidity at six months.

After the successful use of gamma globulin in the chronic inflammatory form of demyelinating polyneuropathy and the anecdotal success of this treatment in acute GBS, a randomized Dutch trial compared intravenous immune globulin treatment with plasma exchanges in 150 patients during the first two weeks of the disease (Van der Mech6 et al 1992). They found a significantly higher number of patients with strength improvement (1 grade improvement) for immune globulin treatment compared to plasma exchange treatment after five courses of each treatment (53% compared to 34%). The median time to achieve a 1-grade improvement of strength was also significantly shorter for the patients treated with immune globulin (27 days compared to 41 days). The immune globulin group had significantly fewer complications and less need for artificial ventilation. This regimen may become the preferred treatment for acute Guillain-Barré syndrome because of its ease and rapidity of administration and its relative safety even in unstable patients.

Treatment of pain

Apart from specific treatments of the underlying condition, much of the management of this usually self-limiting disease is supportive and symptomatic. This includes treatment of pain syndromes.

Apart from drugs and other form of analgesia, it is important to provide a caring environment for the patient, especially addressing the psychological needs of the patient. Presence of family should be allowed which, in the setting of the ICU, is not always easy. Visits from former patients have been found helpful (Ropper et al. 1992). Regular physiotherapy and careful nursing may both alleviate pain and prevent avoidable musculoskeletal stiffness and pressure sores (Soryal et al. 1992).

It is helpful to consider the different pain syndromes encountered in GBS in the light of mechanism of pain. It is suggested that there are two different mechanisms causing pain in GBS, nociceptive, related to tissue damage; and neuropathic, related to injury or dysfunction of nerves. This would influence the choice of the most appropriate treatment for each clinical presentation. A common cause of unsuccessful treatment of pain is failure to recognize the neuropathic component of the pain. The other common reason for inappropriate management of pain is to only consider the pain on a biological basis, and to overlook the other well recognized dimensions of pain, namely psychological and social dimension.

Simple analgesics, such as aspirin and the non-steroidal anti-inflammatory agents may be effective in relieving musculoskeletal symptoms initially but are often disappointing for the other varieties of pain. They are also associated with risks of gastrointestinal ulceration and bleeding, platelet dysfunction, and renal and hepatic dysfunction.

Opioids have been widely used and found effective in relieving the musculoskeletal, and other more nociceptive types of pain (Roper and Shahani 1984). Different ways of administration have been reported. Epidural morphine has also been used in the early intensive care setting where intravenous opioids were ineffective in controlling pain without the patient being unresponsive (Rosenfield et al. 1986, Connelly et al. 1990). Unfortunately, the anecdotal reports do not provide a good evaluation of the incidence of complications for such an intervention. The length of treatment required and the problem of recurrent infections are reasons of concern for this method of treatment. Further, the danger of an epidural infection should be borne in mind, as it will be difficult to distinguish it from the primary disease.

Nevertheless, it is well accepted that neuropathic pain responds poorly to opioids. Connelly et al (1990) reported that some of the dysaesthetic symptoms, such as burning sensations over extremities, did not respond to epidural infusion of morphine, supporting the concept of different mechanism for each type of pain. The management of pain in GBS may require medication commonly used in neuropathic pain such as antiepileptic drugs or tricyclic antidepressant. Tripathi and Kaushik (2000) performed a prospective, double blind, randomly allocated crossover study of 12 consecutive patients with GBS, evaluating Cambamazepine for neuropathic pain. They found significant improvement of pain with a decreased requirement of pethidine and less sedation during treatment with carbamazepine. They recommended Carbamazepine as an adjuvant to treat pain in GBS patients. The main limitation of the study is the short duration of each treatment (three days) and therefore the incidence of complications, well known for Carbamazepine (liver dysfunction, blood dyscrasia, hyponatremia) can not be evaluated.

It is interesting to realize that none of the other drugs commonly used for neuropathic pain have been trialed in the setting of GBS, although most authors acknowledged that pain in GBS may have a dual origin.

Comments on drugs used as adjuvant for neuropathic pain

Neuropathic pain is characterized by distinctive clinical symptoms and signs, such as spontaneous pain, allodynia, hyperalgesia, and pain summation. Neuropathic pain is often considered to be poorly responsive to conventional analgesic medications, including non-steroid anti-inflammatory drugs and opioids analgesics. Both peripheral and central mechanisms of neuropathic pain have been proposed. Peripherally, abnormal activation of sodium channels leading to the generation of ectopic discharges is likely to be associated with symptoms of neuropathic pain, particularly spontaneous, paroxysmal pain. Centrally, sensitization of spinal cord dorsal horn neurons in response to abnormal, repetitive peripheral nociceptive input after nerve/tissue injury plays a significant role in both development and maintenance of neuropathic pain symptoms. A key process of this central sensitization is the activation of N-methyl-D-aspartate (NMDA) receptors by glutamate/aspartate within the central nervous system. In addition, an imbalance between the spinal cord inhibitory and excitatory circuitry, presumably the result of a decreased spinal cord inhibition (γ-amino-butyric acid-GABA) influence, may also contribute to a central hypersensitization state.

Although exhaustive description of mechanisms, indications and outcome of treatment for the different drugs used in the pain management of our patient is beyond the scope of this review, Gabapentin and Ketamine are briefly discussed here.

Gabapentin

Gabapentin was initially introduced as an antiepileptic drug (AED), particularly for partial seizures. For a long time, AEDs, such as Carbamazepine have been recognized as adjunctive drugs for treating certain symptoms of chronic pain syndromes such as neuropathic pain. Gabapentin is better tolerated with fewer side effects and minimal drug interactions as compared with Carbamazepine. This was the main rationale for initiating Gabapentin therapy in this patient.

The mechanisms of action of Gabapentin are complex and yet only partially understood (Mao and Chen, 2000). It has been found ineffective in blocking sodium channel-mediated repetitive action potentials. Gabapentin, although a structural analog of Y-amino-butyric acid (GABA), does not bind to GABA receptors. Although Gabapentin may influence the synthesis and metabolism of endogenous GABA, antagonists of GABA receptors did not affect its action. This makes mechanism of action via GABA unlikely. Some have suggested an action of Gabapentin at the N-methyl-D-aspartate (NMDA)-glycine site, but receptor-binding studies have failed to detect any specific interactions between Gabapentin and the NMDA receptor complex. A Gabapentin-specific site was initially identified in the central nervous system, as the sub-unit of voltage-dependant calcium channels (Gee et al. 1996), but the causal relationship between this Gabapentin binding site and its action of pain relief is yet to be established.

Gabapentin has been well documented with well-designed trials in neuropathic conditions, such as postherpetic neuralgia (Rowbotham et al 1998), diabetic neuropathy (Backonja et al 1998), multiple sclerosis (Solaro et al 1998) and reported in GBS (Khatri & Pearlstein 1997).

Ketamine

Ketamine was initially developed as a dissociative anaesthetic agent, but its use was soon limited by the occurrence of adverse effects, primarily psychomimetic symptoms. Since the incidence and severity of the side effects are dose-dependent, and the dose required for analgesia is much lower, ketamine has benefited from a resurgence of interest for its analgesic properties.

Ketamine interacts with GABA receptors, opioid receptors, non-NMDA glutamate receptors, muscarinic receptors and voltage gated sodium, potassium and calcium channels. However, the analgesic effect of ketamine seems to be specifically mediated by its effect on NMDA-receptor. The NMDA-receptor is a complex sodium, potassium and calcium ion channel. It contributes significantly to the development of "Wind-up" phenomenon and central sensitization (Woolf 1989). The NMDA-receptor has, amongst others, binding sides for glutamate, glycine, magnesium and phencyclidine. Ketamine acts as a non-competitive antagonist at the phencyclidine site of the NMDA-receptor. This antagonistic effect of ketamine on the NMDA- receptor certainly accounts for some of its anti-neuropathic effects. There is, indeed, evidence, in animal studies, to suggest that the NMDA receptors are involved in the development of changes of neuronal excitability found in neuropathic pain states (Vos and Maciewicz 1994).

There are several clinical reports of the analgesic effects of NMDA receptor antagonists for the treatment of neuropathic pain (Felsby et al. 1995). Widespread use of Ketamine has been limited by its psychomimetic adverse effects. In the awake patient in particular, there is only a very small therapeutic range between analgesic efficacy and the development of side effects. However, Ketamine therapy by low dose infusion (ranging from 0.1-0.3 mg/kg) rarely produces any pronounced psychomimetic adverse effects. Our patient did not appear to suffer from any psychomimetic symptoms, although having required at some stage, levels of infusion approaching the dose known to produce side effects (0.5-0.6 mg/kg).

Discussion

The management and good outcome of the case presented demonstrates the importance of the comprehensive interaction of a multidisciplinary team. The neurologists and the intensivists provided most of diagnostic and therapeutic interventions for the Guillain-Barré condition itself. They then called for the help of the Pain team and interact with us on a daily basis. The nursing staff, the physiotherapists and the social worker were able to assist the patient in her most fundamental needs. They also reduced the rate of complications by careful nursing and passive physiotherapy. A careful rehabilitation program was specifically tailored for her specific needs.

An overview of management of the different aspects contributing to the experience of pain and suffering is essential in the role of the pain management team. In this patient we also managed the medications aimed at controlling the pain. This is generally based on the nature of pain, especially in the recognition of the different components of pain. Perhaps the most striking feature in the management of this patient (and likely encountered in many patients suffering from GBS) has been the difficulty in obtaining a proper description of the pain. During the two months, it was difficult to correlate the signs and symptoms of pain especially in the presence of autonomic nervous system disturbances experienced by the patient. For several weeks the patient was only able to communicate with movements of the eyes and a weak movement of the tongue due to her quadriplegia and bulbar palsy. Although pain was definitely present, it was difficult to obtain an exact description. The knowledge of the different types of pain in GBS allowed direct questioning to enable the evaluation of the nature of pain. As a neuropathic component became apparent, the early introduction of appropriate treatments was important.

We added to the continuous (iv) infusion of Morphine a Lignocaine infusion, and a Ketamine infusion, both well recognized for their anti-neuropathic properties. Running these infusions at low doses and at the same time, allowed a lower side effect profile for each of the drugs. In this case the infusion of Ketamine appeared to have played an important role in controlling the pain, which relapsed when Ketamine was discontinued. The pain then was mostly in legs and hips, presenting intermittently and lasting 10-15 minutes, triggered by mobilization. The control of the pain was re-established with the addition of Mexiletine, used for its anti-neuropathic property, although initially when Mexiletine was gradually increased, the patient required more intermittent morphine injections. Mexiletine is a class I antiarrhythmic structurally resembling Lignocaine and is often used for pain control because of its good oral bioavailibility.

During the 3 weeks the patient was on Ketamine, the pain control was achieved mainly adjusting the rate of infusion of Ketamine. Although one might argue that Ketamine has as much anti-nociceptive as anti-neuropathic effect, the fact that most pain control was regained with Mexiletine after discontinuation of Ketamine suggests that the pain at this period was predominantly neuropathic. This regimen with the increase of Gabapentin allowed a lower consumption of morphine, thus, decreasing some of the side effects of Morphine. It should be borne in mind that respiratory depressant effects of morphine, during the process of weaning off mechanical ventilation, was always a concern. However, the need for prolonged respiratory support was caused by the muscle weakness due to the disease.

At time of discharge, the patient had predominantly paraesthesia (allowing the initiation of weaning the neuropathic regimen) and some mild musculoskeletal pain controllable with mild analgesics (formulation containing Paracetamol and Codeine).

Although our patient had some of the criteria that usually are prognostic for residual weakness, (such as rapidly progressive disease, severe electromyographic changes and need for ventilation support for more than a month), she recovered most of her normal function and is so far not suffering of pain.

CONCLUSION

Pain, as well described in the medical literature in association with Guillain-Barré syndrome was a major problem in our patient and required a multi-disciplinary approach. Proper pain management aims at reducing the suffering of the patient, but also a reduction in rate of occurrence of chronic pain and a reduction of morbidity specifically related to uncontrolled pain. Unfortunately, the fact that GBS is uncommon and that pain is not usually one of its long-term sequelea makes controlled studies on appropriate pain treatment difficult. But beyond the normal aim at reducing suffering for the patient, one may expect a reduction of morbidity in GBS with properly controlled pain, such as reduction in cardiovascular and respiratory complications.

ANNEXES

Medications list

Midazolam infusion 11/5 till 1/6 (3mg/h)
Morphine infusion 11/5 till 23/5 (4-10mg/h)
Amitriptyline 11/5 (25-100mg/day)
Lignocaine infusion 14/5 till 29/5 (50-100mg/h)
Ketamine infusion 16/5 till 6/6 (10-40 mg/h)
Gabapentin 25/5 (300-2000 mg/d)
Temazepam 28/5 20 mg nocte
Mexiletine 7/6 till (50-600mg/d)
Kapanol 10/6 till 9/7 (40-10mg/day)

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Faculty Of Pain Medicine

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS ABN 82 055 042 852

GUIDELINES FOR TRAINEES AND DEPARTMENTS SEEKING FACULTY APPROVAL OF POSTS FOR TRAINING IN PAIN MEDICINE

1. INTRODUCTION

1.1 Training is for a minimum of five years and will normally commence during the training program of the specialties of anaesthesia, surgery, medicine, psychiatry or rehabilitation medicine. Trainees must undertake a prospectively approved one year structured training period in a Faculty accredited Multidisciplinary Pain Centre as outlined in Faculty Professional Document PM2 (2001) Requirements for Multidisciplinary Pain Centres Offering Training in Pain Medicine. This mandatory year of training will not commence until a trainee has registered with the Faculty.

1.2 Details of training in Pain Medicine, which must be accepted by training departments, are specified in the Faculty's Administrative Instructions.

1.3 Accreditation of Multidisciplinary Pain Centres approved by the Faculty for training purposes will be reviewed on at least a five yearly basis.

1.4 Approval of training program(s) will require submission of data indicating compliance with Faculty Professional Document PM2 (2000) Requirements for Multidisciplinary Pain Centres Offering Training in Pain Medicine. An inspection of the Centre will be required for accreditation.

2. DEFINITION OF A TRAINEE

2.1 Those registering as trainees for the Fellowship of the Faculty of Pain Medicine will be:

2.1.1 Fellows of one of the following bodies

Australian and New Zealand College of Anaesthetists

Royal Australasian College of Surgeons

Royal Australasian College of Physicians

Royal Australian and New Zealand College of Psychiatrists

Australasian Faculty of Rehabilitation Medicine (RACP); or

2.1.2 Holders of a specialist qualification acceptable to the Board; or

2.1.3 Advanced trainees for the Fellowship of one of the following bodies

Australian and New Zealand College of Anaesthetists

Royal Australasian College of Surgeons

Royal Australasian College of Physicians

Royal Australian and New Zealand College of Psychiatrists

Australasian Faculty of Rehabilitation Medicine (RACP).

2.2 Except as noted in Administrative Instructions, a trainee must have registered prospectively for training in Pain Medicine and must pay all appropriate fees.

2.3 A trainee must work in posts approved for training in Pain Medicine.

2.3.1 Where a trainee is concurrently undertaking other training towards a Fellowship specified in 2.1.3, his or her program must meet the requirements of the Faculty of Pain Medicine and the other College or Faculty. Prospective discussions are mandatory.

2.3.2 Holders of a qualification as specified in 2.1.2 must gain the prospective approval from the Faculty for their training and, when necessary, have relevant past experience accepted for training purposes.

2.4 Part-time training may be approved on prospective application.

2.5 During the year of training in a Multidisciplinary Pain Centre, out-of-hours rostered duties should be predominantly in Pain Medicine.

3. TRAINING COMPONENTS

The following training requirements must be satisfied as set out in the Administrative Instructions:

3.1 Quarterly In-Training assessments by the Supervisor of Training.

3.2 Case Report.

3.3 Log Book.

3.4 Final assessment report by the Supervisor of Training.

3.5 Examination. A trainee is eligible to present for examination in their final year of Pain Medicine training following satisfactory completion of all training requirements.

This document has been prepared having regard to general circumstances, and it is the responsibility of the practitioner to have express regard to the particular circumstances of each case, and the application of this document in each case.

Professional documents are reviewed from time to time, and it is the responsibility of the practitioner to ensure that the practitioner has obtained the current version. Professional documents have been prepared having regard to the information available at the time of their preparation, and the practitioner should therefore have regard to any information, research or material which may have been published or become available subsequently.

Whilst the Faculty endeavours to ensure that professional documents are as current as possible at the time of their preparation, it takes no responsibility for matters arising from changed circumstances or information or material which may have become available subsequently.

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Faculty Of Pain Medicine

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

PROFESSIONAL DOCUMENTS

PM1	(2002)	Guidelines for Trainees and Departments Seeking Faculty Approval of Posts for Training in Pain Medicine *Bulletin September 2002 pg 62*
PM2	(2001)	Requirements for Multidisciplinary Pain Centres Offering Training in Pain Medicine *Bulletin March 2002 Pg 52*
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*
PS 45	(2001)	Statement on Patients' Rights to Pain Management *Bulletin March 2002, pg 72*

College Professional Documents adopted by the Faculty:

PS4	(2000)	Recommendations for the Post-Anaesthesia Recovery Room (Adopted February 2001) *Bulletin November 2000, pg 72*
PS7	(1998)	The Pre-Anaesthesia Consultation (Adopted February 2001) *Bulletin March 1998, pg 73*
PS8	(1998)	The Assistant for the Anaesthetist (Adopted February 2001) *Bulletin March 1998, pg 75*
PS9	(2001)	Guidelines on Conscious Sedation for Diagnostic, Interventional Medical and Surgical Procedures (Adopted May 2002) *Bulletin June 2001, pg 88*
PS10	(1999)	The Handover of Responsibility During an Anaesthetic (Adopted February 2001) *Bulletin November 1999, pg 62*
PS15	(2000)	Recommendations for the Perioperative Care of Patients Selected for Day Care Proceedures (Adopted February 2001) *Bulletin November 2000, pg 75*
PS18	(2000)	Recommendations on Monitoring During Anaesthesia (Adopted February 2001) *Bulletin November 2000, pg 78*
PS20	(2001)	Recommendations for Responsibilities of the Anaesthetist in the Post-Operative Period (Adopted February 2001) *Bulletin November 2001, pg 83*
PS31	(1997)	Protocol for Checking the Anaesthetic Machine (Adopted February 2001) *Bulletin November 1997, pg 84*

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AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS ABN 82 055 042 852

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Chair, Education and Training Committee	Dr Leona Wilson
Chairman of Examinations	Dr Walter Thompson
Treasurer	Dr Michael Martyn
Chairman of Executive	Dr Michael Martyn
Assistant Assessor	Dr Anthony Weeks
Assistant Assessor OTS (New Zealand)	Dr Vaughan Laurenson
Chair, Continuing Education and Quality Assurance Committee	Dr Diana Khursandi
Chair, ASM Committee	Associate Professor Kate Leslie
Quality Activities/Maintenance of Professional Standards Officer	Dr Leona Wilson
Chair, Hospital Accreditation Committee	Dr Anthony Weeks
Chair, Communications and Fellowship Affairs Committee	Associate Professor Kate Leslie
Pharmaceutical, Technical and Safety Officer (Australia)	Dr Kerry Brandis
Pharmaceutical, Technical and Safety Officer (New Zealand)	Dr Bruce Rudge
Bulletin Editor	Mrs Joan Sheales
Honorary Curator - Geoffrey Kaye Museum of Anaesthetic History	Dr Rodney Westhorpe
Honorary Assistant Curator	Dr Christine Ball

EXECUTIVE

Chair	Dr Michael Martyn
President	Dr Richard Willis
Vice President	Professor Michael Cousins
Assessor	Dr Steuart Henderson
Treasurer	Dr Michael Martyn
Dean, Joint Faculty of Intensive Care Medicine	Dr Felicity Hawker
Dean, Faculty of Pain Medicine	A/Professor Leigh Atkinson
and such other Members as the Council may appoint	Dr Walter Thompson

EDUCATION AND TRAINING COMMITTEE

Chair	Dr Leona Wilson
President	Dr Richard Willis
Assessor	Dr Steuart Henderson
Chairman of Examinations	Dr Walter Thompson
Chair, Hospital Accreditation Committee	Dr Anthony Weeks
Chair, CE & QA Committee	Dr Diana Khursandi
Chair, Courses Sub Committee	Dr Walter Thompson
Joint Faculty of Intensive Care Medicine Education Officer	A/Professor Jack Havill
Faculty of Pain Medicine Representative	Dr Julia Fleming
Coopted New Fellows Representatives	Dr Timothy McCulloch
	Dr Andrew Gardner
and such other Members as the Council may appoint	Professor Michael Cousins
	Dr Kerry Brandis
Co-opted Member	Professor Teik Oh

HOSPITAL ACCREDITATION COMMITTEE

Chair	Dr Anthony Weeks
President	Dr Richard Willis
Assessor	Dr Steuart Henderson
Assistant Assessor	Dr Anthony Weeks
Chair, Education and Training Committee	Dr Leona Wilson
and such other Members as the Council may appoint	Dr Diana Khursandi
	A/Professor Greg Knoblanche

GENERAL EXAMINATIONS COMMITTEE

Chairman of Examinations (Chair)	Dr Walter Thompson
President	Dr Richard Willis
Chair, Education and Training Committee	Dr Leona Wilson
Chair, Primary Examination Committee	Dr Neville Gibbs
Deputy Chair, Primary Examination Committee	Dr David Cottee
Chair, Final Examination Committee	Dr David A Scott
Deputy Chair, Final Examination Committee	Dr Anthony M Weeks
Chair, Joint Faculty of Intensive Care Medicine Fellowship Examination	Dr Peter Morley
Chair, Faculty of Pain Medicine Examination Committee	Dr Penelope Briscoe

PRIMARY EXAMINATION COMMITTEE

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Deputy Chair	Dr David Cottee
Chairman of Examinations	Dr Walter Thompson
Chair, Joint Faculty of Intensive Care Medicine Fellowship Examination	Dr Peter Morley
Chair, Faculty of Pain Medicine Examination Committee	Dr Penelope Briscoe
Council Member	Associate Professor Kate Leslie
Members (4)	Dr Gillian Bishop
	Professor Tony Gin
	A/Professor Paul Myles
	Dr Noel Roberts

FINAL EXAMINATION COMMITTEE

Chair	Dr David A Scott
Deputy Chair	Dr Anthony Weeks
Chairman of Examinations	Dr Walter Thompson
Council Member	Dr Leona Wilson
Members (4)	Dr Penelope Briscoe
	Dr Edward Loughman
	Dr Craig Morgan
	Dr Michele Joseph
Coopted Member	Dr Roman Kluger

CONTINUING EDUCATION AND QUALITY ASSURANCE COMMITTEE

Chair	Dr Diana Khursandi
President	Dr RichardWillis
Chair, ASM Committee	Associate Professor Kate Leslie
Chair, Education and Training Committee	Dr Leona Wilson
QA/MOPS Officer	Dr Leona Wilson
Joint Faculty of Intensive Care Medicine Representative	A/Professor Jack Havill
Faculty of Pain Medicine Representative	Dr Roger Goucke
ASA Representative	Dr James Bradley
NZSA Representative	Dr Trevor Dobbinson
and such other Members as the Council may appoint	Dr Rodney Westhorpe
	Dr Kerry Brandis

WORKFORCE COMMITTEE	
Chair	Dr Diana Khursandi
President	Dr Richard Willis
Chair, Education and Training Committee	Dr Leona Wilson
Assistant Assessor	Dr Anthony Weeks
Joint Faculty of Intensive Care Medicine Education Officer	A/Professor Jack Havill
Faculty of Pain Medicine Education Officer	A/Professor Milton Cohen
and such other Members as the Council may appoint	Professor Garry Phillips
	To be advised

INFORMATION TECHNOLOGY COMMITTEE	
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President	Dr Richard Willis
Treasurer	Dr Michael Martyn
CEO	Mrs Joan Sheales
Joint Faculty of Intensive Care Medicine Representative	Dr Mark Finnis
Faculty of Pain Medicine Representative	Dr Bruce Kinloch
Administrative Officer (IT)	Ms Karen Monette
Members (2)	Dr Kerry Brandis
	Dr Joe Novella
Coopted Member	Dr James Derrick

SALARIES REVIEW COMMITTEE	
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Vice President	Professor Michael Cousins
Treasurer	Dr Michael Martyn
CEO	Mrs Joan Sheales
Dean, Joint Faculty of Intensive Care Medicine	Dr Felicity Hawker
Dean, Faculty of Pain Medicine	A/Professor Leigh Atkinson

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Vice President	Professor Michael Cousins
Chairman of the Executive	Dr Michael Martyn
Joint Faculty of Intensive Care Medicine Representative	Dr Felicity Hawker
Faculty of Pain Medicine Representative	A/Professor Leigh Atkinson
CEO	Mrs Joan Sheales
and two other Members as appointed by Council	Mr Michael Gorton
	Professor Garry Phillips

ASM COMMITTEE	
Chair	Associate Professor Kate Leslie
President	Dr Richard Willis
Chair, Communications and Fellowship Affairs Committee	Associate Professsor Kate Leslie
Chair, CE & QA Committee	Dr Diana Khursandi
Joint Faculty of Intensive Care Medicine Representative	Dr Peter van Heerden
Faculty of Pain Medicine Representative	Dr Pamela Macintyre
CEO	Mrs Joan Sheales
Past ASM Scientific Convenor (Brisbane)	Dr Stephen Bruce
Past ASM Convenor (Brisbane)	Dr Kerry Brandis
Current ASM Scientific Convenor (Hobart)	Dr Philip Browne
Current ASM Convenor (Hobart)	Dr Richard Waldron
Future ASM Scientific Convenor (Perth)	Dr Lindy Roberts
Future ASM Convenor (Perth)	Dr Mark Josephson
Australian Society of Anaesthetists NSC Officer	Dr James Bradley
Medical Director of CECANZ	Dr Trevor Dobbinson

COMMUNICATIONS AND FELLOWSHIP AFFAIRS COMMITTEE

Chair	Associate Professsor Kate Leslie
President	Dr Richard Willis
Chair, ASM Committee	Associate Professsor Kate Leslie
Joint Faculty of Intensive Care Medicine Representative	Dr Ranald Pascoe
Faculty of Pain Medicine Representative	A/Professor Leigh Atkinson
CEO	Mrs Joan Sheales
Communications Consultant	Mr Eddie Dean
ASA Representative	President or nominee
NZSA Representative	President or nominee
Members (2)	Dr Michael Martyn
	Professor Garry Phillips

HOUSE COMMITTEE

Chair (Councillor)	Dr Rodney Westhorpe
Joint Faculty of Intensive Care Medicine Representative	Dr Felicity Hawker
Faculty of Pain Medicine Representative	Dr Graham Rice
Honorary Curator, Geoffrey Kaye Museum	Dr Rodney Westhorpe
CEO	Mrs Joan Sheales
Librarian	Ms Shanti Nadaraja
Staff Representative	Ms Helen Morris

ASIA PACIFIC COMMITTEE

Chair (Fellow)	Professor Garry Phillips
President	Dr Richard Willis
Joint Faculty of Intensive Care Medicine Representative	Dr Peter Thomas
Faculty of Pain Medicine Representative	Dr Phoon Ping Chen
ASA Representative	Dr Stephen Kinnear
Member	Professor Teik Oh

ANAESTHESIA CONTINUING EDUCATION COORDINATING COMMITTEE

ANZCA Representative to ACECC Executive	Dr Rodney Westhorpe
ANZCA QA/MOPS Officer	Dr Leona Wilson
ANZCA Chair, Education and Training Committee	Dr Leona Wilson
Joint Faculty of Intensive Care Medicine Representative	A/Professor Jack Havill
Faculty of Pain Medicine Representative	J J Trinca
ASA Representative	Dr James Bradley
CECANZ Director	Dr Trevor Dobbinson
Regional Combined CME Chairmen	Dr Joseph Novella(Vic)
	A/Prof Peter Klineberg (NSW)
	Dr David Kinchington (ACT)
	Dr Lynne Rainey (SA)
	Dr Peter Moran (Qld)
	Dr Michael Grubb (Tas)
	Dr Michael Paech (WA)
	SIG Chairmen

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Faculty of Pain Medicine Representative	Dr Philip Siddall
Members	Professor Tony Gin
	Professor Duncan Blake
	Dr Anthony Quail
	A/Professor Paul Myles
	Dr Timothy Short
	Professor Laurence Mather
	Dr Michael Paech
Coopted Member	Professor Teik Oh

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Trainee Representative	Dr Elizabeth Prentice
Director CECANZ	Dr Trevor Dobbinson
Joint Faculty of Intensive Care Medicine Representative	Dr Richard Lee
Faculty of Pain Medicine Representative	Dr Jack Gerschman
Librarian	Ms Shanti Nadaraja
Members as appointed by Council	Dr James Love
	Dr Rodney Westhorpe
Co-opted Members	Dr Mary Done
	Dr Russell Jones
	Ms Karen Monette
MOPS COMMITTEE	
Chair (QA/MOPS Officer)	Dr Leona Wilson
Director of Professional Affairs	Professor Garry Phillips
Member	Professor Teik Oh
CERTIFICATES COMMITTEE	
Chair (Councillor)	Dr Walter Thompson
Councillor	Dr Mike Martyn
Chairman of Examinations (or nominee)	Dr Walter Thompson
Director of Professional Affairs	Professor Garry Phillips
Fellow nominated by Council	Dr Robert Wong
Member (Chair, Hospital Accreditation Committee)	Dr Anthony Weeks
Two coopted nominees from particular area of expertise	
OTS COMMITTEE	
Chair (Assistant Assessor)	Dr Anthony Weeks
Assistant Assessor OTS (New Zealand)	Dr Vaughan Laurenson
Chairman of Examinations	Dr Walter Thompson
Chair, Final Examination Committee	Dr David A Scott
Joint Faculty of Intensive Care Medicine Representative	Dr Richard Lee
Faculty of Pain Medicine Representative	Dr David Jones
Two other Fellows nominated by Council	Dr Peter Roessler
	Dr Steven Katz
Coopted Member	A/Professor Greg Knoblanche
GILBERT BROWN PRIZE ADJUDICATORS	
Chairman of Adjudicators (Chair, Research Committee)	Professor Michael Cousins
FORMAL PROJECT PRIZE ADJUDICATORS	
Chairman of Adjudicators (Chair, Education and Training Committee)	Dr Leona Wilson
COUNCIL REPRESENTATIVE ON BOARD OF JOINT FACULTY OF INTENSIVE CARE MEDICINE	
	Dr Richard Willis
COUNCIL REPRESENTATIVE ON BOARD OF FACULTY OF PAIN MEDICINE	
	Dr Steuart Henderson
JOINT CONSULTATIVE COMMITTEE ON ANAESTHESIA (JCCA)	
Councillor	Dr Walter Thompson
Councillor	Dr Diana Khursandi
	Dr Frank Moloney
	Dr Daryl Catt

MORTALITY COMMITTEE	
Chair (President)	Dr Richard Willis
State Mortality Committee Chairmen	
ANZCA FOUNDATION	
Chair	Professor Michael Cousins
RURAL RECRUITMENT COMMITTEE	
Chair	Dr Daryl Catt
Councillor	Dr Rodney Westhorpe
Councillor	Dr Diana Khursandi
ASA Executive Committee Representative	President or Nominee
Rural SIG Representative	Dr Daryl Catt
CLINICAL INDICATORS WORKING PARTY	
Chair (Chair, CE & QA Committee)	Dr Diana Khursandi
Faculty of Pain Medicine Representative	Dr Roger Goucke
Members	Dr Walter Thompson
	Dr Anthony Weeks
	Dr Paul Wajon
	Dr Peter Moran
COURSES SUB-COMMITTEE	
Chair (Councillor)	Dr Walter Thompson
Chair, CE & QA Committee	Dr Diana Khursandi
Chair, Education and Training Committee	Dr Leona Wilson
Fellows (3)	Dr Brendan Flanagan
	Dr Jennifer Weller
	Dr Leonie Watterson
ANZCA/ACEM LIAISON COMMITTEE	
ANZCA Representative	Professor Garry Phillips
ANZCA Representative	Dr Walter Thompson
ANZCA Coopted Member	Dr Steuart Henderson
Joint Faculty of Intensive Care Medicine Representatives	Dr Neil Matthews
	Dr Ann Whitfield
NEW FANZCA PROGRAM WORKING PARTY	
Chair	Professor Teik Oh
Chairman of Examinations	Dr Walter Thompson
Joint Faculty of Intensive Care Medicine Representative	Dr Richard Lee
Members	Dr Steuart Henderson
	Dr Peter Kam
	Dr Edward Loughman
	Dr Lindy Roberts
	Dr Anthony Weeks
	Dr Leona Wilson
Coopted Member	Dr Michele Joseph
AMC ACCREDITATION WORKING PARTY	
Chair	Dr Richard Willis
Director of Professional Affairs	Professor Garry Phillips
Chair, Education and Training Committee	Dr Leona Wilson
Chairman of Examinations	Dr Walter Thompson
Dean, Joint Faculty of Intensive Care Medicine	Dr Felicity Hawker
Dean, Faculty of Pain Medicine	A/Professor Leigh Atkinson
Member	Professor John Gibbs
Coopted Member	Dr Steuart Henderson

RURAL EDUCATION AND SERVICES COMMITTEE	
Chair (Councillor)	Dr Diana Khursandi
Councillor	Dr Kerry J Brandis
New Zealand Fellow	Dr Ross Freebairn
Chairman of JCCA	Dr David Merefield

REPRESENTATIVES/NOMINEES TO OTHER OUTSIDE ORGANISATIONS

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS	
Observer to RACS Council	President or nominee
Trauma Committee	*To be advised*
Infection Control Committee	A/Professor Greg Knoblanche
Australian Medical Association	
Anaesthesia Coordinating Committee	President
	Chairman of Executive
National Conference	President or nominee
AUSTRALIAN RESUSCITATION COUNCIL	Dr Alan Rainbird
	A/Professor Victor Callanan
ANAESTHESIA AND INDUSTRY LIAISON COMMITTEE	
Chair	Dr John Lauritz
President (ANZCA)	Dr Richard Willis
President (ASA)	Dr Michael Hodgson
Chair, ASM Committee (ANZCA)	Associate Professsor Kate Leslie
Member (ANZCA)	Dr Rodney Westhorpe
Member (ASA)	Dr James Bradley
Member (ASA)	Dr David Fenwick
AUSTRALASIAN BOARD OF CARDIOVASCULAR PERFUSIONISTS	Dr Paul Forrest
	Dr Andrew Stewart
AUSTRALIAN SOCIETY OF ANAESTHETISTS	
Executive	President or nominee
Joint ASA/ANZCA Liaison Committee	
President	Dr Richard Willis
Vice-President	Professor Michael Cousins
National Scientific Congress Federal Organising Committee	
Chair, ASM Committee	Associate Professsor Kate Leslie
Overseas Liaison Committee	
Chair, Asia Pacific Committee	Professor Garry Phillips
COMMITTEE OF PRESIDENTS OF MEDICAL COLLEGES	
Committee of Presidents	President
Education and Standards Sub-Committee	
Assessor	Dr Steuart Henderson
Rural Health Sub-Committee	Dr Diana Khursandi

AUSTRALIAN DAY SURGERY COUNCIL	Dr Glenda Rudkin Dr Stephen Watts
NATIONAL HEALTH AND MEDICAL RESEARCH COUNCIL Infection Control Committee	A/Professor Greg Knoblanche
EXTERNAL STANDARDS COMMITTEES Co-ordinator of Anaesthesia Representatives	Dr John Russell
AUSTRALIAN COUNCIL ON HEALTHCARE STANDARDS College Representative on ACHS Council	Professor Garry Phillips
NATIONAL CENTRE FOR CLASSIFICATION IN HEALTH (NCCH) Representative	A/Professor Greg Knoblanche

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	(2001)	Guidelines for Hospitals seeking College Approval of Posts for the First Four Years of Vocational Training in Anaesthesia *Bulletin June 2001, pg 92*
TE3	(1999)	Supervision of Clinical Experience for Trainees in Anaesthesia *Bulletin November 1999, pg 67*
TE4	(1997)	Duties of Regional Education Officers in Anaesthesia *Bulletin November 1997, pg 88*
TE5	(1997)	Supervisors of Training in Anaesthesia *Bulletin November 1997, pg 89*
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*
TE9	(1999)	Quality Assurance *Bulletin June 1999, pg 94*
TE11	(1999)	Formal Project Guidelines *Bulletin March 1999, pg 70*
TE13	(2001)	Guidelines for the Provisional Fellowship Year *Bulletin November 2001, pg 76*
TE14	(2001)	Policy for the In-Training Assessment of Trainees in Anaesthesia *Bulletin November 2001, pg 84*
TE17	(1999)	Advisors of Candidates for Anaesthesia Training *Bulletin November 1999, pg 66*
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*
P1	(1997)	Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia *Bulletin May 1997, pg 81*
PS2	(2001)	Statement on Credentialling in Anaesthesia *Bulletin March 2002, pg 65*
PS3	(2001)	Guidelines for the Conduct of Major Regional Anaesthesia and Analgesia *Bulletin March 2002, pg 66*
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	(1998)	The Pre-Anaesthesia Consultation *Bulletin March 1998, pg 73*
PS8	(1998)	The Assistant for the Anaesthetist *Bulletin March 1998, pg 75*
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*
P11	(1991)	Management of Cardiopulmonary Bypass *Bulletin May 1991, pg 43*
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*
PS17	(1997)	Endoscopy of the Airways *Bulletin November 1997, pg 80*
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	(1996)	Sedation for Dental Procedures *Bulletin March 1997, pg 56*
P24	(1997)	Sedation for Endoscopy *Bulletin May 1997, pg 78*
PS26	(1999)	Guidelines on Providing Information about the Services of an Anaesthetist *Bulletin November 1999, pg 63*
P2	(1994)	Standards of Practice for Major Extracorporeal Perfusion *Bulletin November 1994, pg 46*

P28	(1995)	Policy on Infection Control in Anaesthesia *Bulletin March 1995, pg 38*
PS29	(1997)	Anaesthesia Care of Children in Healthcare Facilities without Dedicated Paediatric Facilities *Bulletin November 1997, pg 82*
PS31	(1997)	Protocol for Checking the Anaesthetic Machine *Bulletin November 1997, pg 84*
PS36	(1997)	Sedation for Regional Anaesthesia for Ophthalmic Surgery *Bulletin November 1997, pg 93*
PS37	(1998)	Regional Anaesthesia and Allied Health Practitioners *Bulletin March 1998, pg 79*
PS38	(1999)	Statement Relating to the Relief of Pain and Suffering and End of Life Decisions *Bulletin June 1999, pg 93*
PM1	(1999)	Guidelines for Trainees and Departments seeking College Approval of Posts for Training in Pain Medicine *Bulletin Mar 1999, pg 73*
PS39	(2000)	Intrahospital Transport of Critically Ill Patients *Bulletin July 2000, pg 84*
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*