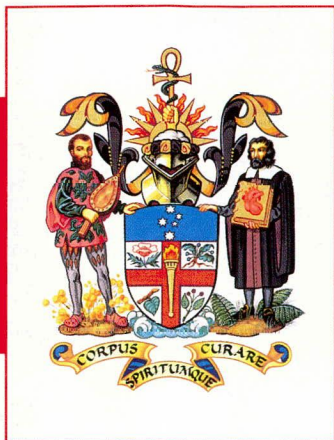


Australian and New Zealand College of Anaesthetists

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'*

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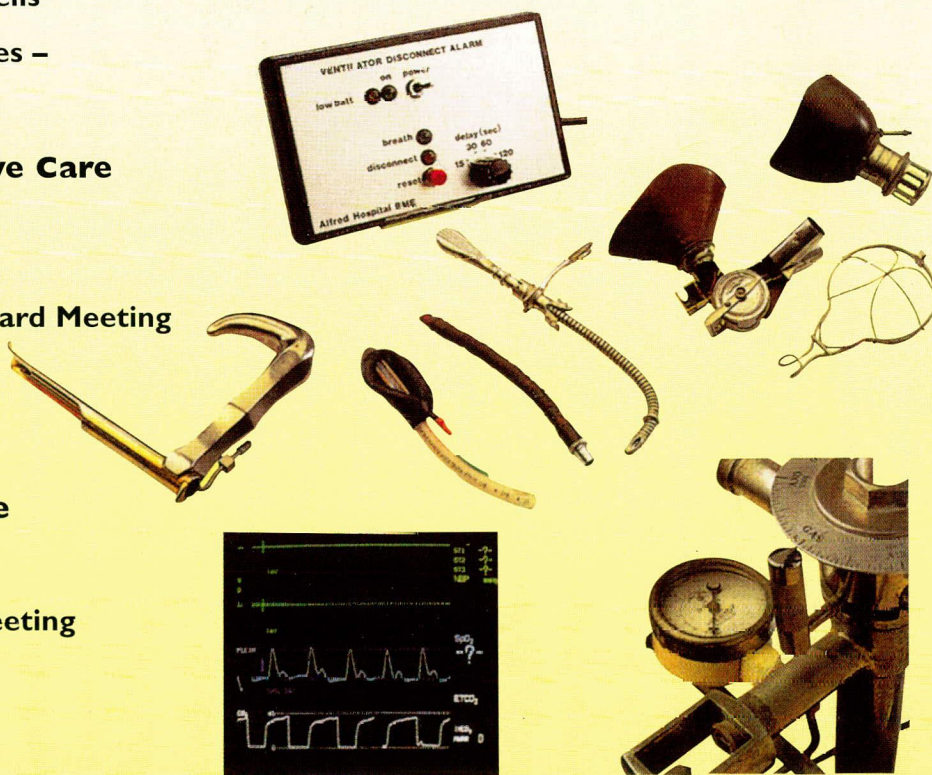
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President's Message

**Teik E. Oh, MD(Qld), FRCP, FRACP, FRCA, FANZCA,
Hon FCARCSI, FFICANZCA**

On Reflection

During my term in office, the College identified four strategic directives: to advance education, to increase services to rural areas, to strengthen ties with Asia-Pacific colleagues, and to improve communications with Fellows.

We moved towards *being* an educational body. Funding for the education umbrella was expanded. Various workshops on teaching, learning, and assessment etc were conducted, putting in place ongoing activities in the Regions. Education materials were prepared, with more to come. A new EMAC course was introduced and other courses are in the pipeline. Regulations were revised and a New FANZCA training program is being considered. There is still much to do, but we now have the critical mass to move education up a few notches.

To facilitate filling rural posts, we introduced an Area-of-Need (AON) and Overseas-Trained Specialists (OTS) processes. The former assesses and matches applicants to the AON job, but success has been mixed, being dependent on numbers applying. The OTS assessment process has been more successful, adding to the anaesthesia workforce, with some new specialists going to rural areas. We drafted two initiatives to promote education and services to rural areas, and sought funding from health ministers. The Australian Federal Minister of Health (Dr Wooldridge) was supportive, but wanted the States to share costs. The State Ministers liked the initiatives but committed no funds. We got nowhere and now need a repeat or a new approach.

ANZCA's strategies for Asia-Pacific neighbours are to aid poorer nations and to form partnerships with wealthier ones. Many Fellows individually contributed to Asia-Pacific countries and the College salutes them. We gave aid to

Papua New Guinea and Fiji in education assistance. Partnership ties with our Hong Kong and China colleagues were enhanced by the joint Combined Scientific Meeting and the Beijing Satellite Meeting in May 2001. A similar venture with our Singapore and Malaysian counterparts is being discussed.

Council increased contacts with the Regional and New Zealand National Committees. Committee Chairs were invited on rotation to Council meetings and participated in teleconferences with me. Executive, in scheduled visits, met with Chairs, Committees, and Fellows locally. I visited those Regions that had not yet been visited. These arrangements allowed Council to better inform the Regions, and in turn, be better informed by the grassroots. Council's new Communications and Fellowship Committee will further improve this link.

What else strikes me on reflection? As a bi-national body, the College faces negotiating projects with not one, but seven different bodies: New Zealand and six Australian States (ten bodies if the Territories are involved). You have to wonder how Snow White coped. I remain impressed and inspired by the work put in by Fellows in College committees and the commitment of College staff. On the flip side, I am saddened and puzzled by some Fellows' hostility towards *their* College that exists for *their* benefit. Professionalism dictates that the driving force of our practice be quality care to our patients and not our vested interests. High standards of professionalism can only generate respect from the public and health professionals and do us good. ANZCA is the paradigm of specialist professionalism in our disciplines. To undermine that and the Fellowship that enables you to practise and earn your living, is to undermine yourself.

Deaths

The death of the following Fellows was noted with regret:

Dr Anna Karolina Havlin (Vic) - FFARACS 1986, FANZCA 1992

Dr Liliias Joan Dunn (QLD) - FFARACS 1965, FANZCA 1992



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To end on a happy note, I congratulate Dr Felicity Hawker, Dean of the Interim Board of the Joint Faculty of Intensive Care Medicine. This joint body with the RACP finally pulls together the two training groups of intensivists in our countries. I also congratulate Professor Leigh Atkinson on being elected Dean of the Faculty of Pain Medicine and Dr Dick Willis on being President-Elect. Dick will take over at our ASM in Brisbane in May 2002. This promises to be a great meeting, our Queensland Fellows have made sure of that.

Finally, for me it has been an exhausting but enriching experience. It has been a privilege to serve the College and Fellows. I give grateful thanks to my wife Lala and our kids, Joan Sheales and her staff, Councillors, members of College Committees and Fellows.



Teik Oh

Honours and Appointments

Congratulations were extended to:

- Professor Stephan Schug (WA) – Professor of Anaesthesia University of Western Australia.
- Associate Professor Michael Paech (WA) – Clinical Associate Professor of Anaesthesia, University of Western Australia.
- Professor Peter Kam (NSW) – Professor of Anaesthesia, University of New South Wales St George Hospital.
- Professor Garry Phillips (SA) – Emeritus Professor Flinders University of South Australia

Accreditation of ANZCA

RICHARD J WILLIS
VICE PRESIDENT



In the last Bulletin, I explained some of the background to the impending accreditation visit to the College by the Australian Medical Council (AMC). This is a new venture by the AMC which is better known for its other activities such as assessment of overseas trained doctors and specialists and for accreditation

of Australian and New Zealand Medical Schools. Two pilot College accreditations were completed last year involving both the College of Radiologists and the College of Surgeons. ANZCA will be the first College to undergo the full process of accreditation.

PROGRESS

There has been considerable progress since my last report in the November 2001 Bulletin. A lengthy written submission of over 100 pages covering all aspects of College activities has been prepared by ANZCA's Director of Professional Affairs, Professor Garry Phillips. Separate but smaller submissions for both Faculties are in preparation. These will be submitted to the AMC for perusal by the Accreditation Team in April.

The Chairman of the team will be Professor Richard Larkins who is the current President of the Royal Australasian College of Physicians and Dean, Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne. Other members of the team have yet to be chosen but it is likely that there will be about five people with varied medical backgrounds and will probably include a New Zealander, a trainee from another College and a consumer representative.

THE CURRENT PLAN

The Accreditation Team will review our submitted documentation in April and will then either request more information or will move ahead with the planned visits to

the College probably in either July or August. At the College headquarters, the team will interview College staff and selected Fellows regarding details of all College activities. All our processes must be well documented, evidence based where possible, and the actual outcomes also documented and compared with the desired outcomes.

College activities to be scrutinised include: selection and support of trainees; structure, content, duration and supervision of training; assessment of trainees both by in-training assessments and by examinations; subspecialty training; assessment of overseas trained specialists; MOPS; continuing medical education; and, retraining.

Visits will also be made to selected training hospitals, both city and non-metropolitan. Hospitals offering training in anaesthesia, intensive care and pain medicine are likely to be preferred as hospitals to visit. Such hospitals will have ample warning of the visit, have access to relevant documentation and will be advised of details of the team's requirements and likely questions. Surveys of trainees may also be undertaken.

TAKE HOME MESSAGES

- ANZCA will be the first specialist medical College to undergo AMC accreditation
- Both Faculties will also undergo this accreditation
- All College activities will be scrutinised in detail
- Fellows and staff at College headquarters will be interviewed
- Selected hospitals will be visited and Fellows and Trainees interviewed
- Do not confuse these accreditation visits with either ACHS or College visits
- Hospitals to be visited will receive ample notification and assistance
- The reporting process will be constructive, non-punitive and will offer opportunities to further refine all College processes and activities

Deaths

The death of the following Fellows was noted with regret:

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Dr Liliias Joan Dunn (QLD) - FFARACS 1965, FANZCA 1992

Highlights of Council

FROM THE FEBRUARY 2002 COUNCIL MEETING

ELECTION OF PRESIDENT ELECT

Dr Richard J Willis (SA) was elected President Elect of the College and will take office following the Annual General Meeting in May 2002.

ANNUAL SCIENTIFIC MEETING - BRISBANE 2002

Council agreed to support the attendance of an anaesthetist from Papua New Guinea to the Annual Scientific Meeting in Brisbane and the New Fellows Conference.

EDUCATION

A review of the Education Unit will be carried out following the completion of its first year of operation.

NEW FANZCA PROGRAM

Currently the Chairman is awaiting input from members of the Working Party on the proposed curriculum in twelve modules. Following the inclusion of comments from Councillors, and members of the Working Party the documents will be updated and forwarded to the Regional/National Committees and published on the website seeking comment from Fellows. This is an evolving process and in line with College policy, changes and modifications will be made according to the feedback.

The Education and Training Committee and the General Examination Committee have been invited to provide suggestions for assessment and examinations for the new programs according to the modules. These draft suggestions will also be forwarded to the Regional/National Committees and Fellows for comment.

Concurrently the Clinical Tutors course will be developed under the aegis of the Education and Training Committee.

JOINT CONSULTATIVE COMMITTEE ON ANAESTHESIA

Paediatric Anaesthesia

Council approved the following policy which applies to General Practitioner Anaesthetists:

That endorsement for elective paediatric anaesthetics down to age 12 months must be granted on an individual practitioner basis after demonstration of the need for such endorsement and assessment/accreditation by regional representatives of the JCCA. Such endorsement is to be related to the area of need, the individual's documented training in paediatric anaesthesia to the age of 12 months, and be dependent on the maintenance of professional standards.

Council also endorsed the Maintenance of Professional Standards Program for 2002-2003 of the JCCA for GP Anaesthetists.



Law Report

“Medico-Legal Influences For Day Surgery”

It is clear that Day Surgery is now an important part of our health care system. On some estimates, there are now over 200 free standing day surgeries throughout Australia, conducting in excess of 500,000 procedures per annum. There are over 1,000 public and private hospital day surgery facilities.

Day surgeries have an increasing level of sophistication of technology involved, and follow dramatic improvements in diagnostic services and procedures.

The growth in the range of procedures offered through Day Surgery has been extraordinary in recent years.

Day Surgery should continue, given government pressure to reduce the costs of our health systems, to develop as an important part of healthcare services.

Pressures

Nonetheless, Day Surgery is conducted in an environment where there are a range of pressures and demands:

- The pressure for time is not limited to Day Surgery, but particularly affects Day Surgery.
- The demand for scarce resources also particularly affects procedures in Day Surgery.
- Staffing levels becomes an issue for the management.
- Competitive behaviour, particularly in the private sector, and with increasing corporatisation, means pressure for greater productivity and efficiencies.
- The increasing need for greater record keeping and bureaucracy.

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

Higher Level of Risk

It can be argued that Day Surgery therefore involves a higher level of risk, and therefore entails a higher duty of care.

Whilst not necessarily prevalent in all cases or all procedures, the following factors might suggest that Day Surgery involves a higher level of risk:

- In many cases, there will be a shorter lead time, and therefore shorter contact time with patients before a procedure, and for informed consent processes.
- Procedures in Day Surgery may have reduced access to the full range of hospital equipment and services which might be available for in-patient procedures.
- There may be greater risk involved in earlier discharge and greater reliance on external post-operative services.

Recognition of these greater risks will help in the development of appropriate risk management strategies.

Legal Risks

A Day Surgery centre will have a non-delegable duty of care, for having responsibility for the overall control and supervision of the facility. Like a hospital, it is not able to remove this duty. Some of the legal risks identified with Day Surgery facilities will include:

- Informed consent, particularly given the more limited time involvement with patients.
- Particular risk associated with limited time for pre-admission assessment.
- Sterilisation.
- Adequacy of equipment and facilities, and whether facilities are sufficiently comprehensive.

- Dealing with emergencies, and whether facilities and policies are adequate to deal with them.
- Adequacy of expertise, skills and training of staff.
- Adequacy of protocols and procedures.
- Premature discharge.
- "Informed Consent" on discharge - Providing patients with sufficient information to deal with post-operative issues.
- Adequacy of follow up and post-operative home care.

Many of these legal risks also apply to hospitals, but are more particularly relevant in the context of a Day Surgery facility.

Duty of Care

Given the general duty of care of Day Surgery facilities, a number of areas should be given particular attention:

- Equipment and facilities.
- Product liability.
- Patient pre-admission assessment and preparation (both whether the procedures are appropriate, and whether the information given is sufficient).
- Liability for contractors (since increasingly, facilities are relying on independent contractors, medical and otherwise).
- Patient assessment immediately upon admission, and upon discharge.
- Training and education of staff.
- Protocols and procedures.
- Accreditation and quality assurance issues.

Informed Consent

Because of the nature of Day Surgery procedures, as previously noted, there may be time constraints, or lack of time, in which important issues for the informed consent process can be dealt with.

It should be noted that, for Day Surgery, there is the same duty to fully inform patients and warn of material risks as for any other procedure in any other facility.

If a procedure in a Day Surgery context involves any additional significant risk than for a formal admission as an inpatient, this may potentially be an additional risk which should be advised to the patient. In such circumstances, the patient should have the opportunity to either have the procedure carried out in a Day Surgery context, or in a full inpatient admission.

Note particularly the reduced time in which anaesthesia informed consent may be obtained.

Given the importance of discharge and post-operative information, in the context of Day Surgery procedures, there is an additional need to inform and warn patients upon discharge in relation to the need for continuing

treatment and attention, warning signs which may require readmission or doctor call out. Because the patient will not be under the care of the hospital post procedure, the patient will need far greater information than might normally be the case.

General information sheets and prepared literature may be of assistance, but should not replace proper communication with the patient on an individual basis.

Discharge and Follow-up

This highlights the need for proper discharge and follow up policies and procedures.

Notwithstanding that the patient has left the care of the Day Surgery facility, there can be a continuing liability for the care of the patient. There is certainly a duty to provide greater information and advice regarding post procedural issues (including warning signs, re-admission and continuing medication).

There may be a need to ensure that appropriate monitoring arrangements are in place with appropriate follow up and verification of post discharge care. For example, a facility may be responsible to ensure that the care that is available to a patient in the home or other environment, post discharge, is appropriate.

This may be particularly difficult in the rural or regional context, where the patient may be far away from medical facilities in the event of some future emergency.

There will certainly be an obligation to ensure that continuing treatment is provided, including continuing service delivery, prescriptions and referrals.

General

Given the growth in the number of Day Surgery facilities and the number and type of procedures carried out through them, there will no doubt be many medical legal cases in the future which deal with and identify particular risks and obligations which differ from those in the usual hospital context.

However, it is important to remember that most of the ordinary obligations currently imposed on our hospitals, both public and private, will apply in the main to the Day Surgery facility. And, given the reduced contact hours with patients in the Day Surgery environment, some of those duties and obligations will be heightened.

It is therefore important that the risks be identified, addressed in a risk management context, and continuing review be undertaken.

Fellow's Profile

Dr Doug Wells

Bob's Dam Win

Once in a while everyone meets a special person or recognises in someone that special quality which makes them different. I am fortunate to have such a friend.

He lives with his wife and four children on a farm near Ballarat, in central Victoria, in a small house that was owned by a mine manager during the gold rush days. When the mine closed in about 1890, the house was cut up into three sections and transported by dray about 12 kilometres to its present location and reassembled.

My friend doesn't own the farm, but works it on behalf of a nonagenarian-plus uncle who provides the property rent free along with the promise of inheriting it on the death of the uncle. All revenue from the farm is split among about a dozen family members.

My friend (whom I'll call Bob) supplements his income by cutting wood, selling gravel, and growing wheat on a separate 50-acre paddock that he owns. His wife has gained a bus driver's licence and every day drives 90 kilometres each way to Geelong where she works as a bus driver. Bob is unable to do such work as he was born blind in one eye. Yet, his great strength and robust physical appearance belie the fact that he has already undergone a prosthetic valve replacement for his congenital bicuspid aortic valve.

In case anyone may be getting the wrong idea, Bob is anything but unhappy with his lot in life. He is smart, organised, progressive to the point of being revolutionary, determined and infectiously optimistic and enthusiastic.

In 2000, he was among half a dozen Victorian farmers to win a Landcare award for progressive farming. His farm was one of the first in Victoria to grow blue gums for the Japanese paper market - a contract Bob negotiated eight years ago. It will see him reap significant rewards when the farm is finally his.

Bob advises me on what shares to buy and so far his tips have all been winners. The only problem is that Bob can't afford to buy the shares himself. My family and I frequently visit Bob and his family. We camp out in the paddocks and talk and view the stars. My kids run free of all the city restrictions and my wife (also a physician) and I get a dose of home grown reality and a needed reminder that love, health, family and self belief are much more important than the house, car, holiday home or bank balance.

On one of our trips to the farm I asked Bob what it might take to improve the financial quality of life of his family. Bob the entrepreneur told me that for about \$60,000 he could dam a valley on the property, fill the dam with fish, and get into eco-tourism. The two of us expanded eco-tourism into having people camp beside the dam, catch their own fish and have it cooked for them, with all the trimmings provided.



Bob and Doug's children standing at what will be the top end of the dam

That night Bob climbed into his tent relaxed and slept as usual - but my mind was captured by the thought of doing something challenging and useful. I figured that anyone who could memorise the amount of knowledge necessary to succeed in the anaesthetic first part examination could probably achieve what I now had in mind - namely, to get on a quiz show and make some "free" money. Bob could be set up in an eco-tourism lifestyle and I would have the satisfaction of meeting a challenge and helping a friend.

After all, didn't I have a fantastic general knowledge? Didn't I know most of the answers on "Sale of the Century"? Two weeks later I sat in a church hall with about 100 other hopeful candidates and took the "Sale" test. About 20 passed. I was NOT one of them. Despair set in and lasted for a day or two.

I decided to give myself a year to prepare as I had for my anaesthetic exams, and return with a knowledge that would result in success. So started the study. Every day that I wasn't working. At night when the kids were in bed. In hospitals when I had "down time". I listened to news broadcasts, actually concentrating on their content as if in a lecture. Every new fact that I came across, I wrote down. I studied over 40,000 trivia questions and, as I write this

story, there are 22 encyclopaedias and fact books on the shelf behind me. These I studied and tried to memorise. I transcribed these "text books" into hand-written note books and read and re-read them.

After 12 months, I re-took the "Sale" test and came in either first or equal first. I was on the boil!!

Then my opportunity for "Who Wants to be a Millionaire" turned up. I had been heavily "researching" the show and had organised a mate to make me an automatic computer dialling system in order to save the time required in manually dialling. I made thousands of phone calls and on my second attempt moved from the "inner sanctum" of 10 people into the hot seat itself.

This was a surreal experience, EXACTLY like sitting an anaesthetic aural. There is no sense of time or where one is in the progression through the questions towards the million dollars. Eddie Maguire gave me great encouragement.

But alas it was not to be. Along with probably every other contestant who has been on the show, I felt that I got a bunch of fairly obtuse questions. But in the end you have to play the hand you get. I stumbled on a question and fell back to \$32,000.

I had deliberately told people in all the hospitals where I work of my intentions. People all over town showed interest in my progress and actually barracked for me as if I was in some major sporting event - even before I got on "Millionaire". It seemed I had tapped into a widespread community feeling of respect for the underdog. Many people told me that they thought my project was "terrific" or "noble" or just "great stuff".

In fact I also became a winner in the nicest possible way. At the end of the day, Bob was so surprised at what I had done and so full of stubborn country pride that he didn't want my financial help. I almost screamed at him: "I've been on national TV telling everyone what I am going to do and you're not going to take the money?"

Bob, as usual, came up with a compromise - he would take money for the dam only if he was allowed to let my family camp beside the dam for the rest of our days. But even then he didn't want all the money.

So I wrote Bob a cheque for \$28,300 dollars and agreed with him to give the remainder to a nurse with breast cancer at one of the hospitals where I work.

And the dam? Well, work is underway as this Bulletin goes to press. It's expected to take a couple of weeks to create this monster dam. The family and I get to camp there forever. Bob gets a beautiful dam in an area that had been heavily eroded. And, like all people who strive towards a goal, I am reminded of some famous words:

He who is silent is forgotten;

He who abstains is taken at his word;

He who does not advance falls back;

He who stops is overwhelmed, distanced, crushed;

He who ceases to grow greater becomes smaller;

He who leaves off gives up;

The stationary condition is the beginning of the end".

(Amiel)



The area which will be flooded.



Education Report

RUSSELL W. JONES, Director of Education, ANZCA

The process for In-Training Assessment (ITA) was revised last year. Consequently a new ITA procedure has been introduced into the College in 2002. Although the new ITA procedure was sent to Regional and National Education Officers last year, for subsequent dissemination to Supervisors of Training (SOTs) and then on to Trainees, it would seem appropriate to overview the new procedure in this issue of the Bulletin.

The objectives of the ITA process are to:

- assess and assist with the Trainee's progress towards appropriate goals,
- provide regular feedback to Trainees, and
- develop any remedial activities for the Trainee that may be required.

Key aspects of the new procedure include the:

- move to a purely formative process,
- incorporation of a requirement that each Trainee maintain a "Training Portfolio" summarising their training history,
- emphasis that Trainees are to participate in a joint activity with their SOT to establish appropriate educational and training goals, and
- use of Trainee self evaluation as a component of their assessment (this helps focus the Trainee on their own performance, makes it clear to Trainees that they are largely responsible for their own performance. It also allows a comparison of their perceived performance with their actual performance thus enabling an evaluation of their degree of insight).

The ITA Procedure

All Trainees must maintain a training portfolio throughout their training. This should include:

- original signed copies of all ITA-2 forms,
- all self evaluation of performance forms,
- voluntary documentation such as log books, and
- originals or copies of formal documents related to training.

Formal meetings must occur between the SOT and each Trainee at the beginning (the initial interview) and the end (the final interview) of each six month period (or sooner if the attachment is less than six months). There should also be regular meetings between the SOT, Head of Department and the Trainees as a group. Any Trainee experiencing difficulty must be encouraged to bring this difficulty to the attention of the SOT as early as possible.

At the initial interview it is the responsibility of a Trainee to show their SOT their training portfolio including copies of all their Final ITAs from all their previous rotations. If forms are missing then the Trainee can obtain copies from either the College or the appropriate previous SOT. At this time the Trainee is also to complete an ITA-1 form for themselves based on their own perception of their performance. The Trainee is to give a copy of this self evaluation to their SOT at the same time as their training portfolio. The training portfolio and completed Trainee self evaluation are to be used by the SOT and the Trainee to set appropriate educational and clinical goals for the training term. These documents are to form the basis of a discussion which should take place at the beginning of each term. When the term is in a new hospital or department, the discussion should be part of the

orientation process. The SOT is encouraged to contact other SOTs to seek additional information to assist with their decisions as to the best educational and clinical experiences for a Trainee.

After six months (or upon completion of the rotation for those rotations of less than six months) the SOT should complete an ITA-2 form using information from:

- an assessment by the three senior staff best placed to provide that assessment, who each complete an ITA-1 form, or
- an assessment by a consensus meeting of the senior staff of the Department in writing using an ITA-1 form.

Selection of the staff to complete the form should be based upon the quantity and quality of their interaction with the Trainee, and their ability to complete documentation in a

timely manner. At the same time the Trainee should complete an ITA-1 form as self evaluation. These two forms, ITA-2 and ITA-1 (self evaluation) should form the basis of the final interview. At the completion of the interview, the Trainee should be asked to add any comments they wish to the ITA-2 form.

The ITA-2 forms are to be retained as part of the Trainee record. Copies of these forms are to be submitted to the Regional or National Education Officer by the SOT. The Education Officer is to review these forms before forwarding them to the College. A copy is to be retained by the SOT. The Trainee is to place the original within their training portfolio.

College Professional Document TE14 (2001) Policy for the In-Training Assessment of Trainees in Anaesthesia formally specifies the new ITA procedure.

The Trade Practices Act And The College

ROD WESTHORPE

The Trade Practices Act has its roots in general economic theory regarding free trade and fair competition. It is similar to legislation regarding these matters in many other countries.

The fundamental principle of the Act is that it is to the general benefit of the economy if there is:

- Free and fair competition between competitors in any market, and
- Consumers can choose from a wide range of products and services with the benefit of truthful disclosures about the attributes of the goods and services available.

Not all of the Act is applicable to the College or its activities. Nevertheless, it is important for office-bearers, employees and any College fellows acting on behalf of the College to understand their obligations under the Act, and the implications of breaches of the Act.

The ultimate responsibility for compliance with the Act rests with the President, the Chief Executive Officer and the Board of Directors (Council). Any questions related to compliance with the Act should be directed to the CEO in the first instance.

The Act does permit the Australian Competition Consumer Council (ACCC) to authorise conduct which might otherwise be considered anti-competitive, if it can be shown that there will be a genuine benefit to consumers.

The Trade Practices Act and the College

The Trade Practices Act is complex and comprehensive. Much of it is unlikely to have any relevance to the College. When the Trade Practices Act came into being in 1974, it applied only to corporations. The Competition Policy Reform Act 1995, together with complementary State and Territory legislation extended the restrictive trade provisions of The Act to "all persons engaged in business".

The two sections of the Act of relevance to the College relate to Restrictive Trade Practices and Misleading Conduct.

Restrictive Trade Practices

In comparatively small economies, such as the Australian economy, there can be a trend towards either monopoly of the market or control of the market by a very small number of companies or organisations. It is then possible for the monopoly or the small number of companies or organisations to control the market, so that goods and services are priced to ensure that excessive profits are made, and/or that it is impossible for new players to enter the market.

The Act regulates this conduct by prohibiting competitors from entering into agreements which fix prices or otherwise prevent competition.

Restrictive Trade Practices include:

- Arrangements affecting competition
- Misuse of market power
- Exclusive Dealing and Third Line Forcing

Arrangements affecting competition

[Note: An "arrangement" may be written or oral, or may be inferred from the conduct of parties.]

1. The Act prohibits any arrangement which has the purpose of, or would be likely to have the effect of, substantially lessening competition. Some areas of interest to the College, under this part of the Act, are described in more detail below, under the heading "The Trade Practices Act and medical organisations such as the College"
2. The Act prohibits any arrangement between competitors which contains an "exclusionary provision", i.e. any provision which restricts the supply or acquisition of goods or services by or from any competitor to particular persons or classes of persons. Such an arrangement is prohibited per se, i.e. the effect on competition is irrelevant.
3. The Act prohibits arrangements which have the effect of fixing, controlling or maintaining prices. (unlikely to be relevant to College activities)
4. Secondary boycotts are prohibited if they substantially lessen competition. Such a boycott involves an action by two or more persons which hinders or prevents a third person from supplying or acquiring goods or services to or from a business, where the target business is not the employer of those imposing the boycott.

Misuse of Market Power

The Act prohibits any person or organisation who has a substantial degree of power in a market from taking advantage of that power or substantially lessening competition in a market for any of the following purposes:

1. Eliminating or substantially damaging a competitor.
2. Preventing the entry of a person into a market
3. Deterring or preventing a person from engaging in competitive conduct in a market.

Note that in order to have "market power", the person or organisation must be able to affect the market by their conduct alone. It is not an offence to have market power, only to misuse that power by taking advantage of it.

Exclusive Dealing & Third Line Forcing

The Act prohibits anti-competitive activity through the imposition of restrictions by a supplier of goods or services, upon a purchaser of those goods or services.

Goods or services must not be supplied on condition that the purchaser:

1. will not acquire, or will limit the acquisition of goods or services from a competitor to the supplier, or
2. will not resupply, or will resupply to a limited extent, goods or services to a particular person, class of person or particular place.

Third Line Forcing involves the supply of goods or services on condition that the purchaser acquires goods or services from a particular third party.

The Trade Practices Act and medical organisations such as the College

Organisations may place various restrictions on members, in an attempt to stop unethical or unprofessional behaviour. These restrictions may be accompanied by disciplinary powers. These restrictions may, by their nature, be anti-competitive.

Restrictions on advertising by members of an organisation may be deemed to be anti-competitive. However, practitioners must ensure that claims or representations (eg. professional qualifications, services, experience, fees, and expenses) are truthful and not misleading.

Professionals must not be restricted for anti-competitive reasons from establishing medical practices with whomever they choose, if they do so, would breach the Act.

The enforcement of proper standards, ethics and credentialing are not affected.

No restrictions may be placed on the right of a medical practitioner to undertake business activities in addition to the provision of their professional medical services (unless ethical, standards or safety issues are involved).

No restriction may be placed on practitioners, which is likely to prevent them from gaining a public profile or sharing knowledge with others.

An organisation may not restrict membership, where the purpose of that restriction is to substantially lessen competition. In particular, changes to qualifications, experience or examination requirements, which affect the number of practitioners in the market place, may be regarded as anti-competitive.

Disciplinary action, which restricts a member's right to participate in a professional market, will be a breach of the TPA if its purpose is to prevent that member from engaging in competitive conduct.

The Australian Competition and Consumer Commission (ACCC)

The ACCC was established in November 1995, by the merger of the Trade Practices Commission, and the Prices Surveillance Authority.

The ACCC is a law enforcement body and has no law-making role.

Penalties, which can be applied for a first breach of the Trade Practices Act in respect of competition, are substantial: i.e. up to \$10 million for companies and \$500,000 for individuals.

Admission to Fellowship

BY EXAMINATION

Aynsley	Christine	NSW	Kenway	Lisa Suzanne	NSW
Bernard	Catherine Gladman	NSW	Lane	Peter Kennedy	QLD
Bremner	Michael John	TAS	Lang	Coran Douglas	VIC
Browne	Sally Maree	NSW	Lardner	David Raoul Rivlin	VIC
Brownridge	Timothy Peter	SA	Liew	Andy Chean Shin	NSW
Buntain	Scott Graeme	QLD	Lindsay	Sarah Margaret	QLD
Caporn	Mark Julian	QLD	Lo	Thomas	ACT
Carll	Andrew Melville	NZ	Lovelock	Neil David William	NSW
Clarke	David Kenneth	VIC	Mann	Angus	QLD
Daley	Mark Richard	NSW	Morgan	Jennifer Mary	WA
Doran	Peter Seamus	SA	Morrissey	Phillip James	ACT
Fabian	Robert Mario	NSW	Moses	Danielle Dorothy Eileen	QLD
Fien	Paul Murray	NSW	Needham	Andrew Paul	NSW
Fisher	Anthony Dean	SA	Ng Ju Mei		USA
Frengley	Robert Wilson	NZ	Nowitz	Andrea	USA
Goetz	Sarah Carroll	WA	Oh	Chiu Beng	VIC
Goldrick	Paul Brian	QLD	Pedersen	Karen	NZ
Goodey	Alan John	NZ	Perry	Margaret Joan	NSW
Hackland	Anthony James	QLD	Phillips	Craig Anthony	QLD
Hampton	Timothy Scott	SA	Poh	John Han-Chong	QLD
Harrison	Stuart Matthew	NSW	Provan	David John	QLD
Hensen	Saskia	NT	Soh	Chai Rick	VIC
Hodges	Penelope Jane	NSW	Sun	Deidre Ann	NSW
Holmes	Christopher Daegal	NSW	Tavakol	Steve Shahdad	QLD
Hooton	Andrew William	NSW	Taylor	Elsa Medland	NZ
Hosny	Mohamed Mourad Mahmoud	NSW	Thomas	Christopher James	QLD
Hu	Julian Moug Kwong	NSW	Wilton	Penny	UK
Johnstone	Charlotte Sarah Hope	NSW	Wolfers	Darren Lindsay	NSW
Jordan	Kirsty Rachel Maule	NZ	Wong	Chui-Wah, Wendy	HK
Kaldor	Jennifer Michelle	NSW	Wood	Carolyn Margaret	SA

HELP MODULE 36 REPORT

Geriatric Anaesthesia

The Geriatric Anaesthesia module proved a surprisingly difficult one for us to present. There seems to be relatively little authoritative reference material and little active research being conducted in the very old. Perhaps this also explains why there were fewer than usual responses to our request for the supply of questions. For those who are interested, the challenge of measurement in the elderly and the lack of good data must make this one of the most fruitful areas to place one's research endeavours.

We apologise for questions 17b, 19b and 20c which were withdrawn from marking due to errors in presentation. Question 17b should read "Specialist cardiologists reject 1/2 to 3/4 of heart failure diagnoses made by nonspecialists". 19b should read "In contrast to asthma dyspnoea in COPD is improved more by anticholinergics than β_2 agonists". The answer to 20c is "FALSE" as noted by a number of respondents.

During preparation of the module we encountered several topics worthy of your attention.

- The appropriateness of drug therapy patients are receiving.

- The level of patient compliance with prescribed therapy.
- The high incidence of untoward drug reactions in the elderly.
- The high incidence of inappropriate heart failure diagnoses in the elderly.
- The reviews of COPD and Asthma in the elderly.

TURP syndrome seems "old hat" to many anaesthetists. However many of those who answered this question failed to recognise hyponatraemia may be isotonic as well as hypotonic. The topic is well reviewed by Gravenstein.

Trauma, even minor trauma, in the elderly is more serious than in younger people. This is well recognised for #NOF. However it is sobering to realise that minor (1-2) rib fractures due to blunt trauma can be associated with a high incidence of pneumonia and death.

There were 1850 mailouts and 358 returns (Australia 224, NZ 126, SE Asia 4, Overseas 4). The mean score was $73 \pm 12\%$ in a sample of 75 returns. The range was 52% - 95%.

TREVOR DOBBINSON
Medical Director CECANZ

Special Interest Groups Annual Reports 2001

Acute Pain

Executive:

- Dr Mary Cardosa (Malaysia)
- Dr Arthur Doughty (Tas)
- Professor Colin Goodchild (Vic)
- Dr Richard Halliwell (NSW)
- Dr Pam Macintyre (SA)
- Dr James Sartain (QLD)
- Professor Stephan Schug (WA)
- Dr Grant Turner (WA - Chairman)

Change in Executive Membership

Dr Paul Christie resigned as Chairman of the Acute Pain SIG following the AGM in November 2000. His efforts as Chairman were greatly appreciated.

The SIG Executive elected Dr Grant Turner as Chairman in December 2000.

Professor Stephan Schug has moved from New Zealand to Perth but has kindly agreed to remain on the SIG Executive. A replacement Executive member from New Zealand will be sought.

Continuing Education Activities:

Canberra November 2000

A two-day CME meeting was held in Canberra in November 2000. This was well attended and was greatly enjoyed both socially and professionally by all delegates. Dr Christie is to be congratulated on convening such a successful meeting.

ANZCA ASM Hong Kong 2001

An Acute Pain Session was held as part of the Combined ASM in Hong Kong in May 2001. In line with the entire conference this session was well planned, executed and well attended.

ANZCA ASM Brisbane 2002

The Acute Pain SIG will again be presenting a session at the Brisbane ASM. The theme for this presentation will be "Acute Pain Management in the Real World".

GRANT TURNER
Chairman

Medical Education

Executive:

- Dr Malcolm Anderson (Tas)
- Professor Cindy Aun (Hong Kong)
- Professor Geoff Cutfield (NSW)
- Dr Kerry Delaney (ACT)
- Dr Patrica Goonetilleke (QLD)
- Dr Barry McCann (QLD - Chairman)
- Dr Simon MacLaurin (WA)
- Dr Kym Osborn (SA)
- Dr Rod Tayler (VIC)
- Dr Jennifer Weller (New Zealand)

Combined Scientific Meeting Hong Kong:

The Medical Education SIG made a contribution to the combined ASM in Hong Kong in May. In keeping with the theme "Anaesthesia, Intensive Care and Pain Medicine Delivery - The Next Generation" a session was conducted on electronic media and anaesthesia to bring delegates up to date in the computer assisted age. Dr David Scott presented an overview of the latest in communication technology, Dr Mike Martyn introduced anaesthesia education using the internet, Dr Joe Novella gave 12 steps

to setting up a department website, Dr Mal Tyers explained WAP technology and Professor Steve Bolsin presented the use of the palm pilot in maintaining quality and safety in anaesthesia. Details of these presentations are to be found in the handbook of the conference and on line at the College website.

Couran Cove:

A major initiative of the SIG, the planning of which began in 2000, has been to establish a teaching course for those involved with training registrars. A course entitled "Effective Teaching Techniques in Anaesthesia" was organized by the SIG. This three-day teaching conference was held at Couran Cove Resort on South Stradbroke Island in June. The initiative was prompted by the need to develop teaching skills in our anaesthetic educators along the lines of those accepted in adult learning environments in the medical teaching arena. Adult education has evolved at a rapid pace in the last twenty years and now embraces techniques such as problem based learning, workshops, snowballing and many others. All these techniques focus on the learner rather than the trainer. While the traditional model is one of didactic teaching, in this new paradigm, the trainer acts as a facilitator responding to the needs of

the learner. Hence this course was seen as an inaugural meeting, the first of many.

Forty participants including facilitators attended the meeting. All states, New Zealand and Hong Kong were represented. The facilitators included the newly appointed Director of Education, Dr Russell Jones, and the Assistant Director of Education, Dr Mary Done as well as people with expertise in special areas. Two external facilitators included Professor Neil Paget the former Director of Education with the Royal Australasian College of Physicians and Dr Lynn Robinson from Med-E-Serv.

The course was launched by a lively debate conducted by Dr Michael Bujor entitled: "Has the traditional lecture had its day?" Following this a session on adult learning with Professor Neil Paget, Dr Ed Loughman, Dr Michele Joseph and Dr Rod Tayler explored the essentials of what the good teacher does. Sessions were then run on selected areas of special interest to anaesthetists including: PBL (Professor Geoff Cutfield), simulators (Dr Leonie Watterson and Dr Brendan Flanagan), small group tutorials (Dr Kersi Taraporewalla), maximizing learning in the OT (Dr Mary Done), principles of measurement (Professor Neil Paget), designing the perfect ITA (Dr Russell Jones), and facilitating learning using IT (Dr Lynn Robinson).

The Couran Cove Resort provided an ideal retreat for such a meeting with excellent facilities for a small group such as this.

I wish to thank our College and AstraZeneca who jointly funded a package, which included meals and accommodation for the participants. In addition, Mr Colin Albert from AstraZeneca personally helped break the ice by providing welcoming drinks. Special thanks should also be given to Ms Helen Morris for her administrative

services.

A major aim of the meeting was to provide the participants with the skills necessary to conduct similar educational training in their own regions with the help of the College educators. Already most states have begun preparations for follow up meetings. Resource material for facilitators is continually being accumulated. If you wish to have access to this please contact Dr Russell Jones.

Some of you may wish to become involved in the ongoing programme. If so please contact either Russell Jones or the following persons in the respective states:

Dr Ed Loughman (NSW)
Dr Jenny Weller (NZ)
Dr Kersi Taraporewalla (QLD)
Dr Rod Tayler (Victoria)
Dr Glenys Miller (SA)
Dr Nedra Vanden Driesen or Dr Lindy Roberts (WA)
Dr Peter Lane (Tas)
Dr Simon Chan, Dr Chow Yu Fat, or Dr Jacqueline Yap (HK)

Canberra:

Dr Rod Tayler with the help of the College Education Unit held a session at the ASA NSC in October 2001. The main topics included: An Introduction to Adult Education (Dr Rod Tayler), How To Run A Workshop (Dr Mary Done) and The Use of Simulators in Teaching (Dr Leonie Watterson).

Web Site:

I am currently investigating the possibility to have a web site for the SIG. If you wish to help or have useful information please contact me.

BARRIE McCANN
Chairman

Cardiothoracic, Vascular and Perfusion

Executive:

The current membership of the CVP SIG Executive is :-

- Dr Malcolm Anderson (TAS)
- Dr Chris Cokis (WA)
- A/Prof Peter Klineberg (NSW Chairman)
- Dr Lisa McEwin (SA)
- Dr Andrew McKee (NZ)
- Dr John Murray (QLD)
- A/Prof Paul Myles (VIC)

Since our last report several long-standing members have left the Executive and I wish to acknowledge the input to this group of Drs David Scott (Victoria), Ken Williams (Western Australia) and Leona Wilson (New Zealand). David and Ken were founding members of the Executive and have given provided input to this group over the years.

It is important that State members of the Special Interest Group use their Executive representatives as spokespersons. We have several teleconferences throughout the year and the direction and activities of the Special Interest Group are managed by the Executive, hopefully in consultation with the State membership with whom they are communicating.

Introduction

The role of the Special Interest Group continues to evolve and represents a broad based forum for those with specific interests within our specialty. This role extends way beyond conducting educational meetings and endeavours to provide an environment for exchange of ideas amongst a peer group. This will allow us to evaluate our practices in the light of peer review and lead to changes and improved patient management.

The CVP Special Interest Group has a broad spectrum of interests but we tend to deal with a sicker group of patients having major procedures. Our area also includes

specific technologies, such as TOE and perfusion, in which there is a broad difference of practice across Australia and New Zealand. This often leads to vigorous discussion at our meetings and this highlights the opportunity which the Special Interest Group offers for discourse. We also maintain a Special Interest Group Website which is located under the CE&QA section of the College Website (www.anzca.edu.au).

Meetings During 2001

Hong Kong ASM

We hosted two sessions at the Hong Kong ASM, with one session dedicated to Aspects of Vascular Anaesthesia and the other to Off Bypass Coronary Surgery. The sessions were well attended and the feedback was positive. A Business Meeting was held at the Hong Kong Convention Centre during the meeting and this was attended by approximately 25 members of the Special Interest Group.

Biennial CVP-SIG Meeting – Uluru, July 2001

Our biennial Special Interest Group Meeting was conducted at Ayers Rock and was attended by 137 participants. The broad topics covered in this meeting included The Management of Thoracic Trauma, Coagulation Disorders and Aspects of Monitoring During Major Surgery. We invited an overseas speaker, Dr Jonathon Mark from Duke University Medical School. Jonathon's special interest is in intraoperative TOE and he is an international authority on this topic. The meeting was well received and both the venue and the content appeared to have been very successful. I particularly wish to thank all of our local presenters who participated in this meeting. The high standard of scientific presentation was acknowledged by all participants and the effort and energy required in preparation and delivery of presentations must be applauded.

The Annual General Meeting of the Special Interest Group was conducted at the Uluru Meeting Place on the 8th July, 2001 and this was attended by 65 members of the group. The main agenda item was a foreshadowed motion on the introduction of certification for TOE. A vigorous discussion by opponents and proponents of this foreshadowed motion ensued prior to the vote being taken. The motion, which proposed that the College not introduce certification, was carried, with 72 in favour and 66 votes against the motion. This vote included 84 proxies.

Throughout the discussion on this issue there was strong support for an educational base to be established in TOE by the College. At the conclusion of the discussion, the Chairman stated that he believed a mandate had been given by the membership to develop training recommendations in TOE and that he and the Executive would work with the College Council to develop these.

ASM in Brisbane, May, 2002

The Special Interest Group will conduct three sessions at the ASM. One will be on aspects of monitoring and there will be basic and advanced TOE workshops.

TOE Recommendations for Training

Following discussions at the Uluru meeting, the Chairman and the Executive worked to produce a document outlining recommendations for training in diagnostic TOE. This document is based upon recommendations already accepted in the USA and Europe and should act to give the specialty of Anaesthesia formal standing in the area of transoesophageal echocardiography. Many of our members have now passed the American NBE exam and the practice of intraoperative transoesophageal echocardiography during cardiac surgery is fast becoming a required standard of practice. This is probably the greatest change in cardiac anaesthesia in many years.

Medical Perfusion

This is an area where there is a broad difference of practice across Australia and New Zealand. We are continuing to work on consolidating our policy documents and updating these. The management of total body perfusion continues to be an area of major medical management during cardiac surgery, encompassing not only the heart-lung machine itself and the extracorporeal circuit, but also the management of the anaesthetised patients and of coagulation status. We shall continue to emphasise this area in our educational activities.

SIG Executive Elections

During 2002 there will be an election for the Executive of the Special Interest Group, and a call for nominations should occur soon. We are planning to hold the AGM at the May ASM in Brisbane. I shall be standing down from the Executive of the CVP SIG, having been a member since its establishment in 1990. It has been a great privilege to serve on this Committee and to participate in both education and policy making. This is a body that has major interests in education and standards of practice and is representative of the College, the ASA and the NZSA.

Finally, I wish to thank Ms Helen Morris for her continued input and contribution to this Special Interest Group. Helen is pivotal to all of our organization and communications and the Uluru Meeting could not have happened without her expert and enthusiastic input. Helen's contribution is greatly appreciated, as is her cheerful and cooperative approach to our business.

PETER L KLINEBERG
Chairman

Obituaries



Dr Liliás Joan Dunn **Queensland - FFARACS 1956, FANZCA 1992**

Dr Joan Dunn (Mrs Noel Webster) died suddenly in Brisbane on Wednesday, 30th January 2002. After her marriage, she continued to practise as Joan Dunn because there was already another Dr Joan Webster in specialist anaesthetics practice in Brisbane.

Liliás Joan Dunn was born in Maryborough, Queensland, on 18th April 1921, the middle of three daughters.

Our family friendship spans almost 100 years. As Liliás Fairley, Joan's mother and my mother, Jane O'Rourke, were contemporaries and close friends at Maryborough Girls' Grammar School.

At the completion of her Senior year in 1938, Joan was Dux of Maryborough Girls' Grammar School. She enrolled in the Faculty of Medicine. Together with her sisters she was a resident at The Women's College and for one year Muriel, a law student, Joan and Barbara, a dental student, were all in College. Joan appreciated that all of this was done at the personal sacrifice of her parents, and her devotion to and respect for them was no better reflected than by her frequent visits to Maryborough as they aged. She hated flying in DC3s, so she would drive to the airport and determine what aircraft was on the tarmac. If it was a DC3 and not a Fokker Friendship, she would continue the 4-5 hour drive to Maryborough, knowing that she would have to face the return drive too.

Joan graduated in Medicine in May 1944, completing the course shortened by World War II. After serving as a resident and senior resident at the then Brisbane Hospital and in Cairns, she returned to Brisbane as an anaesthetics registrar, working with Ray Robinson and later with Ruth Molphy. It can be said without fear of contradiction that Joan, Ray and Ruth established anaesthetics as a specialty in Queensland.

Verna Madden (1938-1941) and Agnes Coates-Earle (1941-45) had worked as Senior Residents in anaesthetics replacing male colleagues who were on active service, but Joan, Ray and Ruth obtained postgraduate training and two-part qualifications, either in the UK or in Sydney.

She did the postgraduate course in Oxford and in 1951 obtained the two-part Diploma in Anaesthetics, the first Queensland graduate to obtain a higher degree in anaesthetics. With the establishment of the Faculty of Anaesthetists, Royal College of Surgeons, she was admitted to its Fellowship on the basis of the two-part qualification. With the inauguration of the Faculty of Anaesthetists Royal Australasian College of Surgeons, Joan was admitted to its Fellowship in January 1956. Subsequently she was admitted to Fellowship of the Royal College of Anaesthetists in 1991 and the Fellowship of the Australian and New Zealand College of Anaesthetists in 1992.

She contributed greatly to the progress of the specialty, not only by her high standard of patient care, but she also accepted willingly membership of the Regional Committee of the Faculty and the State Section of the Australian Society of Anaesthetists - and she encouraged her juniors to do likewise. While in anaesthetics practice she attended the ASA and Faculty Meetings regularly. She delighted in entertaining overseas and interstate visitors at her home at "Craigston".

In 1951 Joan was appointed as the first Director of Anaesthetics (the position was then called Supervisor) at the Brisbane Hospital, a position she held with distinction until 1954. Those of us who came into anaesthetics when it was an established specialty, appreciate only too well what difficulties had to be surmounted. Gentle and dexterous, she ensured that all her registrars were familiar with the scope and usefulness of regional analgesia - and proficient in the techniques - information and experience that was to be invaluable in postgraduate examinations in the United Kingdom.

A highly esteemed clinician with this great technical dexterity, she was also an outstanding administrator who commanded by leadership and respect. Always punctual, she was in theatre and changed by 8.00am, so we were there by 7.45am for the 8.30am lists. She ensured that all the junior staff had morning and afternoon tea and lunch, and that the evening staff had dinner before anyone went home. Needless to say, her junior staff undertook willingly extra work to help such a thoughtful Director. These were the days when the Royal Brisbane had 1200 beds, waiting lists were unheard of, no patients were turned away and most theatre lists went on till 10pm.

Joan never raised her voice - she stated her case firmly and concisely. I well remember a surgeon, telling her that she should roster two registrars for Saturday morning. He had had to wait for a semi-elective procedure while I went to The Women's for a Caesarean Section. Joan said quietly and sweetly that she agreed that there should be two registrars, so would the surgeon accompany her to the Superintendent's office and support her request for more staff. He went with her and she was given the extra staff.

In 1954 Joan made the decision to enter private practice, joining the partnership already established by Mrs McLelland and Ray Robinson. Judy Foote, Lorna Webber, Hilary Fisher (m O'Donnell), Vera Lukursky and I were later to join that partnership. We were all young and slim in those days, and the group became known euphemistically interstate as "The Brisbane Girls". Mrs McLelland quipped that she didn't mind if we were "the girls" provided she wasn't considered "the madam"! It is interesting that Mrs McLelland was never referred to as Dr McLelland - this was kept for her husband, Dr Hugh McLelland, a highly respected gynaecologist!

Joan continued to serve the Royal Brisbane Hospital as a Visiting Specialist Medical Officer and also gave yeoman service at Greenslopes Repatriation Hospital, acting as a role model for the next group of aspirant women anaesthetists. Lest anyone think there was gender bias, Joan had at all times the unobtrusive loyal support of her male anaesthetics colleagues - especially Roger Bennett, Drury Clarke, Gavan Carroll and Dan Hogg in the early days, and later Walter Biggs, John Hains and David McConnel continued the supportive role.

Joan's move from anaesthetics to medical administration at Greenslopes and later in the Repatriation Branch Office followed her marriage to Noel on 18th September 1969.

Joan was an avid reader and it was one of my great pleasures to discuss with her the books we had read or the reviews we should follow up. She hadn't quite convinced me to read Harry Potter, which she was reading, though my grandchildren were exerting the pressure too!

A superb hostess, Joan loved to entertain and, with Noel, extended the hospitality of their home to colleagues and friends. They spent 3 months of each year at Hervey Bay entertaining friends in the spirit of generosity that shaped their lives. Joan's eightieth birthday party was marred only by Noel's absence - he had passed away just 3 months before.

Joan's interest in the welfare of others prompted her to join the Zonta Club of Brisbane North. As a Charter Member, her loyalty and ongoing support for the ideals of that service club were inspirational, just as her regular contributions to the Medical Benevolent Association of Queensland helped her colleagues in times of need.

Joan joined the British Medical Association (now the AMA) on graduation and was an honoured guest at the Special Council Dinner, when she achieved 50 years' membership in November 1993. Typical of Joan, there is in her AMA file a gracious letter of thanks to the President.

Above all, Joan was devoted to her family - to Noel, to his children whom she loved as her own, and who reciprocated her affection to the full. She was a devoted grandmother and great grandmother, showing a particular interest in the education of the grandchildren. Her affection for her sisters was also reflected in her interest in their children.

Joan enriched the lives of so many of us and we are so much the better for knowing her.

Joan was my mentor, teacher, colleague, partner and very dear friend. It is for me a treasured privilege to pay tribute to her and to offer formally sincere sympathy to all her family - her stepchildren, David, Christine and Peter, her sisters, Muriel and Barbara, and the members of the extended Webster and Dunn families.

Tess Cramond



Dr Anna Karolina Havlin
Victoria - FFARACS 1986, FANZCA 1992

Anna died on Sunday night, the 3rd of February, 2002, at the Epworth Hospital. It was totally unexpected. She suffered a complete occlusion of her main coronary artery resulting in a massive heart attack.

Everything possible was done for her at the Epworth, but in the end there was little that could be done. The event itself doomed her from the start. She had been perfectly health before this catastrophic episode occurred. We are still shocked by it all. We miss her greatly.

Anna and I have loved each other since medical school - she was a beautiful young woman - intelligent, strong willed, always in good humour and throughout, retaining a strong sense of morals.

She became an anaesthetist, giving up her career to devote herself to her family - James, Helen, Kathryn and myself - never regretted!

She gave her all to us - and all our memories are of good time - full of love, support, caring, happiness and fun.

Our family, through Anna, has been enriched and engendered with the unity, devotion, moral strength and love that was her persona. Although we say goodbye to our mother and wife, the legacy of her qualities lives on.

We love her so much.

Chris Pappas

Admission to Fellowship by Election

Dr Thomas Bruessel (ACT) was invited to accept Fellowship by Election under Regulation 6.3.1 (a)

The following were invited to accept Fellowship by Election under Regulation 6.3.1 (b)

Dr Colin Peter Marsland (NZ)
Dr Alan Grayson Phelps Bullingham (NSW)
Dr John McGowan Campbell (VIC)
Dr Robert Terrence Clarke (NSW)
Dr Julian Corbett Fuller (NZ)
Dr Christopher Joseph Horrocks (NZ)
Dr Barry Seymour Koonin (NSW)
Dr Alan John McLintic (NZ)
Dr Mark Alastair Moores (NZ)
Dr Andrew James Munro (NZ)
Dr Elizabeth Jenny Tham (SA)
Dr Peter Vernon van Heerden (WA)
Dr Robert Graham van Renen (SA)
Dr Ruth Alison Bourne (VIC)

The following were invited to accept Fellowship by Election under Regulation 6.3.1 (c)

Dr John McGowan Campbell (VIC)
Dr Robert Terrence Clarke (NSW)

Overseas Trained Specialists Performance Assessment

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

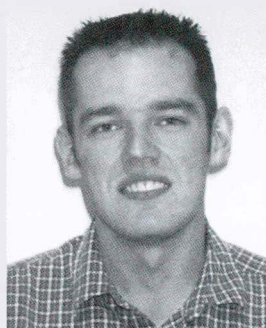
Simon Conor Deehan	WA
Fariborz Moradi	VIC

Clinical Practice Guidelines

The preceding documents were approved by the NHMRC and the Australasian Society for Blood Transfusion (ASBT) in October 2001 and have been reproduced with the permission of the NHMRC and the ASBT:

- Clinical Practice Guidelines: Appropriate Use of Platelets (NHMRC & ASBT, October 2001)
- Clinical Practice Guidelines: Appropriate Use of Fresh Frozen Plasma and Cryoprecipitate (NHMRC & ASBT, October 2001)
- Clinical Practice Guidelines: Appropriate Use of Red Blood Cells (NHMRC & ASBT, October 2001)

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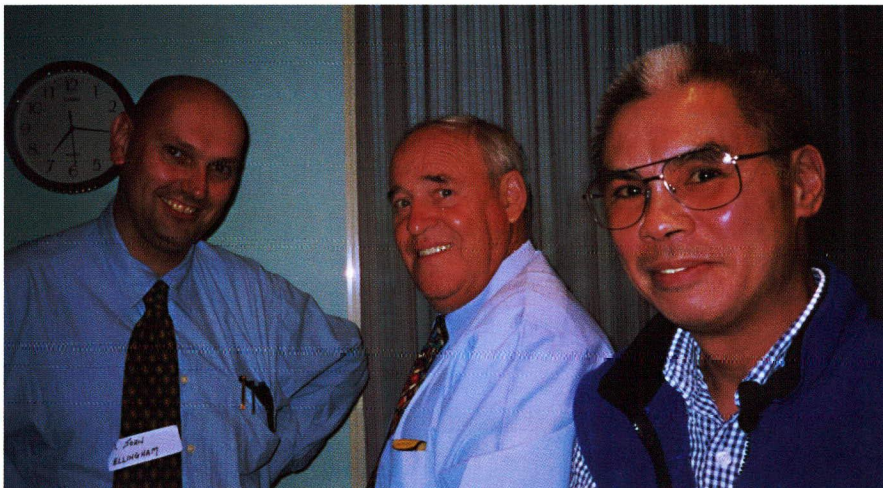
UNDERGRADUATE PRIZE IN ANAESTHESIA

The recipient of the 2001 ANZCA Prize for The Flinders University of South Australia was Dr Ivan Ward. Dr Ward was presented with his Prize at the University's Graduation Ceremony held in December 2001.

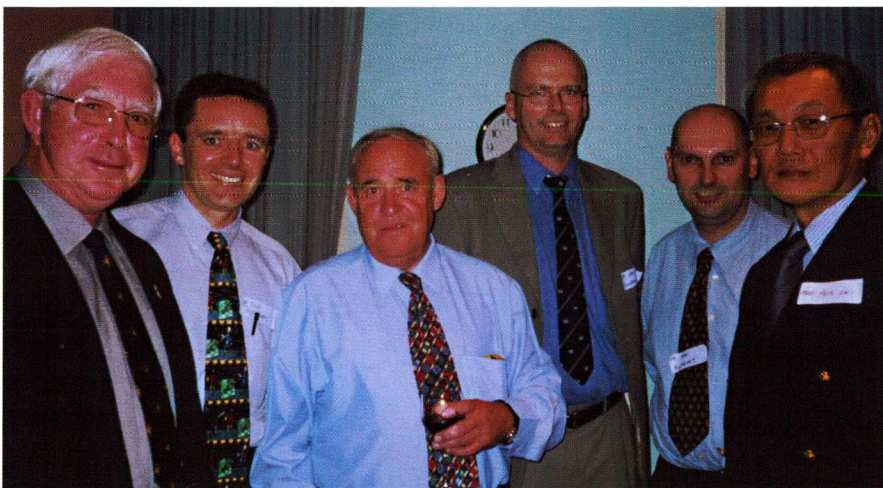
Fellows with the President during a recent visit to the Australian Capital Territory



Prof Tiek Oh Dr Michelle Mulligan Prof Thomas Brussel Dr Ray Cook



Dr John Ellingham Dr Ken Downes Dr Bernard Kwan



Dr Kerry Delaney Dr Guy Buchanan Dr Ken Downes David Kinchington Dr John Ellingham Teik Oh

Queensland 5th Annual Registrars' Meeting

The Queensland 5th Annual Registrars' meeting was held at College House, Brisbane on Saturday 10 November 2001 where Dr Jennifer Morgan was presented with the "Tess Cramond Award".



Professor Emeritus Tess Cramond presenting the "Tess Cramond Award" to Dr Jennifer Morgan



Other presenters of the day:
 Back left to right Drs Dale Gardiner, Angus Mann, Mark Caporn, Neil McKinley
 Front row left to right Jennifer Morgan, Professor Tess Cramond and Dr Christopher Bryant.

Anaesthetic Registrars Welcoming Night / Orientation - WA

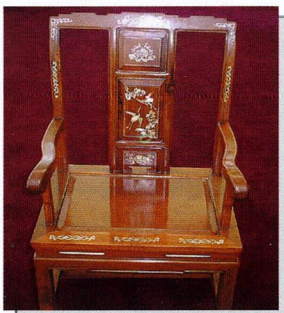


Drs McKenzie, McArthur, Knoeson and Tziaverangos began studying together in July 2001 and have now formed a study group for the Part 1 Examination.

Left to right: Drs Suzanne McKenzie, Julie McArthur, Rowena Knoeson, Professor Teik Oh (President) and Dr Evan Tziaverangos



Anaesthetic Registrars Welcoming/Orientation night held on 24 January 2002 in Subiaco, Western Australia



Gift of 2 carvers and 8 chairs from Dr Ray and Mrs Diane Cook.

These red wood chairs have been constructed in a jigsaw fashion with a mother of pearl back inlay and either ivory or bone side inlays used.



Dean's Message

Felicity Hawker

As this edition of the Bulletin goes to print, the last applications for Foundation Fellowship of the Joint Faculty of Intensive Care Medicine are being assessed by the Admissions Committee. It is likely that the new Faculty will have approximately 420 Foundation Fellows with some 86% of applications being successful. The make up of the Foundation Fellowship is likely to be approximately 67% FFICANZCA, 30% FRACP and < 3% FANZCA. The final figures will be known after the February Board Meeting, after the Foundation Fellows have been admitted.

As discussed previously in this column, the criteria for Foundation Fellowship are based on training and specialist experience in intensive care units accredited for core training by FICANZCA or FRACP. I believe there remain a number of individuals who have made a notable contribution to the science and practice of intensive care medicine but who do not meet these criteria, usually because they practised before intensive care training was widely available. Robust criteria for election to Fellowship have been developed and hopefully will be finalised at the coming Board Meeting. Consequently a small number of elected Fellows may increase the numbers further in the coming year, along with the many trainees who will meet the training and examination requirements for granting of Fellowship.

However, it is the Foundation Fellows who have the opportunity to stand for election to the new Board and to vote in the election. It is proposed that a "call for nominations" for the election of Board Members will be circulated in the coming month. I sincerely hope that Fellows with a FRACP background will be nominated as well as those with a FICANZCA background, although before long, of course, the distinction will be irrelevant.

Nevertheless, at this time of great change I believe it is crucially important for the stability of the Joint Faculty and the several hundred trainees currently registered, for the majority of the current Board members to be re-elected. I ask you to consider this when you vote.

Whoever the new Board Members are, there will be many challenges ahead for them. There are a number of policies and programs being developed by the Interim Board. On the matters of education and training, a major focus has been the proposed new training program with delineation of basic and advanced training, as currently occurs with RACP training and has been proposed for ANZCA training. At the same time we are drafting guidelines for core JFICM training to be undertaken in overseas units.

Other projects are the finalisation of the policy for recognition of Overseas Trained Specialists (OTS) and the conduct of our first OTS interview this month, the preparation of the submission for the accreditation of the Faculty and College by the Australian Medical Council which will take place later in the year, working with the Rural Focus Group to develop better policies and support for intensive care in rural areas, and working with ANZICS to delineate the complementary roles of the new body and ANZICS and to foster maximum communication and cooperation between the two bodies.

In many of my Dean's Messages I have discussed different aspects of the development of the Joint Faculty and what was needed to make it happen. It is now a reality, and only one step remains - the election of the Board. Fellows have the opportunity to contribute to the Joint Faculty of Intensive Care Medicine by electing a Board that will both ensure a smooth transition from the old Faculty and guide the Joint Faculty forward in the years to come.

Items of Interest

FROM THE NOVEMBER BOARD MEETING

JOINT FACULTY OF INTENSIVE CARE MEDICINE

This was to be the last meeting of the Faculty of Intensive Care, ANZCA Board. In September, the successful negotiation of the Joint Faculty between the RACP and ANZCA was finalized, and it was agreed an Interim Board should be appointed. At the commencement of this meeting, the Dean announced all business of the existing Faculty would be referred to the Interim Board of the Joint Faculty of Intensive Care Medicine. In doing so, the Dean acknowledged the College Councils for their assistance and support in what is an historic development of a single training and certification scheme in intensive care for the first time in Australia and New Zealand.

The Board noted applications for Foundation Fellowship of the new body were circulated in September and advertised in the relevant periodicals. The closing date for applications was 31st January 2002. Such applications will be considered by the Interim Board at its meeting in February, when the Foundation Fellowship will be admitted. A call for nominations will then ensue.

In establishing the Interim Board, the current co-opted RACP observers, Drs R. Raper and J. Gillis were given voting rights as full members and a representative of the RACP Council attended the meeting as a Co-opted Member.

EDUCATION AND TRAINING

Award of G.A. (Don) Harrison Medal - 2001

Dr Anthony Delaney, NSW, has been awarded the G.A. (Don) Harrison Medal for 2001.

In-Training Assessment

The Board continues to review the in-training assessment process and will most likely adopt a similar process to that required for anaesthesia trainees.

New Intensive Care Training Program

A working party is considering the revision of the training program, which will consider a number of issues delayed until the formation of the Joint Faculty, such as the possibility of overseas core training and variation in the requirements for anaesthesia and medicine, and structured curriculum modules.

There is support for a model based on the current ANZCA Training Program review; which includes a basic and advanced program. Minimum requirements of six month clinical anaesthesia and clinical medicine are also being considered, as well as the concept of mandating that both years of core intensive care be undertaken as advanced training.

Changes to the Administration of Training/Fees

With the establishment of the Joint Faculty, the fee structure will be changed. All Trainees will pay a fee for each year of accredited intensive care training, in addition to a reduced registration fee. No discount will apply to conjoint training. A reduced administrative fee will be charged for training undertaken in anaesthesia, medicine or other elective training

Trainees, once registered, will be required to complete a prospective application for each year of accredited training. Following approval by a Training Committee, in-training assessments will be required to be completed by Supervisors of Training twice a year, and if favourable, training will be accredited for that year. Further details will be forwarded to Supervisors of Training and Trainees.

Dissolution of JSAC-IC

The Board resolved to dissolve the JSAC-IC Committee, whose primary role was to establish a single training and certification scheme in intensive care. Its other functions relating to the supervision of trainees will be passed on to a new Training Committee, which will ensure proper liaison with the Committee for Physician Training

PROFESSIONAL AFFAIRS

Policy Documents

Minimum Standards for Intensive Care Units

This document will undergo further review following input from Regional/National Committees and the Rural Focus Group. It was agreed that the title of Minimum Standards will be changed to 'Recommendations on Standards for Intensive Care Units' and may assist in resolving some of the staffing issues which prompted its review.

Recommendations on Minimum Standards for Transport of the Critically Ill

The Board reviewed this document and it will be promulgated as a joint document with ANZCA and the ACEM.

Statement on Patients Rights to Pain Management

The Board endorsed this policy statement from the College.

AMC Accreditation

The Board will prepare a submission to the AMC as part of the review of ANZCA scheduled for next year.

Intensive Care Medical Liaison Committee

The last meeting of the Committee, chaired by ANZICS, was held and it was agreed that the President of ANZICS would be invited to the Board of the Joint Faculty on an informal basis.

Privacy Legislation

The Board undertook to examine the effects of the incoming Privacy Legislations on the Joint Faculty.

RACS Trauma Committee

The Board agreed that continued representation on this Committee was advantageous.

CONTINUING EDUCATION

Maintenance of Professional Standards

The Board approved a number of minor changes to the MOPS Program in line with recent changes to the ANZCA Program.

It is anticipated that an on-line diary will shortly be available on the Faculty Website.

Faculty Foundation Visitor for 2003

The Board agreed to invite Dr Dennis Maki as its Foundation Visitor for the ASM in Hobart in 2003.

RESEARCH AWARD

The Board congratulated Dr D.J. Cooper and Dr P. Myles of the Alfred Hospital, Vic for their award of a 5 year NHMRC Practitioner Fellowship.

Admission to Fellowship

OF THE FACULTY OF INTENSIVE CARE, ANZCA

As of February 2002, the following have completed all requirements for admission to Fellowship by examination and were admitted by the Board:

Timothy Peter Brownridge	SA
Robin Leigh Holland	NSW
Deirdre Ann Murphy	VIC
Ubbo Frank Wiersema	SA
Rajeev Hegde	SA
Bruce Huxtable Graham	NSW
David John Evans	SA
Ziauddin Ansari	Vic

Joint Faculty of Intensive Care Medicine

ABN 82 055 042 852

POLICY DOCUMENTS

- IC-1 (1997) Minimum Standards for Intensive Care Units *Bulletin Aug 94, pg 44*
- IC-2 (2000) The Duties of an Intensive Care Specialist in Hospitals with Approved Training Posts *Bulletin Nov 00, pg 53*
- IC-3 (2000) Guidelines for Intensive Care Units seeking Faculty Accreditation for Training in Intensive Care
Bulletin Nov 98, pg 70
- IC-4 (2000) The Supervision of Vocational Trainees in Intensive Care *Bulletin Mar 2000, pg 57*
- IC-5 (1995) Duties of Regional Education Officers in Intensive Care *Bulletin Nov 95, pg 50*
- IC-6 (2001) Supervisors of Training in Intensive Care *Bulletin Nov 95, pg 46*
- IC-7 (2000) Secretarial Services to Intensive Care Units *Bulletin Mar 2000, pg 58*
- IC-8 (2000) Quality Assurance *Bulletin Nov 00, pg 55*
- IC-9 (1997) Statement on Ethics and Patients' Rights and Responsibilities *Bulletin Nov 97, pg 68*
- IC-10 (1996) Minimum Standards for Transport of the Critically Ill *Bulletin Mar 96, pg 42*
- IC-11 (1996) In-Training Assessment of Trainees in Intensive Care *Bulletin Mar 96, pg 46*
- IC-12 (2001) Examination Candidates Suffering from Illness, Accident or Disability *Bulletin Nov 2001, pg 75*
- IC-13 (2000) Minimum Standards for High Dependency Units Seeking Accreditation for Training in Intensive Care
Bulletin Mar 2000, pg 59
- PS38 (1999) Statement Relating to the Relief of Pain and Suffering and End of Life Decisions *Bulletin June 99, 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 Mar 2000, pg 55*



Dean's Message

Michael J Cousins, AM

Accreditation

Dr Roger Goucke and I have been working closely to supply the extensive materials that are required on behalf of our Faculty to gain specialist recognition. I am pleased to inform Fellows that our Faculty has already generated many of the materials that are viewed by the Australian Medical Council (AMC) as being important in the accreditation process. Nevertheless we have found it necessary to generate a very substantial document to accompany the materials that already describe our Committee processes, our educational program, our examination process, hospital inspections etc. The Faculty document will form part of the main ANZCA application which is very much on track for submission. After careful consideration, the Board has come to the clear conclusion that the Faculty's interests are best served by applying for sub-specialty recognition as part of the ANZCA application. The alternative course would be for the Faculty to make a completely separate submission for recognition as a specialty rather than a sub-specialty. At this stage of the Faculty's development, it has been judged that this would be an insuperable task and very unlikely to succeed. Also such an application would be out of keeping with the Faculty's current modus operandi which involves its Fellows first obtaining a specialist qualification from one of the participating specialty bodies.

Fellows will be pleased to learn that Pain Medicine is already listed as a sub-specialty within ANZCA, however, this listing is subject to the current accreditation process.

Increasing the Profile of Pain Medicine

I was interested to read the President's Message by Douglas Justins in the recent issue of "The Pain Society Newsletter" (the British and Irish Chapter of the International Association for the Study of Pain) which

makes it clear that the issues in the United Kingdom are precisely the same as those in Australia and New Zealand. Specifically, there is a serious lack of specialist manpower, inadequate facilities, enormous mismatch between patient demand and clinical services and serious shortages of training positions. In the March 2001 ANZCA Bulletin I provided a summary of the current evidence for chronic pain as a major health problem. As is the case in the UK, it appears that very little notice is being taken of these compelling data at a State or Federal level. In other words we are obviously not getting the message across and thus we must examine new strategies for the sake of the very large number of patients who are simply not gaining access to appropriate and timely treatment.

Many of us have expended great efforts at the level of our health services and State Governments in order to try and improve the situation at a local level. There is some encouraging evidence that gradual progress is being made although most of us would have to acknowledge that the cost-benefit ratio is excessively high. We must continue and re-double these efforts and I would suggest that this is a responsibility of all Fellows at this critical stage of development of the specialty. However I think it is time for an additional strategy which will involve prominent members of the general community.

Again I have referred to this in a previous number of the ANZCA Bulletins but would now like to identify this as the major initiative for 2002. In order to assist me in this endeavour, I would be grateful if Fellows could let me know about prominent members of the general community who are well known to them and who would be prepared to assist in the development of a strategy for placing Pain Medicine as a high priority in health education and healthcare delivery.

Recruitment of Trainees

At the recent examination for the Fellowship, it was encouraging to see some truly outstanding individuals who had been attracted to our specialty. An inspiring example was a trainee with specialist qualifications from Canada, who was awarded the Barbara Walker Prize for the top candidate. This individual is an outstanding clinician with superb knowledge and clinical skills. He will undoubtedly make a major contribution to the development of Pain Medicine in Canada and the new Faculty is very proud to have made this contribution to Pain Medicine in North America.

A substantial challenge for Fellows is to increase recruitment from all of the participating specialty bodies. The majority of trainees continue to be from the specialty of anaesthesia and there is now an important imperative to recruit high quality trainees from surgery, psychiatry, rehabilitation medicine and medicine. Encouragingly we have one neurosurgery trainee interested in undertaking the Pain Medicine training program and there are a number of potential trainees from other specialties who have shown substantial interest.

Recruitment should receive a stimulus from specialty recognition but there is also a need to increase the availability of training positions. One of the important tasks for members of our various specialty bodies is to get

across the message that a psychiatrist, surgeon, physician or rehabilitation medicine specialist can greatly enhance their specialty practice by gaining a qualification in Pain Medicine and thus opening up an extremely wide area of practice that cuts across many specialties. Many trainees in participating specialties currently have no idea about the scope of practice in the specialty of Pain Medicine.

I would like to target an increase in training positions as the second highest priority for 2002. Again all of us should bear some responsibility for using all appropriate means within our own institutions to develop training positions.



MICHAEL J COUSINS AM

Erratum: Please note that in the August 2001 Dean's Message on Evidence Based Guidelines and Pain, there was an error in the extremely valuable reference "Complex Regional Pain Syndromes: Guidelines for Therapy". The correct reference is Clinical Journal of Pain 14:155-166 1998.

Membership of Faculty Working Parties

NHMRC Acute Pain Management: Scientific Evidence, Document Revision

Chair P Macintyre
P Briscoe
S Walker
S Schug
M Cooper - ANZCA representative
D Scott - ANZCA representative
E Visser - ANZCA representative

Paediatric Pain Medicine

Chair J J Collins FRACP
S M Walker FANZCA

Development of White Papers

M J Cousins
C R Goucke
P A Briscoe
B M Kinloch
R L Atkinson

Palliative Medicine

Chair P Glare FRACP
J Agar-Wilson FRCA
R Chye FRACP
D Gorman FRACP
T Cramond FANZCA
B Williams FANZCA
J Collins FRACP- representing
paediatric palliative pain medicine
C R Goucke FANZCA - Board Representative

AMC Accreditation

Chair (Dean) M J Cousins
C R Goucke

Highlights from the Board Meeting

HELD ON AUGUST 29, 2001

Admission to Fellowship by Election

George Chalkiadis was admitted to Fellowship by election.

Education

Survey of Fellows

The Board noted the summary of the survey of Fellows published elsewhere in this Bulletin.

Simulators in Education

The Board referred this item to the Education Committee to discuss the possibility of conducting short courses for both Fellows and Trainees.

Reading List Material

This material is now ready to be distributed to each accredited training unit.

Refresher Courses

The Board referred this item to the Education Committee to discuss the possibility of conducting refresher courses for Fellows from 2003.

Examination

Merit List

The Board agreed to introduce a merit list for candidates who have shown excellence in their examination results but have not achieved a sufficient mark to be awarded the relevant Prize. The Court of Examiners will determine candidates for inclusion on the merit list at the conclusion of each examination. Candidates will be eligible for inclusion on the merit list provided that they have shown excellence in their examination results and achieved a mark in the top 10%. A certificate recognising a pass with merit in the examination will be awarded to the meritorious candidates.

2001 Examination

Dr Penny Briscoe reported that the examination was held at Royal Adelaide Hospital on November 1 and 2. Ten of the twelve candidates who presented passed the examination.

An examination report will be completed when the final comments are received from both Examiners and Candidates.

Completion of Training Requirements Prior to Examination

It was agreed that effective from the 2002 training year:

1. Treatises to be renamed "case reports".
2. Candidates must write one case report with a minimum of 2500 and a maximum of 5000 words with up-to-date referencing, incorporating recent literature.
3. In their first Quarterly In-Training Assessment Report, candidates must identify the case they are going to write.

4. The case report must be assessed as satisfactory prior to a candidate being eligible to present for examination.
5. The case report must be submitted to the Faculty at least 75 days prior to the examination.

It was agreed that the examination continue to be held later in the year, possibly late October or early November.

Barbara Walker Prize for Excellence in Pain Medicine

Dr Michael Negraeff FRCP has been awarded the Barbara Walker Prize for Excellence in Pain Medicine.

Merit Award

Dr Anne Jaumees has been awarded a Merit Award in the 2001 examination.

Hospital Accreditation

Pain Units in the following hospitals have been approved for training:

Royal North Shore Hospital, NSW
Nepean Hospital, NSW
Flinders Medical Centre, SA

Professional Document

The following Professional Document was approved and is published elsewhere in this Bulletin.

PM2 Requirements for Multidisciplinary Pain Centres Offering Training in Pain Medicine

Accreditation

Professor M Cousins and Dr R Goucke will prepare the Faculty's material to be included with the College's submission to the Australian Medical Council as part of the accreditation process.

White Papers

It was noted that a meeting of the nominated Board Members driving each of the task forces has been scheduled to discuss the draft white papers.

Annual Scientific Meeting, May 2002, Brisbane

Dr Rollin Gallagher, MCP Hahnemann University, USA has agreed to be the Faculty's second speaker at this meeting.

A Faculty dinner has been arranged at the Queensland Club on Friday, May 10 prior to the commencement of the Faculty's scientific program on May 11 and 12.

Representation on Committees

The following were appointed as the Faculty representatives to the Regional/NZ Committees:

R L Atkinson, Qld	P E Macintyre, SA
M J Cousins, NSW	C R Goucke, WA
T F Little, Vic	D Jones, NZ

Fellowship Survey

MILTON L COHEN
Chairman, Education Committee

Thank you to all Fellows who responded to this Survey late last year. The overall response rate was approximately two-thirds of the total Fellowship but, as not all Fellows are on e-mail, the effective response rate was over 70%. This is outstanding and a testament to the interest and enthusiasm of Fellows. I would like to record our thanks to Dr Russell Jones and his staff in the Education Office of the College for running the survey and collating the results.

1. What would you like the Faculty to do for you?

Not surprisingly, the provision of refresher courses was endorsed most strongly, closely followed by the development of educational resources and of literature updates. Qualitative (write-in) responses included requests to develop standards of practice and evidence-based guidelines.

2. Which topics would you find most valuable?

"Evidence" (80%) and "neuropathic pain" (70%) were strongly endorsed with "rational use of opioids" supported by 55% and "interventional therapy" by 40%. Write-in topics covered the broad spectrum of pain medicine, with updates on physical examination and input on psychological interventions and medico-legal issues requested.

3. How would you like to be involved?

The responses were as follows:

Presenting at short or refresher courses	81%
Development of educational resources	77%
Examiner	42%
Development of educational modules	28%
Development of white papers	28%

Clearly as a Faculty we are fortunate to have so much latent energy and talent. Fellows who have indicated willingness to be involved can expect a tap on the shoulder soon!

4, 5. Questions regarding preferred mode of learning.

Almost half the respondents had experience of "electronic learning" and almost 70% expressed an interest. Workshops and directly accessing the literature found favour with 65%, lectures attracted 50%, and small group work and web-based modules were preferred by 40%.

What happens now?

As mentioned above, we now know whom to ask to do what!

- A day was held in December to start development of White Papers.
- The Reading List in the Objectives of Training has been updated: this document is available electronically.
- A Refresher Course will be held in association with the 2003 ASM in Hobart.
- "Modules" currently being developed include: Pain-orientated physical examination; practical psychological assessment and epidemiology.

Faculty Of Pain Medicine

Professional Documents

PM1	(2001)	Guidelines for Trainees and Departments Seeking Faculty Approval of Posts for Training in Pain Medicine
PM2	(2001)	Requirements for Multidisciplinary Pain Centres Offering Training in Pain Medicine
PS40	(2000)	Guidelines for the Relationship Between Fellows and the Healthcare Industry
PS41	(2000)	Guidelines on Acute Pain Management
PS45	(2001)	Statement on Patients' Rights to Pain Management

College Professional Documents adopted by the Faculty:

PS4	(2000)	Recommendations for the Post-Anaesthesia Recovery Room
PS7	(1998)	The Pre-Anaesthesia Consultation
PS8	(1998)	The Assistant for the Anaesthetist
PS10	(1999)	The Handover of Responsibility During an Anaesthetic
PS15	(2000)	Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery with amendment to the title to read Recommendations for the Perioperative Care of Patients Selected for Day Care Procedures
PS18	(2000)	Recommendations on Monitoring During Anaesthesia
PS31	(1997)	Protocol for Checking the Anaesthetic Machine
PS20	(2001)	Recommendations for Responsibilities of the Anaesthetist in the Post-Operative Period

Examination for Fellowship of the Faculty of Pain Medicine

November 1 and 2, 2001 Royal Adelaide Hospital

The structure for the examination was:

Written Examination

Short answer questions: five 'core knowledge' questions and five non-compulsory questions. Duration 2.5 hours.

Short Cases

Four stations of ten minutes each. Three of the stations were with patients with acute, chronic and cancer pain respectively and the fourth station was focussed on medical imaging. Two examiners assessed candidates at each station.

Structured Vivas

Four stations of ten minutes each. Three stations focussed

on acute, chronic and cancer pain respectively. The fourth station was a role-play.

Long Case

One hour history taking and physical examination. Twenty minutes to prepare material followed by a thirty minute viva with two examiners.

Ten of the twelve candidates were awarded a pass by the Court of Examiners. Each successful candidate was presented to the Chairman Dr Penny Briscoe and the Court of Examiners. Following the presentation, candidates met for a social function with the Court of Examiners.



Court of Examiners

Back L to R: Drs Julia Fleming, Frank New, Pam Macintyre, Prof Nigel Jones, Dr Bruce Rounsefell, A/Prof Milton Cohen, Dr Ray Garrick

Front L to R: Dr Carolyn Arnold, Professor Michael Cousins, Drs Penny Briscoe (Chair, Court of Examiners), Matthew Crawford, Paul Glare (Dr David Gronow, not in photograph)



Successful Candidates at the 2001 Examination

Back L to R: Drs Ivan Marples, Anne Jaumees, Graham Hocking, Stephen Gibson

Front L to R: Drs Chimene Bhar, Charlotte Johnstone, Michael Negraeff (foreground) Robert Lattik, Sarah Lindsay (Chung Cheung Leung not in photograph)



Successful Candidate at the 2001 Examination

Dr Charlotte Johnson celebrates her examination result with Dr Matthew Crawford



Dr Graham Hocking with Professor Cousins at the social function following the examination

Faculty Of Pain Medicine

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

ABN 82 055 042 852

REQUIREMENTS FOR MULTIDISCIPLINARY PAIN CENTRES OFFERING TRAINING IN PAIN MEDICINE

1. INTRODUCTION

- 1.1 These guidelines establish the minimum standards for Multidisciplinary Pain Centres offering training for Fellowship in Pain Medicine of the Australian and New Zealand College of Anaesthetists.
- 1.2 A Multidisciplinary Pain Centre is a healthcare delivery facility staffed by medical practitioners from at least three (3) specialties, and other allied health professions. These individuals specialise in the diagnosis and management of patients with chronic pain and/or patients with acute pain and/or patients with cancer pain, referred to generically as patients with pain.
- 1.3 The staff of a Multidisciplinary Pain Centre must be able to assess and appropriately treat the biopsychosocial aspects of patients with pain.
- 1.4 A number of allied healthcare disciplines must be represented on the staff of a Multidisciplinary Pain Centre.
- 1.5 The Multidisciplinary Pain Centre must include, or have a close association with appropriately organised Acute Pain and cancer/palliative care services. This Acute Pain Service must be referred at least 1000 new patients per annum.
- 1.6 A session is a notional period of 4.0 hours devoted exclusively to Pain Medicine.

2. ADMINISTRATIVE STRUCTURE AND STAFFING

- 2.1 The Centre should be recognised by the Hospital Management for funding purposes.
- 2.2 All staff in the Centre must be accredited by the Hospital for the duties and procedures they perform.
- 2.3 The Centre should have a Medical Director with a minimum of four (4) sessions weekly and a Deputy Medical Director with a minimum of three (3) sessions weekly. The Medical Director of the Centre must be a Fellow of the Faculty of Pain Medicine, ANZCA.

- 2.4 There must be a minimum of eight (8) additional medical specialist sessions excluding sessions allocated to the Acute Pain Service.
 - 2.4.1 Anaesthesia: regularly scheduled specialist clinical sessions are essential.
 - 2.4.2 Psychiatry: regularly scheduled specialist clinical sessions are essential.
 - 2.4.3 Rehabilitation Medicine: regularly scheduled specialist clinical sessions are essential.
 - 2.4.4 Rheumatology, oncology, neurology, neurosurgery, orthopaedic surgery, palliative medicine, drug and alcohol and other appropriate medical specialties: regular clinical input is highly desirable from these medical specialties.
- 2.5 The following other disciplines form part of staffing.
 - 2.5.1 Nursing staff: there must be senior registered nursing staff exclusively attached to the Centre (excluding the Acute Pain Service) for a minimum of ten (10) sessions weekly.
 - 2.5.2 Clinical Psychologist: there must be a minimum of five (5) sessions weekly
 - 2.5.3 Physiotherapist/Physical Therapist: there must be a minimum of five (5) sessions weekly
 - 2.5.4 Regular clinical input for these disciplines is highly desirable:
 - 2.5.4.1 Occupational Therapy
 - 2.5.4.2 Social Work
 - 2.5.4.3 Other Allied Health disciplines such as Rehabilitation/Occupational Counselling, Dietetics and others may be associated with the Centre.
- 2.6 Centres must establish and maintain regular direct contact with the patient's General Practitioner.
- 2.7 The Centre should offer a range of expertise in the following areas:

- 2.7.1 Review of prior medical records
- 2.7.2 History taking and physical examination relevant to Pain Medicine
- 2.7.3 Psychological assessment and treatment
- 2.7.4 Referral for external medical consultation
- 2.7.5 Medical management
- 2.7.6 Physical therapy
- 2.7.7 Other appropriate services, including:
 - 2.7.7.1 Cognitive behavioural programs
 - 2.7.7.2 Relaxation techniques
 - 2.7.7.3 Biofeedback
 - 2.7.7.4 Work hardening/exercise physiology
- 2.7.8 Pain management therapies
- 2.7.9 Vocational assessment and counselling
- 2.8 Regularly scheduled staff education sessions are essential
- 2.9 Involvement in undergraduate and postgraduate medical, nursing and allied health education is essential.
- 2.10 Regularly scheduled Quality Improvement/Peer Review activities are essential.
- 2.11 An active research program related to Pain Medicine is highly desirable.
- 2.12 A comprehensive patient record system is essential. A computerised data review system for diagnosis treatment is highly desirable.
- 2.13 Documentation of treatment protocols and procedures for patients together with a statement of their rights and responsibilities is essential.
- 2.14 At least one full-time equivalent of secretarial assistance to the Centre is essential.
- 2.15 Allocation of RMOs is highly desirable.
- 2.16 The Acute Pain Service should be a part of the Centre or an affiliated hospital
 - 2.16.1 There must be at least one (1) session each weekday by a specialist anaesthetist and preferably also each weekend day and public holiday
 - 2.16.2 There must be at least ten (10) sessions each week by registered nursing staff
- 2.17 The cancer/palliative care services can be part of the Centre or an affiliated hospital.

3. PHYSICAL FACILITIES

- 3.1 Appropriate consulting and examination rooms are essential.
- 3.2 Access to procedure rooms with adequate equipment and staffing is essential. Staffing will include nurses, technicians and radiographers as required.
 - 3.2.1 Anaesthesia and resuscitation equipment must comply with ANZCA College Policy Document TI (2000) Recommendations on Minimum Facilities for Safe Anaesthesia Practice in Operating Suites.
 - 3.2.2 Recovery facilities and procedures must comply with ANZCA College Policy Document PS4 (2000) Recommendations for the Post-Anaesthesia Recovery Room.
- 3.3 Suitable office space for permanent staff and trainees is essential. See ANZCA College Policy Document TE1 (2001) Guidelines for Hospitals seeking College Approval of Posts for the First Four Years of Vocational Training in Anaesthesia.
- 3.4 Access to in-patient beds.
 - 3.4.1 Access to in-patient beds is mandatory.
 - 3.4.2 In-patient beds designated to the Multidisciplinary Pain Centre are highly desirable.
- 3.5 Access to an adequate library with major pain medicine books and access to bibliographic databases for journal publications are mandatory. The Centre must have access to a library in the institution with all recommended major texts and journal articles and reviews as listed in the Objectives of Training.

4. CLINICAL WORKLOAD AND STANDARDS

- 4.1 Numbers of new patients per annum:
 - 4.1.1 **Acute perioperative/medical/trauma:** a minimum of 500 new patients per annum per trainee.
 - 4.1.2 **Chronic non-cancer pain:** a minimum of 250 new patients per annum per trainee.
 - 4.1.3 **Cancer pain:** a minimum of 50 new patients per annum per trainee.
- 4.2 **Out-patient medical specialist sessions:** There should be a minimum of five per week.
- 4.3 **Formal interdisciplinary case conferences:** must be held at least once weekly (to draw up a treatment plan in discussion among a number of health professionals who have seen the patient in consultation). Preferably three to five per week will be held.
- 4.4 **Procedural sessions:** A minimum of one procedural session (eg: diagnostic and therapeutic nerve blocks, etc.) per procedural specialist per week.

- 4.5 **In-patient rounds:** There must be regular daily rounds to cover patients under the care of the Pain Centre and the Acute Pain Service. There must be medical specialist input to the rounds.
- 4.6 There must be medical specialist cover of the Pain Centre and the Acute Pain Service 24 hours per day throughout the year. This must include scheduled out of hours rounds.
- 4.7 **Radiology:** There must be regular review sessions.
- 4.8 **Therapeutic:** Nerve blocks and other invasive treatments should be sufficient to provide adequate exposure for trainees. Non-invasive treatments must also receive appropriate emphasis to ensure candidates become pain medicine specialists rather than pain proceduralists.
- 4.9 **Psychiatry and Psychology therapy sessions:** Sessions must provide adequate exposure for trainees.
- 4.10 **Audit and clinical review sessions:** These must be held at least monthly and include documentation of results.
- 4.11 The Centre must comply with all current Faculty Professional Documents.

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Date of Current Document: Nov 2001

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Admission to Fellowship

The following have been admitted to Fellowship by the Board having completed all requirements for admission to Fellowship by Examination.

Linda Huggins FRCA	SA
Chung Cheung Leung FANZCA	Hong Kong
Michael Negraeff FRCPC	NSW

Australian And New Zealand College Of Anaesthetists

ABN 82 055 042 852

Review PS2 (2001)

STATEMENT ON CREDENTIALLING IN ANAESTHESIA

Credentialling in anaesthesia allows a medical practitioner to provide clinical services at a healthcare institution. The process of credentialling should be performed by a committee appointed by the institution. Credentialling is an integral part of processes for the maintenance of the professional standards necessary for all Fellows of the College and for other anaesthetists working in any institution. The scope of practice would be determined by negotiation between the anaesthetist and the head of clinical service of the institution.

Medical regulatory authorities are moving towards a requirement that all medical practitioners be regularly credentialled by the healthcare institution(s) in which they work. Credentialling is one of several measures aimed at ensuring ongoing competence to practise in a designated area of medicine. Credentialling indicates that an individual has maintained his/her consulting, communication and procedural skills at an appropriate standard.

The College does not credential its Fellows directly. It does offer its Maintenance of Professional Standards program to all anaesthetists as an integral part of continuing professional development.

The following guidelines for credentialling have been established by the College to assist healthcare institutions with the development of processes appropriate for anaesthetists.

1. Qualifications in Anaesthesia. Anaesthesia should be practised by a specialist anaesthetist and/or a trainee or other staff supervised as described in College Professional Document TE3 Policy on Supervision of Clinical Experience for Trainees in Anaesthesia. It is recognised that in some healthcare institutions, specialist anaesthetists may not be available or present in sufficient numbers to provide a complete service. Under such circumstances appropriately trained general practitioner anaesthetists or career medical officers (see College Professional Document PS1 Essential Training for Rural General Practitioners in Australia proposing to Administer Anaesthesia) may be service providers. In all situations, staff should be aware of the provisions of College Professional Documents TE6 Guidelines on the Duties of an Anaesthetist and PS16 Statement on the Standards of Practice of a Specialist Anaesthetist.

2. Credentialling Committee. When the credentialling of anaesthesia staff is undertaken, two specialist anaesthetists (normally holding FANZCA), including one who does not hold an appointment at the healthcare institution, should be members of the Committee. The Committee should have representative member(s) from other divisions of the healthcare institution.

3. Conditions for credentialling. The following processes are suggested for the operation of Credentialling Committees:

- 3.1 Except where there is prior agreement between healthcare institutions, credentialling should be unique to the granting institution. Work at a new institution ordinarily requires the granting of privileges as part of the process of appointment.
- 3.2 The process and requirements for credentialling should be prospectively determined by each healthcare institution. If changes are made, all staff must be advised, together with a date for application of the new or altered requirement(s).
- 3.3 Credentialling and scope of practice should be approved for a specified time.
- 3.4 Evidence of participation in a Maintenance of Professional Standards program should be obtained.
- 3.5 There should be a written statement of credentialling with a clear indication as to the process followed. This document may be used by the staff member for his/her professional needs, including licensing for practice as a medical practitioner and as an anaesthetist. The staff member must have the opportunity for comment on matters related to credentialling before a final decision is taken by the Committee.
- 3.6 The credentialling may include a review of performance with evaluation by peers and other staff as determined by the Committee. Submissions to the Committee should be in writing.

Promulgated: 1982
Reviewed: 1988, 1991, 1996
Date of current document: Dec 2001

COLLEGE PROFESSIONAL DOCUMENTS

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Australian And New Zealand College Of Anaesthetists

ABN 82 055 042 852

Review PS3 (2001)

GUIDELINES FOR THE CONDUCT OF MAJOR REGIONAL ANAESTHESIA AND ANALGESIA

I. GENERAL PRINCIPLES

- 1.1. Major regional anaesthesia and analgesia must be undertaken only by anaesthetists with appropriate training and experience in the technique, or by trainees under appropriate supervision. All persons who undertake such procedures must understand the relevant anatomy, physiology, pharmacology and complications of the particular procedure and the contraindications to it being performed. They must be able to recognise and promptly treat any complications.
- 1.2. Major regional anaesthesia and analgesia techniques (e.g. epidural, spinal, plexus or intravenous regional blockade) can have serious side effects and complications due to marked physiological changes, local anaesthetic, opioid and non-opioid adverse drug effects and problems associated with needle or catheter technique.
- 1.3. One person must not assume the dual responsibility of both the operator and the

anaesthetist for patients having any form of major regional anaesthesia or analgesia.

- 1.4. Informed consent must be obtained from the patient for all regional anaesthesia and analgesia.
- 1.5. Infection control and aseptic procedures appropriate to the particular regional anaesthesia/analgesia technique must be used. Use of full aseptic technique is essential for spinal and epidural techniques.
- 1.6. Management of major regional anaesthesia/analgesia must include establishment of secure intravenous access prior to commencement of the regional anaesthetic and for its duration, and patient monitoring in accordance with Professional Document PS18 Recommendations on Monitoring During Anaesthesia.
- 1.7. The anaesthetist must be in attendance throughout the procedure or until the blockade has been demonstrated to be satisfactory, its extent determined, the condition of the patient is

satisfactory and stable and the potential for acute complications has passed.

- 1.8 An appropriately trained person must be present to assist the medical practitioner who is establishing major regional blockade.
- 1.9 Appropriate protocols and procedures must be in place for the establishment and continued management of the technique in use.
- 1.10 All staff managing the patient must have appropriate training.
- 1.11 A record of instructions given and observations made must form part of the patient's medical record.

2. SPECIFIC PRINCIPLES FOR MAJOR REGIONAL ANALGESIA MANAGEMENT USING AN EPIDURAL OR OTHER INDWELLING CATHETER

2.1 Safe and effective analgesia via a catheter in situ depends on the following:

- 2.1.1. The availability of adequate specialised postoperative care at the particular institution must be considered in evaluating the risk/benefit ratio.
- 2.1.2 Secure intravenous access must be present prior to, and throughout the administration of analgesia.
- 2.1.3 The catheter must be clearly labelled to avoid the accidental administration of other substances.
- 2.1.4 Selection of the appropriate route (plexus, epidural, intrathecal etc) and site (e.g. lumbar vs thoracic) should be based on individual patient history, surgical requirements and the planned postoperative regimen.
- 2.1.5 The technique and drugs used to establish the regional analgesia and initial management instructions must be recorded by the anaesthetist who performed the procedure.
- 2.1.6 A test dose should be given to establish correct placement of the catheter.
- 2.1.7 Written protocols for the management of acute problems such as overdose, hypotension, respiratory depression, over-sedation and central nervous system toxicity must be readily available for reference at all times.
- 2.1.8 Monitoring and recording of the following parameters should be carried out: pain, blood pressure, heart rate, temperature, respiratory rate, sedation score, oxygen saturation, sensory and motor function, bladder function.

2.1.9 Available protocols describing the identification and management of suspected complications at the catheter insertion site, particularly with regard to epidural abscess, epidural haematoma, spinal cord compression and other potential complications.

2.1.10 Patients must be reviewed at least daily by an anaesthetist and an anaesthetist must be available for consultation or management of complications at all times. The catheter site should be inspected for signs of inflammation/infection and review of neurologic function shall be performed. An unexpected increase in pain or the development of new pain (especially in the back) requires urgent evaluation and if necessary, arrangements should be made for an MRI scan.

2.1.11 Removal of the catheter must be documented in the patient's record, including the date, time, state of the catheter and of the puncture site. Follow-up assessment is desirable. An appropriate protocol must be available in patients on anticoagulants for timing of anticoagulant doses in relation to catheter insertion and removal.

2.1.12 Surgical and/or other medical staff caring for the patient after surgery or trauma must be aware of the analgesic technique used, its potential complications and any specific implications for the surgery performed or other management issues for the patient. The need for appropriate consultation of specialised pain management staff should be communicated to other medical staff.

2.1.13 Regular medical review to detect possible complications (e.g. compartment syndrome, haematoma etc) is essential, bearing in mind the particular implications of the regional analgesia technique.

2.1.14 Use of dilute local anaesthetic, and/or opioid mixtures is desirable: to enable retention of motor function and minimal sensory loss, to facilitate detection of deterioration in neurologic function; and to aid resumption of normal activities. Care should be taken to preserve bladder function – where appropriate post voiding bladder scanning should be performed.

2.2 The anaesthetist may delegate the further intermittent administration of drugs or the supervision of an infusion to another medical practitioner or registered nurse or to a pain service provided that:

- 2.2.1 The personnel managing major regional anaesthesia and analgesia have received specific training and accreditation concerning epidural or other catheter analgesia management and complications, and have carried out a sufficient number of administrations satisfactorily under supervision.
- 2.2.2 The anaesthetist has satisfied himself/herself of the competence of the person or service to manage the analgesia and its potential complications.
- 2.2.3 All drugs have been prescribed by an anaesthetist.
- 2.2.4 When patient-controlled or continuous infusion devices are in use, the anaesthetist establishing regional analgesia, or delegate, is satisfied that both patient and attending staff understand the use of the technique including its advantages, limitations and potential risks.
- 2.2.5 When an infusion pump is used, it must have safety features which prevent inadvertent overdose. The pump and the container sourcing it must be clearly labelled.

- T1 *Recommendations on Minimum Facilities for Safe Anaesthesia Practice in Operating Suites*
- T2 *Recommendations on Minimum Facilities for Safe Anaesthesia Practice outside Operating Suites*
- PS2 *Statement on Credentialling in Anaesthesia*
- PS4 *Recommendations for the Post-Anaesthesia Recovery Room*
- PS8 *Recommendations on the Assistant for the Anaesthetist*
- PS9 *Guidelines on Conscious Sedation for Diagnostic, Interventional Medical and Surgical Procedures*
- PS10 *The Handover of Responsibility During an Anaesthetic*
- PS18 *Recommendations on Monitoring During Anaesthesia*

Promulgated: 1982
 Reviewed: 1987, 1993, 1998
 Date of current document: Dec 2001

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3. SPECIFIC PRINCIPLES FOR MAJOR REGIONAL ANALGESIA IN OBSTETRICS

- 3.1 Major regional analgesia has the potential to change many of the normal physiological processes of labour and delivery. From the time that major regional analgesia is instituted, it is essential that the mother is under the care of a medical practitioner with obstetric training who can assess the mother as necessary, and rapidly effect delivery of the baby by whatever technique is appropriate.
- 3.2 The practitioner establishing regional analgesia must establish that the mother has consented to the procedure after having been informed about advantages, disadvantages and alternatives. This should normally be part of ante-natal education.
- 3.3 From commencement to completion of epidural analgesia in labour, there must be appropriately skilled staff and equipment available to monitor and care for both mother and fetus, and to manage any complications arising from the regional analgesia or labour. (see 2.1 and 2.2)

4. EQUIPMENT AND STAFFING

Equipment and staffing of the area in which the patient is being managed should satisfy the requirements of the relevant Australian and New Zealand College of Anaesthetists Professional Documents:

Australian And New Zealand College Of Anaesthetists

ABN 82 055 042 852

Review PS43 (2001)

STATEMENT ON FATIGUE AND THE ANAESTHETIST

INTRODUCTION

The provision of anaesthesia requires a high level of knowledge, sound judgement, fast and accurate responses to clinical situations, and the capacity for extended periods of vigilance.

In the interests of patient safety, it is important that anaesthetists are aware of the following principles and their responsibilities in respect of working while fatigued.

PRINCIPLES

1. Fatigue has been demonstrated to impair vigilance and accuracy of response (1,2). Decreased performance of motor and cognitive functions in a fatigued anaesthetist may result in impaired judgement, late and inadequate responses to clinical changes, poor communication and inadequate record keeping (3,4,5,6). The decrement in cognitive psychomotor performance after 17 hours of sustained wakefulness is equivalent to the performance impairment observed with a blood alcohol level of 0.05%, and after 24 hours to a blood alcohol level of 0.1% (1).
2. Fatigue may contribute to adverse events and critical incidents (7,8). In other industries these have been shown to be commonest in a bimodal distribution between 0300 and 0600 and between 1300 and 1500, when circadian drowsiness is greatest (9).
3. Adults require (on average) eight hours of sleep each night. Fatigue will occur with sleep debt; this sleep debt is cumulative and does not dissipate. Short sleep nights (4 - 6.5 hours) are associated with a cumulative impairment in the performance of psychomotor tasks requiring vigilance (10). Sleep efficiency decreases with increasing age (11). Ageing reduces the capacity to recover from fatigue (11).
4. Many individuals cannot reset their body time clocks to allow for effective daytime sleep after night duties. Daytime sleep is typically shorter and of inferior quality compared with sleep at night (11).
5. Individuals are often unable to recognise fatigue and their reduced capacity to continue working safely (11,12). "Microsleeps", a sign of extreme fatigue, may be equally unrecognised (20).
6. Use of caffeine and other stimulants is an attempt to combat rather than to prevent the problem and as such is not recommended. Sleep loss-induced deterioration in performance is only mitigated by naps and caffeine for the first 24 hours of continuous wakefulness (13). Naps are followed by a period of "sleep inertia" (drowsiness after waking) associated with reduced performance (14).
7. Health facility employers have a responsibility under occupational health and safety legislation to provide a safe working environment for their employees (15,16,17).
8. Inappropriate work practices and rosters that contribute to fatigue may put employees at risk of accidents to themselves and their patients while at work, and while travelling to and from work (18).

RESPONSIBILITIES

1. Anaesthetists have a responsibility to organise their lives in a way that ensures fatigue does not regularly impact on clinical duties (3). Individuals and Departments must have knowledge of fatigue related risk categories, as set out in the Australian Medical Association National Code of Practice (March 1999)(21). Anaesthetists have a moral and ethical responsibility to consider not proceeding with clinical duties if physical or mental fatigue, stress or ill health, alone or in combination, might interfere with safe patient care.
2. After working out-of-hours with significant disturbance to normal rest and sleep, the anaesthetist should be able to divest him/herself of clinical commitments on the subsequent day until there has been the opportunity for an adequate rest period.
3. For shift work, forward-rotating shifts (mornings - evenings - nights) are associated with the least disturbance to normal sleep patterns (14). As many individuals cannot readily reset their biological clock to accommodate night shifts, it is recommended that night shifts should be for a maximum of five nights (14,19).
4. Departments, hospitals and groups of anaesthetists should have a management plan to address the short-term consequences of anaesthetists being unavailable for clinical duties because of fatigue following "on-call" work.

5. Long-term work patterns should be based on the following principles:

- 5.1 Adequate time must be available for leisure activities.
- 5.2 Adequate breaks must be taken during a day of clinical work.
- 5.3 Rosters for shift and weekend work must be available for a significant time ahead.
- 5.4 Recreation leave should be taken regularly.

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Promulgated: March 2001
Date of current document: Dec 2001

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Australian And New Zealand College Of Anaesthetists

ABN 82 055 042 852

Review PS44 (2001)

GUIDELINES TO FELLOWS ACTING ON APPOINTMENTS COMMITTEES FOR SENIOR STAFF IN ANAESTHESIA

The College considers that it should provide advice to Appointments Committees in Australia or New Zealand when appointments in anaesthesia are being considered. This is best carried out by designating a specific Fellow to work with or be a member of the Committee. When trainee appointments are being considered, the procedures laid down in the College document Guidelines for the Selection of Trainees should be followed. For Committees dealing with senior staff appointments, the following matters are relevant:

1. The College representative should give advice on matters related to the qualifications and status of applicants.

In the case of specialist appointments, consideration must be given as to whether applicants:

- 1.1 Hold the Fellowship of this College or will hold that Fellowship by the date on which they take up appointment.
 - 1.2 Hold another specialist qualification in anaesthesia. In this situation, the implications in respect of Overseas Trained Specialist Assessment by the College and registration as a specialist in Australia or New Zealand must be considered.
 - 1.3 Have appropriate experience for the position under consideration.
2. The College representative may be a full member of the Appointments Committee, in which case his/her other duties will be determined by the employing authority. The employing authority must be asked to prospectively determine the status of the College representative. In matters other than those stated in Item 1, the Fellow will be acting on behalf of the employing authority and not as an ANZCA representative.
3. The nomination of Fellows to serve on Appointments Committees shall be made by Regional Committees or the New Zealand National Committee, and copied to the College for information.
4. The College nominee must have knowledge of College guidelines on matters related to the duties of senior staff. He/she should not be a member of the Medical Staff of the hospital seeking the appointment.
5. College nominees should serve in this capacity for a maximum of 12 years and should be in active practice.

If the College nominee is unable to attend a meeting, he/she should seek permission to nominate a proxy after discussion as to an appropriate person with the Chair of the relevant Regional or National Committee.

6. Fellows acting on Appointments Committees should be aware of the following:

- 6.1 Confidentiality and privacy must be maintained as part of the requirements of the employer.
- 6.2 Written documentation of all relevant decisions and of significant issues should be maintained by the employer.
- 6.3 Because of the significance of the matters considered, it is essential that the employer maintains fair procedures and follows due process.
- 6.4 If a College representative has any doubts about a process or decision, the matter should be formally discussed with the employer in the first instance. If the issues cannot be resolved, advice from the College should be sought through the CEO.
- 6.5 Appointments Committees must be free from bias. Its members must not have any relationship with an applicant which might prevent them from making a fair decision.
- 6.6 Appointments must be made strictly according to prospectively established, relevant and objective criteria. Matters considered by the Committee must be strictly relevant to those criteria. Irrelevant personal issues may be potentially defamatory.

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

- TE6 *Guidelines on The Duties of an Anaesthetist*
- PS1 *Recommendations on Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia*
- PS2 *Statement on Credentiailling in Anaesthesia*
- PS16 *Guidelines on the Standards of Practice of a Specialist Anaesthetist*

Overseas Trained Specialists - Assessment Process

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Australian And New Zealand College Of Anaesthetists

And Faculty Of Pain Medicine
And Joint Faculty Of Intensive Care Medicine

ABN 82 055 042 852

Review P45 (2001)

STATEMENT ON PATIENTS’ RIGHTS TO PAIN MANAGEMENT

Since the time of Hippocrates, pain management has been regarded as being an important priority of the physician. However as knowledge of disease processes rapidly advanced, the emphasis moved to diagnosis and treatment of underlying cause, as the main imperative in patients presenting with pain. Renewed focus on pain management per se re-emerged because of humanitarian aspects, improved outcome after surgery and trauma, enhanced rehabilitation in patients with persistent pain and potentially improved survival in patients with cancer pain. Standards and practice guidelines have been developed in parallel with substantial improvements in management of all forms of pain [1-4]. Effective pain management usually requires assessment of physical, psychological and environmental factors in each patient; the aim of such assessment is to enable planning of pain management strategies that will improve physical and mental functioning, in order to restore quality of life as rapidly and completely as is possible in the circumstance of each patient.

ANZCA recognises that severe unrelieved pain can have severe adverse physical and psychological effects on patients, with associated emotional, social and spiritual effects causing suffering in patients, their families and those close to them [2]. At times severe pain can be extremely difficult to treat and management must be subject to the availability in each health care setting of appropriate, safe and effective methods. However ANZCA recognises the following rights of patients to management of acute pain, cancer pain and persistent non-cancer pain:

1. The right to be believed, recognising that pain is a personal experience and that there is great variability among people in their response to different situations causing pain (see IASP) [1].
2. The right to appropriate assessment and management of pain; patients and their families have a key role in working with the health care team to develop realistic goals for pain management.

3. The right to have the results of assessment regularly recorded in a way that assists in adjusting treatment to achieve effective and ongoing pain relief.
4. The right to be cared for by health professionals with training and experience in assessment and management of pain, and who maintain such competencies by all necessary means. Where such competencies are unavailable, the patients should be referred appropriately.
5. The right to appropriate effective pain management strategies. These must be supported by appropriate policies and procedures and must be appropriate for use by the health professionals employing them.
6. The right to education about effective pain management options for their particular problem; families should also be included in such education.
7. The right to appropriate planning for pain management after discharge from immediate care.

Footnote:

IASP Definition of Pain

"An unpleasant sensory and emotional experience, associated with actual or potential tissue damage, or described in terms of such damage".

References:

1. IASP Task Force on Taxonomy Classification of Chronic Pain. 2nd Edition IASP Press, Seattle 1994 pp 210
2. NHMRC Acute pain management: scientific evidence NHMRC 1998
3. Cousins MJ. Relief of acute pain: a basic human right? MJA 2000;172:3-4
4. Joint Commission on Accreditation of Healthcare Organizations. USA 1999
5. In NZ there is a related document "The Code of Health and Disability Services - Consumers' Rights"

Promulgated: 2001
 Date of current document: Dec 2001

COLLEGE PROFESSIONAL DOCUMENTS

College Professional Documents are progressively being coded as follows:

- TE Training and Educational
- EX Examinations
- PS Professional Standards
- T Technical

POLICY – defined as ‘a course of action adopted and pursued by the College’. These are matters coming within the authority and control of the College.

RECOMMENDATIONS – defined as ‘advisable courses of action’.

GUIDELINES – defined as ‘a document offering advice’. These may be clinical (in which case they will eventually be evidence-based), or non-clinical.

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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 Nov 1999, pg 67*
- TE4 (1997) Duties of Regional Education Officers in Anaesthesia *Bulletin Nov 1997, pg 88*
- TE5 (1997) Supervisors of Training in Anaesthesia *Bulletin Nov 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 Nov 1999, pg 69*
- TE9 (1999) Quality Assurance *Bulletin June 1999, pg 94*
- TE11 (1999) Formal Project Guidelines *Bulletin Mar 1999, pg 70*
- TE13 (2001) Guidelines for the Provisional Fellowship Year *Bulletin Nov 2001, pg 76*
- TE14 (2001) Policy for the In-Training Assessment of Trainees in Anaesthesia *Bulletin Nov 2001, pg 84*
- TE17 (1999) Advisors of Candidates for Anaesthesia Training *Bulletin Nov 1999, pg 66*
- TE18 (2000) Guidelines for Assisting Trainees with Difficulties *Bulletin Mar 2001 pg 76*
- EX1 (2001) Policy on Examination Candidates Suffering from Illness, Accident or Disability *Bulletin Nov 2001, pg 75*
- T1 (2000) Recommendations on Minimum Facilities for Safe Anaesthesia Practice in Operating Suites *Bulletin Mar 2001 pg 68*
- T2 (2000) Recommendations on Minimum Facilities for Safe Anaesthesia Practice outside Operating Suites *Bulletin Mar 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 Mar 2002, pg 65*
- PS3 (2001) Guidelines for the Conduct of Major Regional Anaesthesia and Analgesia *Bulletin Mar 2002, pg 66*
- PS4 (2000) Recommendations for the Post-Anaesthesia Recovery Room *Bulletin Nov 2000, pg 72*
- PS6 (2001) Recommendations on the Recording of an Episode of Anaesthesia Care (the Anaesthesia Record) *Bulletin Nov 2001, pg 77*
- PS7 (1998) The Pre-Anaesthesia Consultation *Bulletin Mar 1998, pg 73*
- PS8 (1998) The Assistant for the Anaesthetist *Bulletin Mar 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 Nov 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 Nov 2001, pg 43*
- PS14 (1998) Guidelines for the Conduct of Major Regional Analgesia in Obstetrics *Bulletin Nov 1998, pg 81*
- PS15 (2000) Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery *Bulletin Nov 2000, pg 75*
- PS16 (2001) Statement on the Standards of Practice of a Specialist Anaesthetist *Bulletin Nov 2001, pg 81*
- PS17 (1997) Endoscopy of the Airways *Bulletin Nov 1997, pg 80*
- PS18 (2000) Recommendations on Monitoring During Anaesthesia *Bulletin Nov 2000, pg 78*
- PS19 (2001) Recommendations on Monitored Care by an Anaesthetist *Bulletin Nov 2001, pg 82*
- PS20 (2001) Recommendations for Responsibilities of the Anaesthetist in the Post-Operative Period *Bulletin Mar 1996, pg 52*
- P21 (1996) Sedation for Dental Procedures *Bulletin Mar 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 Nov 1999, pg 63*
- P27 (1994) Standards of Practice for Major Extracorporeal Perfusion *Bulletin Nov 1994, pg 46*
- P28 (1995) Policy on Infection Control in Anaesthesia *Bulletin Mar 1995, pg 38*
- PS29 (1997) Anaesthesia Care of Children in Healthcare Facilities without Dedicated Paediatric Facilities *Bulletin Nov 1997, pg 82*
- PS31 (1997) Protocol for Checking the Anaesthetic Machine *Bulletin Nov 1997, pg 84*
- PS36 (1997) Sedation for Regional Anaesthesia for Ophthalmic Surgery *Bulletin Nov 1997, pg 93*
- PS37 (1998) Regional Anaesthesia and Allied Health Practitioners *Bulletin Mar 1998, pg 79*
- 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 Mar 2000, pg 55*
- PS41 (2000) Guidelines on Acute Pain Management *Bulletin Nov 2000, pg 80*
- PS42 (2000) Recommendations for Staffing of Departments of Anaesthesia *Bulletin Mar 2001 pg 63*
- PS43 (2001) Statement on Fatigue and the Anaesthetist *Bulletin Mar 2002 pg 69*
- PS44 (2001) Guidelines to Fellows Acting on Appointments Committees for Senior Staff in Anaesthesia *Bulletin Mar 2002 pg 71*
- PS45 (2001) Statement on Patients' Rights to Pain Management *Bulletin Mar 2002 pg 72*
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