

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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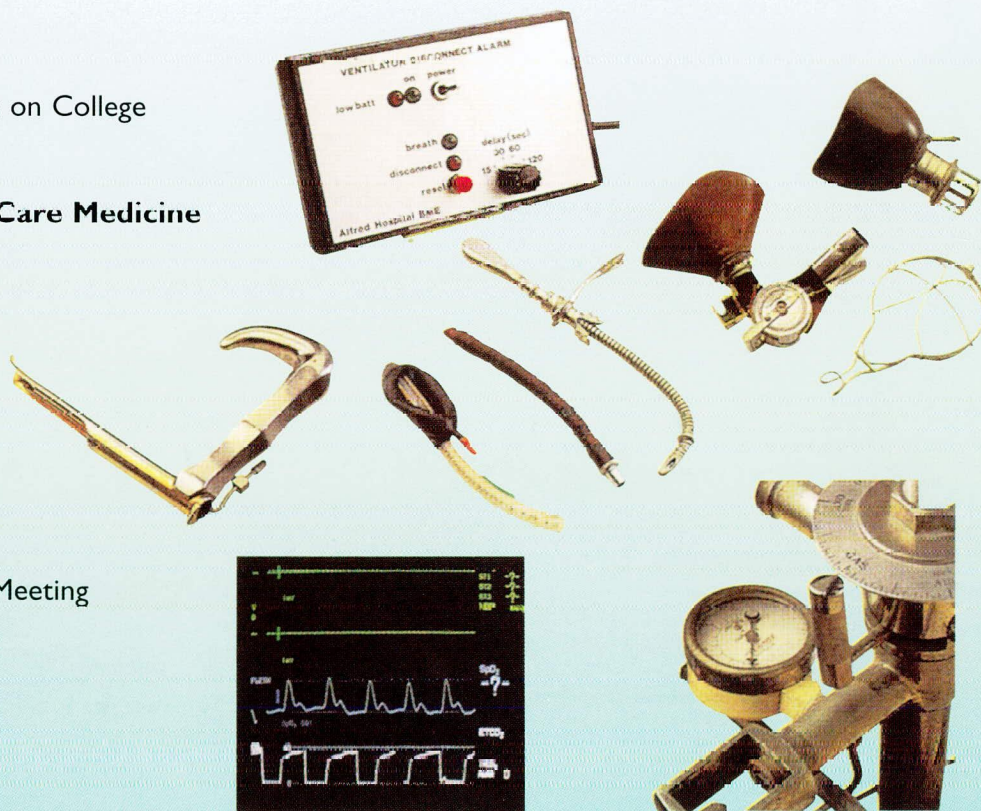
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Editorial

Mrs Joan Sheales, Editor

Dr M. Marilyn

Dr R.S. Henderson

Dr R.N. Westhorpe

Mr E. Dean

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Telephone: + 61-3 9510 6299

Facsimile: + 61-3 9510 6786

E-mail: ceoanzca@anzca.edu.au

Internet: <http://www.anzca.edu.au>

Regional and New Zealand Committee offices can be contacted via email as follows:

ACT: act@anzca.edu.au

NSW: nsw@anzca.edu.au

NZ: nz@anzca.edu.au

QLD: qld@anzca.edu.au

SA: sa@anzca.edu.au

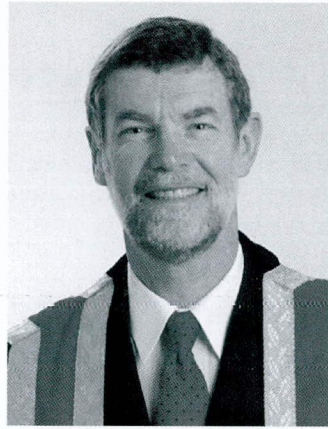
TAS: tas@anzca.edu.au

VIC: vic@anzca.edu.au

WA: wa@anzca.edu.au

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President's Message

Richard J Willis, ANZCA

Recently, I had the opportunity and privilege of attending the Australian Health Care Summit as one of over 250 invited delegates representing all relevant groups of Australians who have an interest in health care. Such groups included professional and political medical bodies, managers, nurses, allied and other health professionals, economists, politicians, and most importantly many consumer and support groups (indigenous health, mental health, physically and intellectually disabled and many more). As would be expected in such a disparate group, there was spirited discussion on most issues, significant argument on some but also a remarkable amount of agreement on many. The problems inherent in our present health system were spelled out with great clarity, priorities were identified and solutions were suggested.

Significantly, Aboriginal health, care of those incapacitated or with chronic illness, health promotion, workforce, and inefficiencies associated with different health responsibilities of State and Federal governments were all identified as major priorities. Common threads were drawn together, resulting in a broadly supported consensus Communiqué that was publicly presented to politicians at the completion of the meeting as a 'Blueprint For Health Reform'. This Communiqué plus many of the presentations are available on the following website: www.healthsummit.org.au These documents make interesting reading. As an example, you may be tempted to read the presentation of Prof. Stephen Duckett entitled 'Integrating the Healthcare System: Taking Medicine Forward OR What to do when we (at last) accept existing health insurance policies have failed'.

The representative views of such a diverse group of health-related professionals may well be unique in Australia and should therefore be heeded by politicians, but the downside would seem to be the total lack of response, at least at the time of writing, from the Federal Government.

I quote from the editorial in the MJA of 15 September 2003, 'If only one message comes from the Summit it is that Australian healthcare reform is in dire need of political champions and cooperative federalism to harness the people and professional power so evident at the Summit. Without the spirit of cooperation, future health ministers may look back to 2003 and say 'we did nothing'. And that would be a shame.'

One recurring theme of the Health Summit was the equitable access to health care for all members of society, and hence the necessity to assist the less privileged who currently fare poorly. This brings me to another topic. There are many Australian and New Zealand anaesthetists who can stand tall in their commitment to the less fortunate by their ongoing assistance with the development of anaesthesia services in many neighbouring countries, both with clinical service and by contributing to training programs. These Fellows step outside of their comfort zone, forego personal income and give generously of their time, knowledge and skills to a wide variety of aid programs in countries less 'lucky' than our own. In this regard, I commend your attention to the article elsewhere in this Bulletin entitled 'Letter from Nepal' written by Dr Maurice Lee, a New Zealand Fellow of ANZCA. He sent this only at *my* request and then subsequently granted me permission to reproduce it. This is just one story of commitment to helping others by one of our Fellows. There are many more, and I hope this one may act as a stimulant for others to come forward and tell their own stories. The rewards for this type of work are certainly not financial but there are much richer currencies than money. The rewards for this work are more valuable and much more enduring. In recent years, Fellows of ANZCA have worked essentially pro bono for various durations in many nearby countries. Those that immediately spring to mind are East Timor, Papua-New Guinea, Fiji and the Pacific Islands, Myanmar, Mongolia, India and

Indonesia. I'm sure there are others. Anaesthetists attached to surgical teams and to armed forces medical units have ventured even further afield. A feature that seems to be common to all these anaesthetists is a general reluctance to draw any attention to themselves, so that we are often quite unaware of the good work that is being done and the personal sacrifices that are involved. I am sure all Fellows will join me in applauding their humanity and generosity.

I was in Malaysia and Singapore recently for the Combined Scientific Meeting of their Academies of Medicine and also to speak to trainees and supervisors about the changes to the FANZCA Training Program. It was reassuring to know that there is still a great deal of interest in achieving Fellowship of ANZCA in both countries. The College will continue to foster strong relationships with them and endeavour to facilitate training that will integrate with their own MMed specialist anaesthesia training programs.

On the subject of pro bono work and as a person with a strong concern for environmental protection, I will leave you with the following Cree Indian Prophecy that I saw in a National Park in East Malaysia.

Only after the last tree has been cut down
Only after the last river has been poisoned
Only after the last fish has been caught
Only then will you find that money cannot be eaten.

Finally, I wish all Fellows, trainees and the College staff a happy, relaxing and enjoyable Christmas and New Year.

A handwritten signature in black ink that reads "Richard Willis". The signature is written in a cursive, flowing style.

Richard Willis
President



Law Reports

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

A conflict between confidentiality and care

A recent New South Wales Supreme Court decision was concerned with a difficult situation where a doctor's duty of confidentiality to one patient was in conflict with his duty of care to another patient.

In *PD v Dr Nicholas Harvey*, a couple contemplating marriage jointly attended a medical clinic to be tested for the Human Immunodeficiency Virus ('HIV') and other sexually transmitted diseases. The plaintiff, known as PD, was concerned that her future husband, known as FH, was in a high risk category because he was from Africa.

PD tested negative to HIV, and FH tested positive.

The doctor who initially saw the couple and arranged for the testing, did not inform PD of the result of FH's tests due to the constraints of confidentiality. In fact FH falsified the test results. PD later discovered the correct outcome of FH's test and discovered that she had contracted the virus just prior to the birth of their baby.

The scenario was complicated by inadequate clinical documentation, poor pre-test and post-test counselling and the conduct of FH which the judge described as 'despicable'. The Court found that FH lied to PD and showed her a forged pathology result to convince her that he had also tested negative.

Justice Cripps found that the doctors who saw PD and FH were negligent, and awarded PD \$727,437 in damages.

SEEK LEGAL ADVICE

This case highlights the importance of seeking legal advice where such a dilemma is posed. Doctors should be constantly aware of the ever changing boundaries of their duty of care to a patient.

It is well known that doctors owe a duty of confidentiality to their patients. However, in this case, the doctors mistakenly believed that their duty of confidentiality to one patient overrode their duty of care to another patient.

The Court upheld doctor-patient confidentiality, but found that there were further steps which were lawfully open to the doctors in NSW which were not inconsistent with their obligation of confidentiality. For example, in NSW the *Public Health Act 1991* allows the Director General of Health to break the confidentiality of HIV related information where it is in the public interest to do so.

Other states will usually have similar mechanisms. For example, in Victoria the *Health Act 1958* (Vic) allows the Secretary to the Department of Human Services to order that a person with an infectious disease undergo counselling about the disease. Where it is likely that the disease will be transmitted and there is a serious risk to public health, the Secretary may also order that such a person's behaviour or movements be restricted.

AVOID THE CONFLICT

The Court also found that the conflict also could have been avoided by having adequate pre-test counselling. Prior to undergoing testing, the couple and their doctor did not discuss how the test information would be dealt with. PD just assumed she would have access to FH's results.

Expert witnesses gave evidence that the question of possible discordant results should have been raised with the couple at the first consultation. It would have been prudent for the doctor to have clarified and documented that the patients mutually consented to the disclosure of their test results and a joint consultation should have been arranged for both parties to receive their results.

GOOD DOCUMENTATION IS ESSENTIAL

The Court found that inadequate medical documentation also contributed to the errors in this case.

The doctor, who initially arranged for the testing of PD and FH, did not make a reference in PD's clinical records to FH and vice versa even though there was a joint consultation.

The Court found that making a cross reference on client records in these circumstances is not prohibited by the duty of confidentiality, because it is only the disclosure of confidential information which is prohibited, not the receipt of it.

If the cross reference had been made on PD's clinical records, the alarm bells would have rung for the second doctor, another doctor at the medical clinic, who subsequently saw PD regarding a prescription for the contraceptive pill.

The medical clinic had all the information that would have been necessary to uncover the fraud committed by FH, but they were unable to take action to prevent reasonably foreseeable loss to PD due to inadequate cross-referencing of patients' cards.

IN SUMMARY

- Ensure there are adequate documentation procedures in place to identify a conflict between the duty of confidentiality and duty of care to patients.
- Minimise the risk of conflict through proper pre-test counselling procedures and post-test counselling, if necessary.
- If a conflict does arise, seek legal advice to identify any other steps to protect a patient who is at risk.

(I am grateful to **Andrea Drobnik** for assistance in the preparation of this article).

'Raising Jordan'

The High Court compensates parents for the reasonable costs of raising a healthy child

In the recent decision of *Cattanach v Melchoir*, the High Court decided by a slim majority that a doctor must pay the reasonable costs of raising a child born as a consequence of a negligent sterilisation.

The decision has been applauded by some for being made on the basis of rational legal principles rather than emotive policy arguments. Others deplore the Court's decision to place a monetary costing on a human life. All recognise that this will place additional strain on the medical profession and medical indemnity issues, in particular.

THE FACTS

There was no dispute about the negligence of Dr Cattanach's actions.

Mr and Mrs Melchoir decided they were happy with the size of their family and Mrs Melchoir consulted Dr Cattanach, who advised that a tubal ligation was appropriate. Mrs Melchoir told Dr Cattanach that her right ovary and fallopian tube had been removed when she was 15 years old. So when Dr Cattanach performed the tubal ligation, he only attached a clip to the left fallopian tube. The doctor failed to confirm Mrs Melchoir's account, nor did he inform her that if her right fallopian tube and ovary were functioning, her risk of becoming pregnant after the operation increased ten-fold.

Mrs Melchoir's right fallopian tube and ovary were actually intact, so the couple sued Dr Cattanach for negligence when she fell pregnant and gave birth to a healthy son called Jordan in 1997. The following damages were awarded:

- \$103,672.39 to Mrs Melchoir for pain and suffering, the loss of part time earnings and various medical expenses related to the pregnancy;
- \$3,000 to Mr Melchoir for loss of consortium; and
- \$105,249.33 to Mr and Mrs Melchoir for the reasonable costs of raising the child.

Only the final award of damages was disputed before the High Court.

THE DECISION

The costs of raising a child are a reasonably foreseeable consequence of performing a negligent sterilisation, so on the face of it, these damages are claimable. The seven justices of the High Court had to consider whether there was a public policy reason against awarding damages in this situation.

The four justices in the majority decided that these damages were recoverable. They concluded that doctors should not receive a special immunity from having to pay all reasonably foreseeable damages.

The three justices of the minority decided that there were policy reasons for refusing to award these damages. Chief Justice Gleeson declined to award damages for the costs of raising a child because it was 'incapable of rational or fair assessment' and could lead to the creation of an indeterminate burden on society. The other judges declined to award damages where the child born was 'normal' or did not have special needs.

POLICY ARGUMENTS AGAINST AWARDING DAMAGES

Children are a blessing

Justice Hayne in the minority and courts in England have given weight to the argument that a child is a blessing and that it is 'morally offensive to regard a normal, healthy baby as more trouble and expense than it is worth'.

However, Justices McHugh and Gummow dismissed this argument because it denies the damages awarded for pain and suffering in this case, and it also denies the widespread use of contraception to avoid such a case.

Purely economic costs should be limited

The courts are traditionally more willing to limit damages for purely economic loss, because unlike damages for physical injury, financial harm may create indeterminate liability.

In the minority, Justice Gleeson categorised the reasonable costs of raising a child as being purely economic. On this basis, his Honour held that the doctor did not owe a duty not to cause reasonably foreseeable financial harm. Otherwise, the burden that would be imposed upon citizens would be intolerable.

The majority again dismissed this reasoning. They held that the mother had suffered physical injury so the loss could not be described as purely economic. The mother was therefore entitled to recover all consequential losses, including the financial costs of raising the child.

The financial costs should be offset against the intangible benefits of parenthood

Dr Cattanach argued that if damages are awarded for the cost of rearing a healthy child, they should offset against the benefits of having a healthy child.

The court unanimously disagreed with this argument. Justices Gleeson, McHugh and Gummow disagreed on the basis that it was not appropriate to offset a financial loss against a non-financial benefit. Justices Kirby, Hayne and Callinan disagreed on the basis that the emotional and other benefits resulting from such a birth cannot be assessed comprehensively at the beginning of life.

Disabled children

In England and Scotland, the courts have held that the costs of raising a normal, healthy baby are not claimable. However, the extraordinary costs of a healthy mother raising a disabled child or the extraordinary costs of a disabled mother raising a healthy child are claimable.

In the minority, Justice Hayne agreed with this reasoning and Justice Heydon left open whether damages would be recoverable where the child born is not normal and healthy.

The majority found this reasoning arbitrary and undesirable, and held that the differential treatment of children with disabilities has been a mark on the societies and political regimes which we least admire. Justice Kirby held that this reasoning reinforces views about disability that are contrary to contemporary Australian values.

ESTIMATING THE REASONABLE COSTS

The Melchoir's calculated their claim based on the anticipated costs of raising Jordan until the age of 18. They took into account the costs of food, clothing, medical and pharmaceutical expenses, child care, travelling to and from school, entertainment, birthdays, and Christmas presents.

The minority found the Melchoir's 'losses' were too difficult to assess, and an attempt to quantify the losses would result in the commodification of the child.

The majority dismissed these arguments on the basis that 'hard choices are to be made'. However, the majority did

not discuss the really difficult question, namely the basis upon which the reasonable costs should be calculated.

Justice Kirby commented that the claim was comparatively modest, and if arbitrary limitations on the amount claimable had to be made, this was a role for Parliament rather than the courts.

IMPLICATIONS

This decision establishes that the reasonable costs of raising a child born as the result of a negligent sterilisation are claimable, whether or not the child is healthy. It is clear the court will not discount the damages claimed to allow for the intangible benefits of parenthood. However, the decision does not establish a basis upon which such reasonable costs should be calculated.

The implications of this decision depends on the government's response. NSW Premier Bob Carr has called on the Commonwealth Government to introduce national laws to protect doctors where they act in line with widely held medical opinion. John Anderson, who was acting Prime Minister at the time, also expressed concern about the moral and ethical problems of classifying children as an economic burden. Whether these sentiments will be acted upon is another matter.

The decision has wide ramifications for the expected 'Implanon' cases currently foreshadowed, as well as for the IVF industry. The decision cuts across recent government reforms to limit or cap medical liability claims.

[I am grateful to Andrea Drobnik for assistance with this report.]

Refusal of Medical Treatment: PEG Feeding

Russell Kennedy Solicitors acted in the recent landmark decision of the Victorian Supreme Court, which found that percutaneous endoscopic gastrostomy ('PEG') feeding is a type of medical treatment, and can be refused under Victorian law.

In February 2003, the Victorian Public Advocate was appointed the limited guardian of a patient known as 'BWV' by the Victorian Civil and Administrative Tribunal ['VCAT']. BWV is a 68 year old woman with Pick's disease, an advanced form of dementia. The Public Advocate sought and was successful in obtaining declarations from the Court that:

1. The provision of nutrition and hydration via a percutaneous endoscopic gastrostomy ('PEG') to BWV constitutes medical treatment within the meaning of the Medical Treatment Act 1988; and
2. The refusal of further nutrition and hydration, administered via a PEG, to BWV constitutes refusal of medical treatment, rather than refusal of palliative care, within the meaning of the Medical Treatment Act 1988.

The Court considered the background to the Medical Treatment Act 1988, including the numerous bills and lengthy parliamentary debates, to determine the intention of parliament. He also considered the evidence of medical specialists. He accepted the medical evidence which supported the view that the provision of artificial nutrition and hydration to BWV 'is futile, in the sense that it has no prospect whatever of improving her condition'.

The Court found that PEG feeding falls within the definition of medical treatment in the Act. The Court stated:

'... unquestionably in my judgment, the use of a PEG for artificial nutrition and hydration, or for that matter any form of artificial feeding, is a 'medical procedure'. Artificial nutrition and hydration involves protocols, skills and care which draw from, and depend upon medical knowledge.'

and went on to say:

'I also find that the administration of artificial nutrition, via a PEG, to BWV is the administration of a substance like a drug; and, hence, is also within the meaning of the definition of medical treatment.'

The Judge said that PEG feeding is a procedure to sustain life, 'not a procedure to manage the dying process, so that it results in as little pain and suffering as possible'. Accordingly, Parliament intended that the management of the dying process could not be refused.

It was the Court's opinion that the expression 'palliative care', standing alone, means care, not to treat or cure a patient, but to alleviate pain or suffering when a patient is dying. Indeed, palliative care extends to care for the relatives of the dying patient.

The Judge was satisfied that the PEG feeding was not palliative care.

Policy implications of BWV decision

Following the decision of BWV there is now greater certainty about a patient's rights to refuse medical treatment and what comprises such treatment. Similarly this certainty extends to the duties of health practitioners in their care of patients.

The health and aged care sectors have an obligation to ensure that policy and practices reflect the understanding of the law as a result of the BWV case.

Specifically what must be ensured in the health and aged care sectors is:

- a patient's right to execute a refusal of treatment certificate for a current condition; and
- a person's right to appoint an agent to refuse medical treatment on their behalf when they become unable to make decisions themselves.

It is in this context an understanding is required of

- how a refusal of treatment certificate should be executed?
- how an agent should be appointed?
- what does an agent have to consider when making a decision to refuse medical treatment?
- what is prima facie 'medical treatment'?
- what is a medical procedure?
- what is palliative care?
- what information must be provided to the patient or their agent when such a decision is made?
- what is the role of carers?

Good policy and practice are essential for services to ensure appropriate and lawful decision making.

This case is based on particular Victorian legislation but has implications for all states and territories and New Zealand. However, the particular application in other jurisdictions may vary depending on local legislation. Specific legal advice should always be sought in similar cases.

27th ANZCA-ASA Annual Continuing Education Meeting (Queensland)

11-12 July 2003

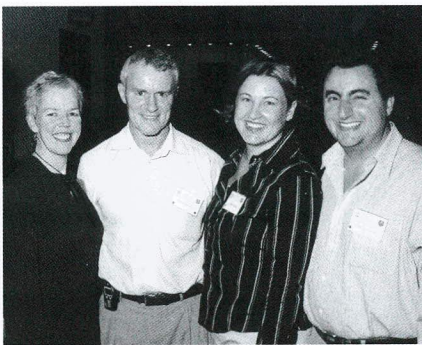
The 27th ANZCA-ASA Annual Continuing Education Meeting of Queensland was held on 11-12 July 2003 at the Conrad Jupiters Conference Centre at Broadbeach and was attended by over 200 delegates and 20 healthcare industry representatives.

The theme of the meeting was 'PerioperativeCare: the Anaesthetist's Role'. Speakers focussed on perioperative physiology and management rather than specific clinical scenarios. The keynote speaker, Dr Adrian Hall, Deputy Director of ICU at Western Hospital, Footscray spoke on the theory and application of cardiopulmonary exercise testing as a functional assessment of cardiopulmonary fitness and reserve. Other aspects covered included starvation and perioperative nutrition, the use of TOE, management of complex pain problems, the postoperative anaesthetic round and audit. The final session was presented by speakers from Darwin who discussed communication issues and the hospital and anaesthetic response to the Bali bombing victims. Delegates were highly satisfied with the educational program.

The Conference was opened by the President of the ASA, Dr James Bradley and the President of ANZCA, Dr Richard Willis, presented Council Citations to Drs Alison Holloway, A. John Board and Anton Neilson.

I would like to acknowledge the invaluable assistance of Joyce Holland, Regional Administrative Officer, Queensland during the organisation and running of this conference.

Hamish Holland
Conference Convenor



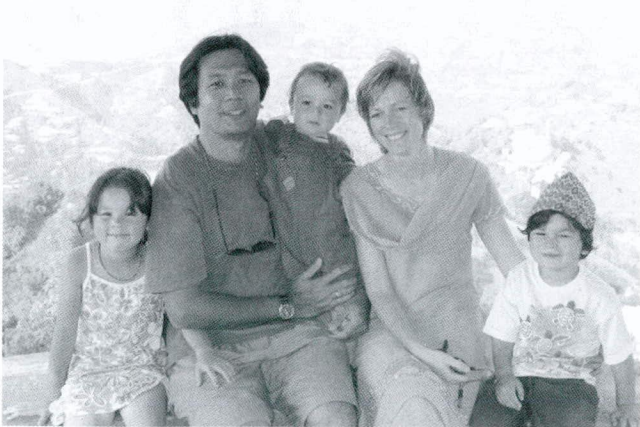
Fellow's Profile

A Letter from Nepal

Dr Maurice Lee, FANZCA, his wife Michelle and three children have recently moved to Tansen in Nepal for 2-3 years. Maurice will be contributing to an anaesthesia training program for physicians, nurses and technicians. He would welcome any communication or support from Fellows who are looking for a new challenge in a beautiful country and who would like to contribute to the training program. Contact details are available from the College. The following letter describes his early experiences in a country desperately in need of medical resources.

We left Auckland, New Zealand on 9 January 2003 and after a 3 day stopover in Bangkok to shake off the non-existent jet-lag in our 3 children, we flew on to Kathmandu. Fifteen minutes out of Kathmandu, there it was, the magnificent sight of Mt Everest poking through the clouds. We had arrived.

Now, the flight time didn't seem that long but we discovered to our horror that we had been in the air for a REALLY long time because when we landed the date was 29th Pus 2059!! Talk about jet lag! (Well, the name of the month didn't seem all that inviting either.) The date discrepancy wasn't because we detoured into the Bermuda Triangle but because the Nepali calendar starts about 57 years before the Gregorian calendar!

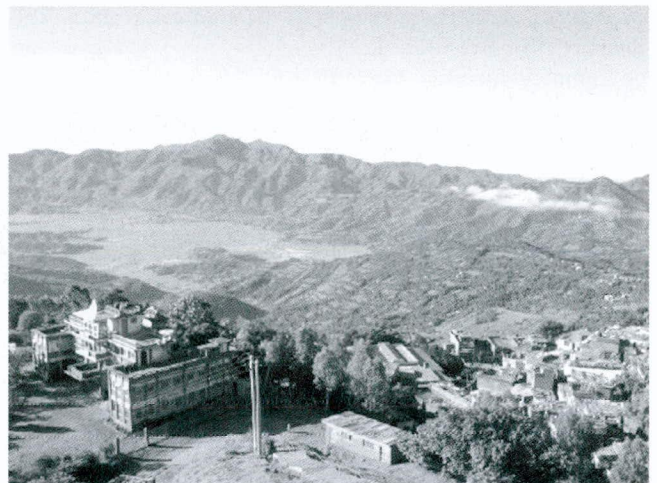


So, what are we doing in Nepal with our 3 young children? It had been the desire of my wife and I for many years to work in a developing country. Our first taste of this came about 8 years ago when we traveled to Nepal to do volunteer work with a Christian mission agency in Pokhara. I went there with the view to do GP/A&E work. However, the greatest need then was for an extra pair of hands in Anaesthesia, so I said 'Show me what you want me to do and I'll do it'. That kick-started my career in

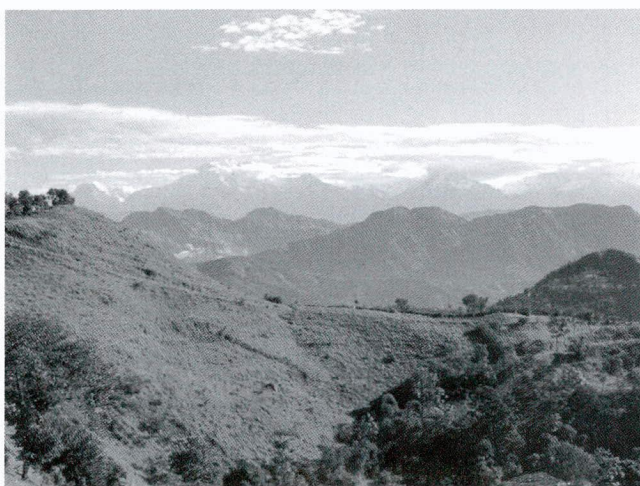
Anaesthesia because on return to NZ my plans to do Paediatrics were wiped off the table when I got accepted into the Anaesthesia training program in Auckland. The portability of our specialty and ability to be rapidly deployed into disaster zones in developing countries was a drawcard. Instant gratification with drugs was another! Whoops, that doesn't sound good, does it? I mean along the lines of, 'Here, take this blood pressure pill and come back and see me in two weeks to check if it is working'. Nah.

This time around we spent the first 4-5 months in Pokhara doing a full-time course in Nepali language and culture orientation. The program is crucial to helping the expatriates settle in well and to allow for culture shock to occur in an environment that provides you with the support that you need. We found at this time frequent communication from friends and family at home helped ease the difficulties. After we had grasped the basics of the language we headed south along an incredibly bendy but scenic road to a mission hospital in the hilltop town of Tansen. Having ridden a motorbike along the Great Ocean Road between Melbourne and Adelaide, I figure this has to be the second best biking road in the world. Except for the frequent landslides and the large trucks that come around corners taking up the whole road.

Tansen will be our home for the next 3 years. It is about 110 km away from Pokhara and it takes four hours to drive the newly sealed road (it used to take 6-7 hours before) and guaranteed to make anyone who has to sit above or behind the rear axle very nauseous. Tansen used to be the seat of power for one of the ancient kingdoms prior to the unification of Nepal in the 18th century. The whole town is on the steep slope of a ridge, and the United Mission Hospital is at the northeast end of town, near the top of



Srinagar Hill at about 1400m. The top of the hill is 1600m. Just as a comparison, the Turoa ski field ticketing area in the central North Island of NZ is about 1400m. Tansen overlooks the Madi Valley to the south and the view is just AMAZING. The bright green valley floor is a quilt patchwork of fields and the surrounding hills are heavily terraced. To the north, when you peer over the top of Srinagar, out the side windows of our house you see the Himalayas. I will not bore you with the grim statistics about the degree of poverty of this country, but one detail I shall mention. The Far-Western region of Nepal came near the bottom of the WHO's Human Development Index. It is easy to overlook the poverty and suffering for the romantic beauty of the Himalayas.



This mission hospital in Tansen, which started 50 years ago when Nepal opened its doors to the rest of the world, has a capacity of 131 beds. However, in the 3 months we have been here that number has never gone below 140. The patients are often lying on low beds along all the corridors. We have had a typhoid epidemic in the district earlier in the monsoon months as things have got wetter and water sources have got contaminated. There is a group of about 9 expat doctors (surgeons, GPs, Obstetrician, Pediatrician and me) and 4 senior Nepali doctors, with a team of about 15 Nepali RMOs. This is a popular rotation for Nepali junior doctors because of the high quality of teaching and standards that they see and experience here. The Nepali staff is paid a salary from the revenue the hospital gets from patients. There is no government funding. There is a poor fund whose coffers are filled by donations from overseas aid and Christian agencies, and from some of the revenue the hospital gathers. 10% of patients get their treatment fully funded from the poor fund. Equipment and capital funds also come from overseas sources.

The Anaesthesia Department comprises of six Nepali anaesthetic nurses whose work experience ranges between 30 and 6 years. These folk do a tremendous job anaesthetising all types of patients from neonates with burns and imperforate anus to elderly, late-presenting abdominal sepsis patients. The equipment we have available here are drawover systems utilizing the OMs,

EMO and Oxford Inflating bellows. Two years ago, two anaesthesia machines were purchased/donated to the hospital. It is in the light of such acquisitions that you at once realize the clear importance of self-sustainability. Along with the anaesthesia machines that have plenum vaporizers, cylinders of oxygen and nitrous oxide had to be bought. Some months ago one of the anaesthesia machines spent a few months in Kathmandu getting fixed and the other one has a ventilator that is no longer working. They do not have a trained person here to fix these machines. The drawover systems meanwhile gather dust. For the developing world, particularly one as poverty-stricken, politically unstable, isolated and rugged as Nepal, one has to question the rate of rise of inappropriate technology. Some things we take for granted in the West may be at best inappropriate, at worst dangerous in this setting. For monitoring we only have pulse oximetry, aneroid sphygmomanometry, and one ECG machine. Capnography? What's that?

My primary role here is to train Nepali nurses from remote district hospitals to administer basic anaesthesia. This is a government initiative in conjunction with a number of international aid agencies, including institutions like The Johns Hopkins University. In order to improve maternal health, anaesthesia services have to be provided for emergency caesarian sections. The mission organisation that we are with stepped up to the plate and provided two expatriate consultant anaesthetists who have laid the groundwork, made the manuals and seen one class of trainees graduate. The program is very short, with the trainees learning all they must in six months. It is a competency-based practical course in spinal anaesthesia and general anaesthesia. We have received funding for an AMBU intubation trainer and also a spinal trainer. These trainees will be taught spinal and drawover anaesthesia principles and basic CPR. Upon completion of the course they will return to the district hospitals, and hopefully be able to provide safe anaesthesia for emergency obstetric cases.



One other role that I have here is to provide anaesthesia services for mobile surgical camps, which are held in remote districts for the population that just would never get to a hospital. Even the patients to our hospital often

come after a full 24 hours of travel, be it by bus or foot. It is expected that every two months I will be away for a week or two on these camps. This seems the right balance for me right now, where I am part of a training project that equips locals for work, and also part of a project that is purely service orientated that may not have the important self-sustainable component yet provides help to the individual whom we come across.



People often present late to this hospital, like nearly every other hospital in Nepal. Most patients with severe abdominal sepsis are seen at 72 hours, get operated on, but often do badly. This has a lot to do with the malnourished state that most people are pre-morbidly. We have a lot of burns here, from babies whose hands are charred from falling into open fires to electrical burns from hitting the many low-slung wires. We don't usually get survivors from 30% TBSA burns. Diseases related to excesses are rarely seen, like obesity and coronary artery disease. I now know what opisthotonus and risus sardonicus looks like as we get, on average, two patients a week with advanced tetanus. I have helped drain a 750 ml pericardial effusion from a cachectic 9 year-old with TB. Not infrequently we get bear and tiger-attack victims, and a fair number of snake-bites. Our family had been under the impression that the big, wild beasts only lived in the Terai region, the southern third of Nepal where it is as flat as a pancake. Down there, the highest thing they climb is the bund on their ubiquitous paddy fields. That is where the most fertile (nearly the only fertile) land is, where it is unbearably hot almost all year, and Where The Wild Things Are (You know that book? Really good book). Them tigers, well, that's where they live. They do enjoy some R&R so sometimes they sneak up into the hills (Where The Lees Are) to cool off a little and check out the menu. A couple of months ago one of the local doctor's dog became hors d'oeuvres for a tiger. About the same time a chap came into hospital after a tiger had attacked him. Recently, there was a tragic but funny story when Goldilocks came into hospital. Nope, not a Nepali name, but that was what he was nicknamed. You see, he went creeping into a cave in the hills somewhere and disturbed two bear cubs and one angry mama bear. Baaaad move. Tiptoe Tiptoe,

Hoowoo Hoowoo, Stumble trip Stumble trip, Squelch squerch, Squelch Squerch, Splash Splosh, Swishy Swashy. He ain't going on no bear hunt no more. (You must know THAT book!). Anyway, he just had his face and hands nibbled a little, no big deal.

Road trauma resulting from overloaded, poorly maintained vehicles driven badly on even badder roads make for a busy hospital. I think that recently a bus that went off a cliff three hours from here resulting in about 20 fatalities made the world news. In the past 3 weeks, we have had mass casualties from 3 crashes within a couple of hours' drive from the hospital. We do not have the privilege of advance warning and constant updates of patient conditions as they are brought in from the field. The first we hear about them is when a truck pulls up at the front gate and disgorges its load of bleeding and mangled victims, with no idea of how many more to come. No Golden Hour out here. We try for the Silver Day or Bronze Week. The first accident occurred when a bus plunged off the side of a cliff, killing 8 at the scene, and sending 42 to our hospital, 21 of whom were admitted. Back home don't we get excited over the news of 3 trauma victims coming in? Boy, was I stunned. A few days later a fully laden, small jeep ran into a truck and 16 people came in from that one. Finally this morning the first inkling of trouble we got was the sight of 3 large water tankers and a truck parked in a haphazard manner on the muddy, slippery dirt track outside the hospital. Who needs ambulances? It was a special delivery from another accident!



Earlier this year the first Primary Trauma Course was run in Nepal, a contextualised ATLS for developing countries. I hope to be involved in the next one that they run. I did not do any extra prior training to be working here except for the Nepali language study, and deliberately working in a hospital with a burns unit in the final year of my fellowship, plus some work in a paediatric hospital. There is a course that Haydn Perndt and George Merridew run in Tasmania that would prove invaluable to any anaesthetist wanting to work in a developing country. Apart from covering the basics of drawover anaesthesia with practical use in an OR, they also discuss a lot of the philosophy behind the why and how we can help other countries.

After my language training in Pokhara, I went to Kathmandu to attend a two week Training of Trainers course, which was run in conjunction with a Swiss aid agency with materials from the Johns Hopkins University. This gave me some ideas and skills in adult and formal teaching which I am certain, will be helpful during classroom based teaching

A comment on the political situation. The ceasefire between the government and the Maoist insurgents fell apart nearly a month ago. This country has seen vicious killings and fighting between the two sides, which over the last few years have resulted in over 5000 deaths, a number of these innocent villagers. We have to live in a state of preparedness for immediate evacuation from our hospital should things worsen. Even as the fighting continues we do live as normal a life as we can, still doing our weekly 30 min trek to the bazaar to do the 'grocery shopping'.

For Michelle and I, being here and doing this with our children has been a big step of faith that we are truly enjoying, despite the difficulties. In the light of the suffering and hardship the people here have to face, the ones I have to serve, I have been humbled. Our children have settled really well and we have made lots of friends with the small team here. Some months ago a group of friends all chipped in and sent us a sum of money to get our brick, cement, mud and straw house kitted out with furniture and appliances, which was a fantastic response to our request for help. When I think of all the things that we have been privileged to enjoy, good education, good jobs, good friends, I wondered how could we possibly keep this all to ourselves.

Maurice Lee, FANZCA

Honours and Appointments

Dr Richard Willis (SA) – Admitted to Fellowship, Academy of Medicine of Malaysia

Dr Michal Kluger (NZ) – Doctor of Medicine (MD), University of Auckland

Dr Phoebe-Anne Mainland (VIC) – MA Medical Law and Ethics (London)

Dr Alan Duncan (WA) – Chief Editor, *Anaesthesia and Intensive Care*

Mr Michael Gorton (VIC, Hon Fellow) – Chairman, Victorian Biotechnology Ethics Advisory Committee

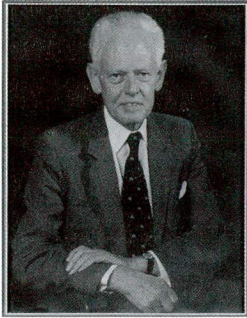
Deaths

Dr Margaret Innes (NZ) – FFARACS 1952, FANZCA 1992

Sir Anthony Jephcott, Bt (NZ) – Hon FFARACS 1990, FANZCA 1992

Professor Gaisford Gerald Harrison (South Africa) – Hon FFARACS 1990, FANZCA 1992

Obituaries



Sir Anthony Jephcott, Bt (1924-2003)

Hon. FFARACS 1990, FANZCA 1992 – New Zealand

John Anthony Jephcott (born 21 May 1924) was the eldest son of the first baronet Sir Harry Jephcott who became Managing Director and later Chairman of Glaxo Pharmaceutical Company. Anthony Jephcott attended Aldeham School where he obtained the Physics Prize, and St John's College, Oxford, where he enrolled in medicine and had CG Douglas (of the 'bag') as a tutor in physiology. Unfortunately the Second World War intervened and young Anthony volunteered, after just two years at Oxford, serving in the Royal Electrical and Mechanical Engineers where he qualified as a Craftsman 1st Class rising through the ranks to Sergeant. He was later commissioned a Captain in the Royal Army Education Corps whilst serving in Egypt in 1946 where he also contracted poliomyelitis which fortunately was relatively mild leaving him with a disability to the muscles of his left hand.

In this same year he took a financial interest and a directorship in the Longworth Scientific Instrument Co. Ltd. of Abingdon, Oxfordshire. This company had been founded by a group of technical friends from Physiology and other departments at Oxford University to produce the ESO (Epstein-Suffolk-Oxford) chloroform vaporizers for the RAF from a rented room in Longworth Street, Oxford. By 1946 they were producing Macintosh laryngoscopes and riding this wave to fame though not fortune because of business naivety for this valuable product. Following demobilisation, and still recovering from poliomyelitis, Anthony was advised to take a long holiday away from one of the worst British winters on record (1947/48) and he visited Australia and New Zealand, taking with him as reading material a copy of *Anaesthetic Methods* by Kaye, Orton and Renton! This visit was to prove the first of many subsequent trips to the antipodes. On return to the UK he decided against continuing his medical studies, instead marrying (Sylvia known as Jill) and enrolling in the London School of Economics where he graduated B.Com. in 1951 after specialising in industrial subjects. At this stage he joined Longworths fulltime and became Managing Director in 1954. His management style was described by a former employee as 'decisions based on logic and executed with reason and tolerance permeated the whole organization and provided a happy work environment which I was sorry to leave' [1 p74]. In 1959 Longworth, which by now was producing and marketing EMO (Epstein-Macintosh-Oxford) ether vaporizers, became 'Penlon', and in *A History of Longworth Scientific Instrument Co. Ltd.* [1] Anthony described his industry philosophy that 'business is done between people' [1 p103], and that there is 'the need for carefully thought out designs, for drawings and schedules to cover every stage of manufacture and, as a result, for parts to be interchangeable so that a customer half a world away could obtain spare parts which would fit without trouble' [1 p107]. 'Penlon' was sold in 1972 and Anthony Jephcott migrated to Wellington, New Zealand, where he set up Pen Medic Ltd. This successful firm was sold five years later, and Sir Anthony (as he became following his father's death in 1978) married Jo and retired to become an orchardist in Keri Keri, later moving to Whangarei and then Auckland.

I first met Anthony in 1969 when I was searching for the Oxford Nuffield Department of Anaesthetics' museum collection which I discovered he had rescued from dispersal following Sir Robert Macintosh's retirement. This friendship was later cemented in New Zealand with visits between Wellington and Dunedin and a mutual interest in anaesthetic history, the International History of Anaesthesia Conferences, and anaesthetic equipment. In retirement his history contributions continued with publications about the Macintosh laryngoscope [2,3] and his definitive history of Longworths [1].

Sir Anthony inherited a substantial collection of old Apothecary Jars from his father and these have been bequeathed to the Museum of Victoria in Melbourne which will then house probably the world's finest collection of such Jars. He maintained a very wide international circle of friends and professional acquaintances, and was noted for his generous hospitality. At conferences he was meticulous with his diary arrangements so that time was spent with all friends at the meeting.

In 1990 the Faculty of Anaesthetists, RACS, elected Sir Anthony to Honorary Fellowship in recognition of his outstanding contribution to anaesthesia as a manufacturer of anaesthetic equipment and for his support of local manufacture in this region particularly in New Zealand. He strongly supported our College Meetings from that time, and with his worldwide contacts was often publicising College activities. About five years ago he was diagnosed as suffering from multiple myeloma. With characteristic determination and scientific approach he sought out the latest and most effective medical

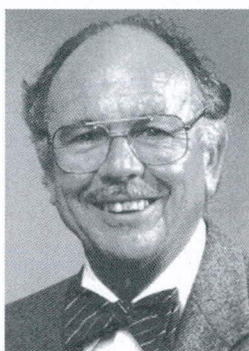
management. He died at home in Auckland on 7th August 2003 and was buried in Whangarei. He is survived in England by his former wife, two daughters (Helen Ashbury and Caroline Flower), and brother Neil (who inherits the title); and in Auckland by his wife Jo who ensured his retirement years were so happy, and who nursed him devotedly through his final illness.

Anthony Jephcott was a true supporter of old style business where personal contact, reliable service and a useful product came before profit. He expected no direct *quid pro quo* and expended great efforts throughout his professional career to provide the best technical options for anaesthetists and their patients.

A B Baker

References

- [1] Jephcott A., A History of Longworth Scientific Instrument Co. Ltd., Regency Press: London 1988
- [2] Jephcott A., Ignition capabilities of laryngoscopes, *Anaest.Intens.Care* 1981; 9: 397-8
- [3] Jephcott A., The Macintosh laryngoscope. A historical note on its clinical and commercial developments., *Anaesthesia* 1984; 39: 474-9



Gaisford Gerald Harrison (1926-2003)

Hon. FFARCS 1990, FANZCA 1992 – South Africa

Professor Emeritus Gaisford Gerald Harrison (Gai) died recently at his home in Cape Town, South Africa. He was born there on 5th October 1926. He grew up in the Cape Province, graduating in Medicine from the University of Cape Town in 1948. He then trained in anaesthesia, completing the FFARCS (England) in 1955. Later in his career, he obtained the degree of MD and in 1993 was awarded the degree of DSc(Med), both from the University of Cape Town. In 1990, he was elected to Honorary Fellowship of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons.

His training in anaesthesia and most of his working life was spent at the Department of Anaesthetics, Groote Schuur Hospital. He rose through academic and clinical ranks to become Professor in the University of Cape Town and was Head of Department from 1981 until 1988. At that time he became Emeritus Professor but continued to be actively involved in teaching, research and writing until a few months before his death.

Gai was a tireless traveller and contributor to anaesthesia in many parts of the world. He made many visits to Australia and New Zealand. He contemplated moving to work here on more than one occasion. He was globally recognised for his work on malignant hyperpyrexia (MH) and was able to demonstrate the efficacy of dantrolene as an effective treatment for the condition using MH susceptible pigs. He was a pioneer in the field of the epidemiology of anaesthesia associated mortality. He also worked to establish the metabolic pathways of some drugs used in anaesthesia and in particular was an expert on the problems of anaesthesia in patients with porphyria - a common problem in South Africa. For his broadly based work, the University of Cape Town made him a lifetime Fellow in 1977.

Gai was good company and a wonderful host. He was an enthusiast in everything that he undertook. His lectures were carefully crafted and presented his views and knowledge succinctly and impartially. Many South African anaesthetists consider him to be a most important influence in their training.

Gai is survived by his wife, Mary and three adult children. One of his sons, Christopher, is an anaesthetist.

John M Gibbs

Highlights from the Council Meeting

OCTOBER, 2003

WELCOME

The President welcomed Dr Peter Cooke, Chairman of the New Zealand National Committee, A/Professor Geoff Gordon, Chairman of the Queensland Regional Committee and Dr Simon Maclaurin, Chairman of the Western Australian Regional Committee.

EDUCATION AND TRAINING

Communication Workshops

Council has agreed to engage the Cognitive Institute to conduct workshops on communication during the forthcoming Annual Scientific Meeting in Perth. Following this pilot it is anticipated that Communication Workshops will be available to Fellows and trainees throughout the various Regions.

Clinical Teaching Pilot Course

A Clinical Teaching Pilot Course is planned for March 2004 to enhance the educational capacity of Fellows and senior trainees involved in trainee education. It is planned that the pilot course will be a two day meeting held at 'Ulimaroa'. Participants will be representatives of the various Regions who would be expected to assist with the provision of the course in their Region. It is anticipated that 15 participants will attend the four half-day modules – Introductory Principles, Small Group Learning, Evaluation and Assessment, and Teaching in the Clinical Setting. It is envisaged that the participants will undertake a couple of hours of preparatory reading or other work and will follow up the workshop with a workplace exercise involving the application of the workshop principles.

EXAMINATIONS

Panel of Examiners – Appointment/Reappointment Process

Following the AMC Accreditation it has been necessary to establish a more structured process for the appointment/reappointment of Fellows to the Panel of Examiners. The new process was approved by Council and includes the description of the commitment of an Examiner at the time of application for appointment. Following the initial appointment of three years, the Examiner will be required to apply for reappointment, such application to include details of participation and involvement during the previous term. New Examiners will be required to undergo a full day's training prior to their participation in an examination, in addition to attending ongoing workshops for all Examiners each year.

FINANCE

Concessional Registration for Retired Fellows at Continuing Education Meetings

Whilst retirees have always enjoyed basic complimentary registration at Annual Scientific Meetings, Council considered a request that concessional registration be available to retirees at State Continuing Medical Education Meetings and Special Interest Group Meetings. Council resolved that concessional registration be offered to retirees, the extent of which is to be decided by the Organising Committee.

Fees

There has been no increase in fees for College activities for 2004 and 2005 subscriptions apart from the inclusion of GST on Trainee's Registration and Annual Training Fees.

- Subscription for ANZCA Fellows for 2005, due and payable on 1 January 2004, remains at A\$990 plus GST where applicable
- Non Fellows Participation in MOPS Program A\$500 plus GST
- OTS and OTV Accreditation Fees
 - OTS Assessment Fee (Australia) A\$1300 plus GST
 - Occupational Training Visa Assessment Fee A\$100 plus GST
- Register of Training Fee A\$950 plus GST
- Annual Training Fees for 2004
 - Australian Trainees A\$925 plus GST
 - New Zealand Trainees NZ\$925 plus GST
 - Hong Kong Trainees A\$925
 - Malaysian Trainees MYR 925 (converted into A\$)
 - Singapore Trainees S\$925 (To be capped at an amount in AUD, equivalent to that paid by Australian Trainees)
- Examination Entry Fee A\$1900

Subscription Concessions

The College Subscription Concessions were reviewed and resolved as follows:

1. Fellows over the age of 60 years, but less than 65 years 25%
2. Fellows over the age of 65 years practising any form of medicine 50%

- | | |
|---|------|
| 3. Fellows under the age of 65 years practising medicine but not practising anaesthesia, intensive care medicine, pain medicine or related disciplines | 50% |
| 4. Fellows not practising any form of medicine | 100% |
| 5. Fellows working in a missionary or similar field where the income is small | 100% |
| 6. Fellows engaged in full-time College-funded or College-approved research and undertaking no more than two clinical sessions per week | 50% |
| 7. Fellows undertaking two or less sessions per week over one full year in anaesthesia, intensive care medicine or pain medicine, not practising any other form of medicine or related activity | 50% |
| 8. Fellows resident outside Australia and New Zealand | 50% |
| 9. Fellows resident outside Australia, New Zealand, Hong Kong, Singapore or Malaysia after five years of residency outside these countries | 75% |

Council has deleted the 80% concession for Fellows of the Joint Faculty of Intensive Care Medicine wishing to maintain their FANZCA. As the Joint Faculty of Intensive Care Medicine prepares to move to financial independence this concessional subscription has been withdrawn. In addition, all Fellows retiring from practice will be granted a 100% subscription exemption whilst continuing to enjoy all other privileges of Fellowship. The subscription exemption for Fellows over the age of 70 years but continuing in some form of practice has been deleted.

ANZCA International Scholarship

The ANZCA International Scholarship for 2004 has been awarded to Dr Nguyen Tat Nghiem (Vietnam).

INTERNAL AFFAIRS

Joint Consultative Committee on Anaesthesia (JCCA)

Council accepted the Advanced Rural Skills Curriculum in Anaesthesia for the purposes of training and accrediting GP Anaesthetists.

Recognition as a Specialist in Anaesthesia

A rewrite of Regulation 23 was approved by Council and is printed elsewhere in this Bulletin

Library

The Library's provision of on line anaesthetic journals has been extremely popular and strongly utilised by Fellows. Council was made aware that the charges for this initiative are escalating, however, the Library is committed to continue this service and is pursuing other means of access. Council agreed to continue to support this initiative as a service to Fellows and trainees.

Gilbert Troup Lecture

Council agreed to a request to recognise and honour the late Dr Gilbert Troup with the inclusion of the Gilbert Troup Lecture at the forthcoming 2004 Annual Scientific Meeting in Perth.

Overseas Trained Specialist Process

The current process has been reviewed to allow a reduction in the Clinical Practice Assessment period following a successful Performance Assessment, provided the practitioner has completed a total of five years of supervised practice including previous training for their specialist qualification. A copy of the revised document is available from the College website.

CONTINUING EDUCATION AND QUALITY ASSURANCE

2003 Annual Scientific Meeting – Presentations by Professor Ted Eger

Council has agreed to a request from Baxter Healthcare that the Gwen Wilson Lecture, including slides, delivered by Professor Ted Eger during the Annual Scientific Meeting in Hobart be distributed to Fellows on CD.

2004 Annual Scientific Meeting – Perth

His Honour Justice Ipp, Federal Appeal Court Judge, has accepted the invitation to deliver the Oration at the College Ceremony in Perth.

2005 Annual Scientific Meeting – Auckland

Dr Leona Wilson was appointed the Councillor to the Organising Committee.

Australasian Anaesthesia 2003

The 2003 edition of Australasian Anaesthesia will be launched at a function to be held in the College Office in Sydney on Monday, 1 December 2003.

Clinical Indicators Working Party

At the request of the ACHS, the Clinical Indicators Working Party has been reconvened to review the current Anaesthetic Clinical Indicators. The Working Party is chaired by Dr Diana Khursandi and will include representatives from the Acute Pain and Obstetric Anaesthesia Special Interest Groups with a view to developing Indicators in those areas, with the Day Care Anaesthesia Special Interest Group to review existing Clinical Indicators. Paediatrics has been highlighted as another potential area for inclusion.

ANAESTHESIA CONTINUING EDUCATION COORDINATING COMMITTEE

Satellite Meetings to Large National Meetings

The need for early communication with Convenors of the ASM or NSC is required from SIGs to ensure appropriate planning and smooth running of all meetings.

Combined Mailing List

In an endeavour to compile a mailing list of the anaesthetic community to enable full distribution of material relating to National Scientific Meetings, it is proposed that

authorisation be included on the subscription notices of the College, the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists providing the opportunity for Fellows/Members to either accept or decline the inclusion of their mailing details on a combined mailing list. This combined mailing list would then be available to the College and Societies for the purpose of dissemination of material relating to CME meetings only.

Unfortunately, under the Privacy Act it is not possible for the various organisations' databases to be matched thus resulting in either multiple copies of material being received by Fellows or, in some cases, not at all. In addition to being a very costly exercise, this is most frustrating for organisers and it has been agreed to again attempt to establish a combined mailing list for these purposes.

Election to Fellowship

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

Dr Peter Tolley (Vic)
Dr Joseph John Herbert Scherriff (NZ)
Dr Jone Irene Sutherland (Vic)
Dr Michele Anne Duffy (Tas)

ANZCA Council Citation

An ANZCA Council Citation was awarded to Dr Carl Edmonds (NSW) for his contributions to Diving Medicine. This Citation will be presented to Dr Edmonds at an appropriate occasion.

PROFESSIONAL DOCUMENTS

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

- PS7 *Recommendations on the Pre-Anaesthesia Consultation*
- PS8 *Guidelines on the Assistant to the Anaesthetists*
- TE11 *Formal Project Guidelines*

Report of Audit of 2002 MOPS Returns



Dr Leona Wilson

The rate of participation in MOPS has increased across the Fellowship from 38% in 2001 to 47% in 2002. The number of Fellows who met the criteria for the year has also increased slightly.

The biggest increase in Fellow participation occurred in NSW where compulsory evidence of CPD was introduced as a requirement of registration (from 44% in 2001 to 62% in 2002). Tasmania also had a significant increase from 29% in 2001 to 44% in 2002. West Australia and South Australia continue to have low participation rates. New Zealand participation remained high at 84% of Fellows. 110 non Fellows submitted returns; 65 of whom were from New Zealand.

The participation in Professional Practice Review and Hospital Attachments increased; as did that in Simulator and Skills Laboratory Courses. These are all activities that have been identified as likely to improve practice.

The 2002 calendar year was the first year where the Online and Paper Diaries were the two alternatives. About half the participants submitted an annual return using the Online Diary.

Overall the feedback received regarding the web based diary has been positive. A few participants were unaware that they still needed to go through a submission process. A few complaints were received regarding the slowness of the program and the cost of being online. The speed of the program is something we hope to address in the next revision of the program.

For the 2002 program a declaration was included in the annual return. The declaration was to certify that the participant had been continuously registered with a Medical Board/Council, was willing to provide evidence of their MOPS activities if audited, was free from chemical dependence and did not have any illness which prevented them from practicing anaesthesia safely. Because of the difficulty in auditing freedom from chemical dependence and illness that prevented practising anaesthesia safely, those two declarations have been deleted.

For the 2003 year, the certificates of those who did not meet the criteria will indicate which criterion was not met, and in the case of QA and CME points, the number of points credited.

An audit of returns was conducted.

1. 40 participants were randomly selected for auditing. 37 returned the documentation supporting their returns. Returns from the other 3 are still awaited. The participants audited came from QLD (9), VIC (5), NSW (8), NZ (4), SA (6), WA (2), TAS (2), and HK (4).

2. The members of the CE & QA committee who are also Councillors performed the audit.

3. The returns were audited according to the criteria set out in the programme manual, that is accuracy of returns and relevance of activities.

4. Results:

- 25 returns had no errors,
- 9 returns had minor errors,
- 3 returns had significant errors in documentation.

5. The auditors were pleased to see the range of activities that participants had taken part in. It was also noted that some participants had under claimed, in that when reviewing the documentation, it was apparent that they could have claimed for more activities to be credited in their return.

6. The auditors considered that the activities that the participants recorded were relevant to their practice.

7. Recommendations (many of these are repeated from the 1999, 2000 and 2001 audits):

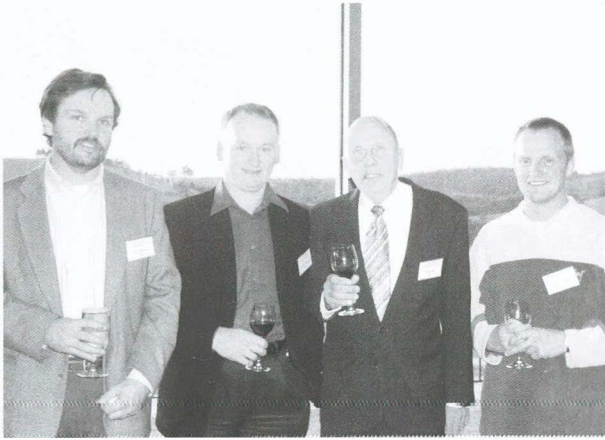
- Participants claiming attendance at major QA meetings should ensure that the meeting does meet the definition of major QA meetings in the MOPS manual, if prior points assignment has not been made.
- The documentation of attendance at local CME and QA meetings should be improved; I would recommend that an attendance register is kept for such meetings, and if possible, annual statements of attendance issued.
- Participants will be reminded of the definitions of local QA meetings, QA committee meetings and major QA meetings, and that there are separate points for participants and presenters / instructors for the activities.
- The same format and timetable should be used for next year. Selected Councillor members of CE & QA will be asked to perform the audit of 40 randomly selected returns.
- Those participants who had major errors in documentation will not be exempt from audits for the next five years; from 2004, those with major errors should be selected for audit the following year.

8. The auditors made a note of any outstanding issues with each participant's returns, and these were notified to the participant when the material was returned to them.

Leona Wilson
QA / MOPS Officer

SIMULATION AND SKILLS TRAINING SIG CME

The Simulation and Skills Training Special Interest Group held its 2nd Continuing Education Meeting on 29 September to 1 October 2003 at the Sebel Lodge, Yarra Valley. The theme of the meeting was *Advancing Education Through Human Patient Simulation*. The meeting was a great success, particularly the highly entertaining show and tell session of simulator tricks and presentations from flight simulator experts.



Welcome Drinks – Drs Brian Robinson, Brendan Flanagan, Mr Ray Page and Dr Rob Frengley



Mannequin Display



Workshop Session



Conference Dinner at Yering Station – Drs Debra Nestel, Kevin Arthur, TW Lee, Michael Bujour, Rob Frengley, Michele Joseph, Prof. Don Harrison, Mrs Suzanne Harrison and Dr Leonie Watterson.

SUPPORT SCHEME FOR RURAL SPECIALISTS and RURAL ADVANCED SPECIALIST TRAINEE SCHEME



Professor Garry Phillips

SUPPORT SCHEME FOR RURAL SPECIALISTS (SSRS)

The Support Scheme for Rural Specialists (see Bulletin August 2003, p.3) has reached its first milestone for the College. Two, two-day courses in Clinical Crisis Management were held in Orange on 12th and 13th, and 14th and 15th September. A team of instructors and technical staff brought a high fidelity simulator and support equipment from the Simulation Centre, Southern Health, Monash Medical Centre to Orange in an event filled trip. Orange Base Hospital provided the venue for the course, which was attended by anaesthetists, intensive care, and emergency medicine specialists from eleven rural centres.

The two, two-day courses to be held in Cairns on 24th and 25th, and 26th and 27th October were nearly fully subscribed by the end of September.

RURAL ADVANCED SPECIALIST TRAINEE SCHEME (RASTS)

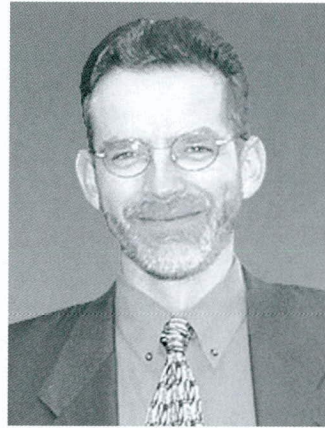
The Rural Advanced Specialist Trainee Scheme (see Bulletin August 2003, p.3) pilot video conference series finished on the 2nd October. The topics and format were varied, depending on the subject matter and the presenter. Four sites (Melbourne, Sydney, Adelaide and Perth) were used to deliver the series to twenty three rural locations in all states and the Northern Territory. At any one time, the College has up to 50 trainees in rural hospitals, in all years of training, so the potential for distance education delivery is considerable.

Evaluation

Both the SSRS and the RASTS projects are being evaluated to assess the potential for future delivery of similar projects in 2004. A number of factors will be taken into account in planning, including ways of making the material available to more centres, particularly the more remote, in Australia, as well as to New Zealand. Both pilot programs were funded by the Commonwealth Department of Health and Ageing, without which funding from other sources will have to be considered, as the cost of these projects is high.

Feedback has been sought from participants in both projects, but Fellows and trainees are all invited to comment, especially with suggestions about other ways of reaching those not easily able to attend education sessions in the cities.

GARRY PHILLIPS
Director of Professional Affairs



Education Report

Russell W. Jones, Director of Education, ANZCA

The 2004 FANZCA Training Program

Overview

The Revised FANZCA Training Program (FTP) will commence for all Trainees at the beginning of the 2004 hospital employment year. The FTP will apply to all Trainees who do not complete their training under the current program prior to the commencement of the 2004 hospital employment year. Naturally this will include all new Trainees who commence after the beginning of the 2004 hospital employment year. All Trainees in good standing in the current FANZCA Training Program at the commencement of the 2004 hospital year will automatically be accepted into the FTP. New candidates are eligible for entry into the FTP when they have completed at least 24 months of clinical general hospital experience, which may include up to 6 months of anaesthesia and/or intensive care medicine. The FTP will comprise five years of approved vocational training:

- Year 1 = Basic Training Year 1 (BTY 1)
- Year 2 = Basic Training Year 2 (BTY 2)
- Year 3 = Advanced Training Year 1 (ATY 1)
- Year 4 = Advanced Training Year 2 (ATY 2)
- Year 5 = Advanced Training Year 3 (ATY 3)

Modules

The FTP divides the curriculum into components called 'modules'. Each module matches specific learning objectives with clinical experience. It is important to note that modules are not necessarily fixed dedicated rotations. Rather they are a concept to record experience gained during training. The FTP comprises 12 modules:

- Module 1 Introduction to Anaesthesia and Pain Management
- Module 2 Professional Attributes

- Module 3 Anaesthesia for Major and Emergency Surgery
- Module 4 Obstetric Anaesthesia and Analgesia
- Module 5 Anaesthesia for Cardiac, Thoracic and Vascular Surgery
- Module 6 Neuroanaesthesia
- Module 7 Anaesthesia for ENT, Eye, Dental and Maxillofacial Surgery
- Module 8 Paediatric Anaesthesia
- Module 9 Intensive Care
- Module 10 Pain Medicine – Advanced Module
- Module 11 Education and Scientific Enquiry
- Module 12 Professional Practice

More than one module can be undertaken concurrently. Experience to complete some clinical modules may be obtained outside a dedicated 'block' if appropriate experience is available. Experience in a module may be gained in part or in full outside the Trainee's base hospital. The Supervisor of Training (SOT) of a hospital is responsible for all Trainees working at the hospital. Training requires 33 months in clinical anaesthesia and at least 3 months in Intensive Care.

Module Supervisors

To assist with the FTP, Module Supervisors will be appointed in some hospitals. They will be responsible for:

- Knowing module learning objectives, required clinical experience and assessment.
- Guiding Trainees in setting goals and gaining appropriate experience.
- Signing off on module assessment.
- Participating in In-Training Assessment (ITA) and assisting SOT(s).

In some smaller hospitals it is likely that the SOT may choose to assume the role of Module Supervisor.

Module Completion

Requirements for module completion are specific to each module. For example, for module 2 Trainees are required to complete assigned reading and the self-assessment test. Other modules may require completion of clinical activities. Specific requirements are stated in the curriculum documents associated with each module. Validation of module completion is undertaken by the Module Supervisor if there is one, or the SOT of the hospital where the Trainee has spent the most time in the module. Modules are completed once a Trainee has confirmed with the Module Supervisor (or SOT) that he or she has:

- Completed specified clinical experience.
- Achieved the 'Core Aims' stated in the module curriculum.
- Completed all module specific assessments.

Confirmation of completion is to be provided by the Module Supervisor (or SOT) in discussion with the Trainee, using the Learning Portfolio.

Basic Training

Basic Training consists of two years. During this time a Trainee must:

- Complete modules 1-3 and at least one of the clinical modules (clinical modules are modules 4-9).
- Pass the Professional Attributes web-based self-assessment test.
- Pass the Primary Examination.

After successfully completing BTY 1 a Trainee will remain in BTY 2 until they complete requirements to enter ATY 1. A Trainee must complete an EMAC (Effective Management of Anaesthetic Crises) or EMST (Early Management of Severe Trauma) course sometime during their training. It is recommended that this be completed during BTY 1 or BTY 2.

Advanced Training

Advanced Training consists of three years. During this time a Trainee must:

- Complete the remaining clinical modules (ie, the remaining modules 4-9).
- Complete modules 10-12.
- Pass the Final Examination.
- Complete the Formal Project (unless this project has been approved prior to the 2004 hospital employment year). The Formal Project has been retained in the FTP and is incorporated into module 11.

Overseas Experience

Trainees may spend up to 12 months undergoing training overseas in each of Basic Vocational Training and Advanced Vocational Training. It is essential that prospective approval is sought and obtained from the Assessor prior to the Trainee undertaking such experience.

Further, the training provided must be acceptable to the College and comparable to that required for satisfactory completion of applicable Training modules. Trainees may apply for retrospective approval of some prior training subject to the requirements of Regulations 15.3 and 15.4.

Assessment

The Primary and Final Examinations will be retained in the FTP. These Examinations will continue to evolve to keep abreast of evolution within anaesthesia. The Primary Examination must be completed before a Trainee can commence their Advanced Training. The Primary Examination can be sat any time after a Trainee is registered with the College provided they have completed 12 months of General Hospital Experience. The Final Examination must be completed during ATY 2 or 3 after completing the clinical modules (ie, modules 4-9). The current ITA system will remain, with regular goal setting/feedback interviews. Recording of clinical experience and of the learning objectives associated with each module will also occur.

Self-Assessment Tests

The FTP has incorporated two web-based Self-Assessment Tests; the first for module 2 and the second for module 12. These tests each contain 40 questions. A Trainee may apply to sit a Self-Assessment Test when they have achieved sufficient mastery of the educational outcomes associated with module 2 or 12. The tests are web-based and Trainees will need to log onto the ANZCA website. Trainees should treat the Self-Assessment Tests as they would a normal examination with the exception that they may work through the multiple-choice questions at their own pace and convenience. Trainees will receive initial feedback as to performance on the tests and copies of Trainee responses will be automatically forwarded to the College.

Learning Portfolio

Trainees will receive a Learning Portfolio from the College. Trainees will be responsible for their own Learning Portfolios (not SOTs, Module Supervisors or the College). This responsibility includes ensuring all entries are complete, accurate and up-to-date. A Learning Portfolio is a detailed inventory that allows the Trainee to record and reflect on processes and key events during their entire FANZCA training period. Specifically the Portfolio shows the Trainee's progress as records of modules completed, clinical experience gained, special cases undertaken, skills learned and assessments completed.

The Learning Portfolio has four sections:

1. Records of Training. These include details on registration, training posts, Basic and Advanced Training, assessments and examinations.
2. Records of Modules. These include clinical experience (clinical sessions), Learning Plans (including time management), a self-appraisal for each module and a sign-off sheet for Module Supervisors (except for modules 2, 11 and 12).

3. Records of Continuing Professional Development. These include records of learning experience in clinical skills, education skills, academic activities and continuing education.
4. Reflective Learning. Although there is a reflection component in other sections, reflective learning is executed and recorded in this section.

Effective self-directed learning depends on self-planning and self-reflection. Use of a Learning Portfolio allows learning to be planned and recorded. It also adds value to the learning experience thorough reviewing, reflecting on, and assessing the learning experience. Learning Portfolios are a useful foundation to discuss training with Supervisors. Learning Portfolios are also quality assurance tools to continually improve learning and performance.

They:

- Allow the Trainee to establish Learning Plans (and revise them when necessary), schedules for Time Management and Reflective-Learning.
- Remind the Trainee of the Objectives of Training and the Attributes of a Specialist Anaesthetist that they are to achieve.
- Promote self-directed learning.
- Help the Trainee and their Supervisors plan and implement training and develop critical and reflective learning and practice.

Regulations 14 and 15 and Professional Documents TE1, TE2, TE3, TE5, TE8, TE10 and TE17 are useful reference documents in relation to the FTP. All have been changed substantially from the documents in force until the end of 2003. In particular, TE2, TE8 and TE10 are completely new documents.



Professor Garry Phillips

Australian Council For Safety and Quality in Health Care Agenda

The Australian Council for Safety and Quality in Health Care (ACSQHC), sometimes referred to as the 'Barraclough Council', has released nine reports in 2003. Fellows will recall the publicity surrounding publication of 'The quality in Australian health care study' by Ross Wilson, Bill Runciman et al in the Medical Journal of Australia in 1995, when the Federal Health Minister 'jumped the gun' with media releases of the terrible cost of adverse events in hospitals.

The Australian Health Ministers established the Taskforce on Quality in Australian Health Care in 1995, then the National Expert Advisory Group of Safety and Quality in Australian Health Care in 1996, then the ACSQHC in 2000. Two and a half years later the multiple reports now available indicate the broad approach taken by the Council.

Some of the reports are of general interest, and some have a more specific focus.

1. **Patient Safety: Towards Sustainable Improvement** is the Fourth Report of the Council to the Australian Health Ministers' Conference (July 2003). It is a very positive, forward-looking document, which proposes a range of initiatives, many already under way, to 'redesign systems of health care to facilitate a culture of safety.'
2. **Standards Setting and Accreditation Systems in Health: Consultation Paper** sets out to address a number of issues relating to standards development and processes including the quality of standards; access to standards; accreditation processes; organisational impact and responses to accreditation. The paper notes that while accreditation is accepted as a valuable method of assisting health care organisations to improve the safety and quality of care they provide, its direct impact on safety and quality of care has not been determined by research.
3. **Safe Staffing: Discussion Paper** is sure to generate a lot of interest. The paper refers to the AMA 'National Code of Practice - Hours of Work, Shift Work and Rostering for Hospital Doctors', published in 1999, the follow up paper 'Risk Assessment of Junior Doctor Rosters' (2001), some of the findings of the AIMS study and Alan Merry and Alexander McCall Smith's book

'Errors, Medicine and the Law' (2001). An interesting section is 'Unintended consequences, trade-offs and cost', with mention of a number of examples: (a) 'one of the contributing factors to the KLM crash at Tenerife was the chief pilot's awareness that if he did not take off quickly the crew would exceed their allowable hours'; (b) 'In Holland where they moved to a maximum of 48-hour weeks for junior medical staff, they have required 1000 extra positions to fill the gaps'; (c) 'Patients and communities, when forced to make a choice between no service and a poor quality service have shown their bias for the latter'. This paper is available and open for comment via the ACSQHC website.

4. **Improving the Consistency of Approaches to Qualified Privilege Schemes** is a report which examines the issues surrounding the development of a model national legislation in lieu of the current separate Commonwealth, State and Territory legislations, which differ significantly. The time frame for change seems likely to be long.
5. **Open Disclosure Standard: A National Standard for Open Communication in Public and Private Hospitals following an Adverse Event in Health Care** will be of particular interest to Fellows. The standard 'provides a framework for communication with patients and their support person following an adverse event' (as defined by Wilson, Runciman et al., *Quality in Health Care Study*. Med. J. Aust. 1995;163:458-471). The principles for open disclosure espoused by the document include (i) openness and timeliness of communication; (ii) acknowledgement of the adverse event; (iii) expression of regret; (iv) recognition of the reasonable expectations of patients and their support person; (v) staff support; (vi) integrated risk management and systems improvement; (vii) good governance; (viii) confidentiality. Under 'Staff Support', health care organisations are advised to:
 - Provide advice and training on the management of adverse events
 - Promote an environment that fosters peer support and discourages the attribution of blame
 - Ensure that staff are not discriminated against

- Provide facilities for formal or informal debriefing of staff involved in an adverse event, where appropriate, as part of the support system and separate from the requirement to provide statements for the purpose of investigation
- Provide information to staff involved in the adverse event on the investigation and its outcomes
- Provide information on the support systems currently available for staff distressed by adverse events and encourage timely consultation
- Give consideration to developing specific systems of support in their own institutions or in collaboration with neighbouring facilities.

The standard outlines organisational responsibilities, legal considerations, and details the open disclosure process.

6. **National Strategy to address Health Care associated Infections** was a surprise. I had thought that the 'Infection Control Guidelines' endorsed by the National Health and Medical Research Council and the Australian National Council on AIDS (1996) was up to date but the May 2002 Draft Version 3 is yet to be completed. The ACSQHC has recommended that a National Health Care Associated Infections National Advisory Committee be established to provide national leadership in this area. The reasons are impressive: some 180,000 health care associated infections may occur in Australia each year, with 7,000 deaths, many of which could be prevented. It is estimated that

surgical site infections could be costing as much as \$268 million per year, and that the total annual health care costs associated with bloodstream infections may be as high as \$686 million.

All of the above documents are available from the Australian Council for Safety and Quality in Health Care via their website www.safetyandquality.org; Tel: 02 6289 4244; Email safetyandquality@health.gov.au.

Related publications accessible via the ANZCA website www.anzca.edu.au include: P28 (1995) Policy on Infection Control in Anaesthesia (to be updated when the Infection Control Guidelines have been completed.); PS43 (2001) Statement on Fatigue and the Anaesthetist; AP11 Welfare of Anaesthetists' Group Action Plans.

Not yet available, but in the later stages of preparation, is the **Credentials and Clinical Privileges Project**, which is developing a national standard and organisational support package to assist health care organisations to establish appropriate processes for credentialling and clinical privileging. The objectives of these processes are to allow verification and evaluation of the qualifications and experience of an individual medical practitioner, as well as delineating the scope of practice of the individual within the particular health care organisation. The process also covers ongoing review of performance, and support of professional development.

Garry Phillips
Director of Professional Affairs

Prize Sessions for Research Papers at ANZCA ASM

The Prize Sessions at the Annual Scientific Meeting of ANZCA are designed to showcase research performed by the newer members of the College fraternity and to encourage them to pursue their interests in research in anaesthesia, intensive care medicine and pain medicine.

Gilbert Brown Prize



Dr Gilbert Brown

The Gilbert Brown Prize was established by the Faculty of Anaesthetists, RACS, in 1961 to honour Dr Gilbert Brown.

Dr Brown was born and educated in England. He was the first anaesthetist appointed to the Adelaide Children's Hospital (1920) and the Royal Adelaide Hospital (1921). Dr Brown was the first President of the Australian Society of Anaesthetists and was a Foundation Fellow of the Faculty of Anaesthetists, RACS. He had a life long commitment to scientific enquiry and teaching.

The Gilbert Brown Prize session is given a prominent place at the ASM. The presentation and questions are usually of a high standard and the competition is lively! As you can see, the list of previous winners is an interesting and varied group.

Fellows within eight years of obtaining their Diploma of Fellowship who have conducted research in anaesthesia, intensive care medicine and pain medicine are invited to submit their abstracts for inclusion in this exciting session

Previous Winners of the Gilbert Brown Prize Faculty of Anaesthetists, RACS

1963	Bruce Warren Gunner New South Wales	1976	Malcolm McDougal Fisher New Zealand
1964	Trevor Talbot Currie Victoria	1977	Thomas Christopher Kenneth Brown Victoria
1965	John Francis Mainland Victoria	1978	Karl Douglas Alexander Victoria
1966	M R Milne Western Australia	1978	William Ben Runciman South Australia
1967	Teresa Rita Brophy Queensland	1979	Robert Oliver Edeson Western Australia
1968	Trevor Talbot Currie Victoria	1980	Walter John Russell South Australia
1970	Alexander Waddell Squire New Zealand	1981	Richard Woodleigh Davis South Australia
1972	John Michael Gibbs New Zealand	1982	Session not held
1973	Frank David Pilditch Queensland	1983	Peter Edgeworth Lillie South Australia
1973	Anthony John Newson New Zealand	1984	Charles Marcel Domaingue Victoria
1974	Neville James Davis Western Australia	1985	Navaratnam Sivanewaran New South Wales
1975	Thomas Andrew Gabriel Torda New South Wales	1986	Michael Martyn Tasmania
		1986	Craig Nancarrow South Australia

1987	Stevenson Philip Petito South Australia	1995	Katherine Leslie Victoria
1988	Edward John McArdle Queensland	1996	Paul Stewart Myles Victoria
1989	Mark Robert Upton South Australia	1997	Warwick Dean Ngan Kee Hong Kong
1990	David Bruce Frederick Cottee New South Wales	1998	John Thomas Moloney Victoria
1991	Tony Gin Hong Kong	1999	Philip Bruce Cornish New Zealand
Australian and New Zealand College of Anaesthetists			
1992	Neil Raymond Warwick New South Wales	2000	Adam Philip Tucker Victoria
1993	Suen Ka Lok Hong Kong	2001	Winifred Jeannette Burnett Victoria
1994	Alexander Leslie Garden New Zealand	2002	Richard Anthony French New Zealand
		2003	Kwok Ming Ho Hong Kong

2004 Simulation/Education Grant Award

Dr Leonie Watterson (NSW)

\$12,700 (2 Year Grant)

Evaluation of simulation training transfer on skills acquisition and subsequent learning behaviours



2004 Research Grant Awards

The following Research Grants for 2004, recommended by the Research Committee, were awarded by Council at the October Council Meeting:

 <p>Associate Professor Bala Venkatesh (QLD) \$35,000 <i>Modulating cell death with anti-PARP and anti-caspase to improve outcome in hemorrhagic shock</i></p>	 <p>Dr Tony Chow (VIC) \$20,000 (Grant in Aid) <i>A multi-centre randomised controlled trial to prevent chronic post-amputation pain</i></p>	 <p>Associate Professor Kate Leslie (VIC) \$19,529 <i>Intravenous rehydration to prevent hypotension in patients undergoing colonoscopy</i></p>
 <p>Dr Gerald Power (QLD) \$22,358 <i>The effect of an epidural blood patch on physiology cerebrospinal fluid</i></p>	 <p>Dr Adam Tucker (VIC) \$40,000 <i>Creating an anaesthetic knowledge map: extraction of new information from Medline using text-mining</i></p>	 <p>Dr Neil Pollock (NZ) \$49,872 <i>Identification and characterisation of mutations in RYR1 that cause malignant hyperthermia</i></p>
 <p>Professor Stephan Schug (WA) \$39,840 <i>Pharmacokinetics of sublingual ketamine for pain treatment</i></p>	 <p>Associate Professor Michael Paech (WA) <i>Epidural blood patch: volume and efficacy</i> \$15,617 (2 year Grant) <i>Intranasal analgesia: the pharmacokinetics and clinical efficacy of hydromorphone nasal spray</i> \$27,979 <i>Safety of tramadol in breastfeeding: a study of post-operative use following caesarean section</i> \$37,128 (2 year Grant)</p>	

The **Harry Daly Research Award** was awarded to Dr Neil Pollock for his project '*Identification and characterization of mutations in RYR1 that cause malignant hyperthermia.*'

The **Organon Research Award** was awarded to Professor Stephan Schug for his project '*Pharmacokinetics of sublingual ketamine for pain treatment.*'

Primary Examination

July/September 2003

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

The viva examination was held at College Headquarters, Melbourne.

A total of one hundred and fifty nine (159) candidates presented for the Primary Examination and one hundred and eleven (111) candidates were approved.

One hundred and forty five (145) candidates presented for the Pharmacology Module and one hundred and eighty three (183) candidates presented for the Physiology Module.

SUCCESSFUL CANDIDATES:

Penelope Jane Alderson	QLD	Claire Elizabeth Ann Frost	NZ
Vanessa Kathryn Andean	VIC	Winnie Wing Lei Fung	NSW
Nicole Leanne Anderson	QLD	Anil Singh Gill	MAL
Bronwyn Jane Avard	NSW	Rachael Sarah Glew	NZ
Maryanne Balkin	VIC	Maria Masha Golikov	QLD
Jarrett Barker-Whittle	NSW	Yukiko Goto	WA
Renee Gail Beer	VIC	Simon Thomas Gower	VIC
David Belavy	QLD	Cameron Scott Graydon	VIC
Aaron Joseph Bellette	ACT	Andrew Benjamin Green	VIC
Barry Wayne Benham	QLD	Robert Hackett	NSW
Aparna Bhatt	NSW	Sarah Louise Hedges	TAS
Rebecca Jane Branch	NZ	Andrew Peter Hehir	NSW
Roger Malcolm Browning	NZ	Christopher Owen Jackson	SA
Katharine Emily Brunette	NZ	Daniel Howard Jolley	NT
Van Tung Bui	NSW	Delyth Angharad Jones	NSW
Jane Frances Calder	NZ	Navkiran Kaur	NSW
Michelle Yee Ling Chan	VIC	Elizabeth Karlie Keating	ACT
Brett Arthur Chaseling	QLD	Kong Kau Fung Vincent	HKG
John Andrew Chippendale	QLD	Michal Zdzislaw Kulisiewicz	NSW
Brett Daniel Coleman	VIC	Tai Quy Lam	NSW
Kathleen Mary Cooke	QLD	Thien Le Cong	SA
Tamara Joan Culnane	WA	Gene Sit Yee Lee	NSW
Lisa Louise Dayman	NSW	Lee Ka Yee	HKG
Alexandra Evan Douglas	QLD	Wan Ling Leong	SIN
Billy Markus Drew	NSW	Martyn Ian Lethbridge	QLD
Christopher Charles Duffy	WA	Ling Sing Tao, Thomas	HKG
Aruna Shantha Evana Hennedige	SA	Eu-gin Lim	NSW
Rebekah Jane Ferris	QLD	Khai-Ching Lim	VIC
Barton John Hughes Fielden	NSW	Kristen Sarah Llewelyn	SA
James Alexander Fowlie	SA	Andrew David Lo	NSW
Kate Elizabeth France	SA	Lo Chor Kwan	HKG

Francis Ling Check Loh	VIC	Andrew John Snell	SA
Knox Crichton Low	NSW	Marcus David Soo	QLD
Daniel Edward Magee	NSW	Vincent Michael Sperando	NSW
Anna Catherine McDonald	TAS	Tony Stambe	VIC
Kylie Jayne McGregor	NZ	Anna Louise Sullivan	SA
Ian Duncan Henare McKay	NZ	Alice Kathleen Summons	NSW
Martin Peter Misur	NZ	Jacqueline Vanessa Sushames	VIC
David Moore	NZ	Mark Benjamin Suss	VIC
Eleanor Margaret Moreno	VIC	Chiew Peng Tan	SIN
Nicole Cherie O'Brien	NZ	Jamal A A Tashkandi	NZ
Catherine Nabuduwa Olweny	VIC	Darren Choon Aik Teoh	VIC
George Kit Fai Pang	QLD	Benjamin Roger Towell	VIC
Jennifer Jane Philip	WA	Theresa Phuong Trinh	VIC
Brendan David Powers	NSW	Alpha Mang Sze Tung	NSW
Roger Eric Stirling Pye	NSW	Evangelos Tziavrangos	WA
Catherine Anne Quigg	VIC	Sharyn Mary Van Alphen	VIC
Frank Raineri	VIC	Burger Van Der Merwe	NZ
Hari Ravindranathan	TAS	Andrew David Weatherall	NSW
Maziar Razavian	NSW	Heidi Leigh Werder	NZ
David Jeremy Rowe	QLD	Denise Wing Yin Wong	NSW
Andrew Leigh Rubinfeld	VIC	Roger Tzekin Wong	TAS
Stefan Christian Sabato	VIC	Cheryl Lok See Yeung	HKG
Anil Jason Sen Gupta	NSW	Mark Graham Young	QLD
Caroline Anne Sharpe	VIC		
Lyndon Wai Lun Siu	VIC		
Barry Michael Slon	NZ		

RENTON PRIZE

The Renton Prize for the period ending 30th December, 2003 was awarded to **Tamara Joan Culnane** of Western Australia.

MERIT LIST

The following candidates were awarded a Merit Certificate for their performance at the July/September 2003 Primary Examination:

Daniel Howard Jolley	ACT	Roger Malcolm Browning	NZ
Christopher Charles Duffy	WA	Brett Arthur Chaseling	QLD

Final Examination

September 2003

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

The viva examination was held at Prince of Wales Hospital and Sydney Childrens' Hospital, Randwick.

SUCCESSFUL CANDIDATES:

Scott Kendall Aaronson	WA	Kwok On Ki	HK
Leinani Salamasina Aiono-Le-Tagaloa	NZ	Lan-Hoa Le	NSW
Ammar Ali Beck	NSW	Philip Seng Loong Lee	SA
David Geoffrey Allen	NZ	May Ling Lim	VIC
Peter John Allsop	NSW	Phang-Chien Lim	SA
Rafidah Atan	MAL	Lim Boon Kian	HK
Linda Aykut	NSW	Peta Gayle Lorroway	QLD
Joanne Marie Berkahn	NZ	Justine Marilyn Lowe	WA
Maged Samir Bishay	NSW	Hang Wai James Lui	NSW
Matthew Lawrence Norman Bowman	VIC	Justine Mary McCarthy	QLD
Luke Philip Bromilow	NSW	Forbes McGain	VIC
Simon Lloyd Mortlock Burrows	NSW	Brenton Clifford Millard	SA
Neroli Anne Chadderton	NZ	Helen Frances Nicol	NSW
James Dat Hing Chee	NSW	Luke John O'Halloran	VIC
Charles Maxwell Clegg	SA	Annabel Orr	VIC
Michael Peter Clifford	VIC	Michael Robert Bruce Ranger	NZ
Erin John Cook	NSW	Jason Ray	QLD
Heinrich Raubenheimer Cornelissen	NZ	Reinette Robbertze	NZ
Stephen James Davies	ACT	Christine Lee Rowe	QLD
Stuart Kenneth Day	TAS	Martin Russnak	VIC
Peter Dzendrowskyj	NZ	Joyce Savage	VIC
Tod Richard Eggleton	NSW	Catherine Ann Sayer	NZ
Anna Englin	VIC	Vera Spika	NZ
Elizabeth Anne Ferguson	WA	Kylie Marie Stanton	NSW
Kenneth Robert Fitzsimmons	QLD	Timothy Stavakis	NSW
Clement Wang Chee Fong	NSW	Fiona Louise Strahan	VIC
Fong Cheuk Ying, Cherry	HK	Tan Khong Cheong	MAL
Paul Clinton Frank	QLD	Tan Kian Hian	SING
Liadain (Lia) Anne Freestone	VIC	Adel Shokry Ishak Tanious	QLD
Matthew Rhys Grill	SA	Bernice Teh	VIC
Bruce Richard John Hammonds	NZ	Wendy Hui Ling Teoh	SING
Nicole Annette Healy	QLD	Savas Totonidis	TAS
Catherine Mary Hellier	QLD	Phong Thanh Do Tran	QLD
Sin Shing Ho	HK	Ingrid Halina Walkley	SA
Ho Whei Wern Lorraine	SING	Viraj Paul Wijeyewickrema	NZ
Lewis Charles Holford	NZ	Gail Kwei-Mun Wong	NSW
Phillip Andrew Holz	NSW	Kathy Ming-Lai Woo	NSW
Zamil Mehboob Karim	NZ	Damien Frederick Wood	QLD
Eugenie Kayak	VIC	David Andrew Wright	WA

Cecil Gray Prize

The Court of Examiners recommended that the Cecil Gray Prize for the half year ended 31 December 2003 be awarded to Dr Nicole Annette Healy, Queensland.

Merit List

The following candidates were awarded a Merit Certificate for their performance at the September 2003 Final Examination:

Dr Michael Peter Clifford	VIC	Dr Justine Marilyn Lowe	WA
Dr Matthew Rhys Grill	SA		

OTS Performance Assessment

SEPTEMBER 2003

The following candidates were successful at the recent Overseas Trained Specialist Performance Assessment and are yet to complete the requirement of the OTS Assessment process:

Meher Chinthamuneedi	QLD	Michael Hooper	QLD
Kurt Kaiser	NSW	David Rapeport	WA
John Morris	QLD	N. Reddy	NSW
Jacobus Van Westing	NSW	Peter Schenk	NZ
Niraj Vishnoi	NSW	James Schlimmer	QLD
Kerstin Weidmann	NSW	Frederick Steyn	NZ
Yatim Young	NZ	Lars Wang	WA
Weiner de Wilzem	QLD		

Erratum

The Merit List for the May 2003 Final Examination, printed in the August 2003 Bulletin (pg 44), should have indicated that Dr Anthony Charles Keeble is from Victoria (not New Zealand).

Admission to Fellowship by Examination

Robyn Sheila ALLEYN	NSW	Tania Lea MORRIS-WEBB	QLD
Suzanne Rebecca BERTRAND	WA	Nicolaas Frederick MOSTERT	NZ
David BUTLER	WA	Kar Woh NG	SA
Brenda Janet Esther CASSIDY	SA	NG Ka Lai	HK
Kin Wai CHAN	HK	Christopher John REID	VIC
Lisa Jane CHAPMAN	NZ	Patrick Brian RONCHI	VIC
Janet Oi-Ling CHEUNG	SA	Nabil Yehia SALEH	NSW
Yien Leng CHIN	SINGAPORE	Reny SEGAL	NZ
Patrick King Yan CHUNG	NSW	Jocelyne SLIMANI	SA
Patrick Joseph COLEMAN	WA	Shawn STURLAND	QLD
Ann Bernadette DUGGAN	NSW	Simon Jude TAME	NSW
Vincent Victor FONG	NZ	TAN Chee Keat	SINGAPORE
Erfan HEDAYATI	NSW	Deral TANIL	VIC
Chui Mei HEW	UK	Katherine Louise TAYLOR	NSW
Bruce John HULLETT	WA	Gabrielle Louise VAN ESSEN	VIC
Cameron Martin HUNT	NSW	Henrik Gustaf WANGEL	SA
Nicholas Chee Kong LAM	USA	Kylie Adrienne WRIGHT	VIC
LAW Cheuk San	HK	Boyd YIM	VIC
Christopher David Thomas LIESSMANN	QLD	YUEN Man Kwong	HK
LIU Kwok Kuen	HK	Tasoula ZAFIROPOULOS	VIC
Alastair John MARK	NZ	David Camillo ZOANETTI	SA
Jannett MARXSEN	VIC		
Jane Louise MORRIS	QLD		

Admission to Fellowship via OTS Performance Assessment Process

Aileen Dorothy CRAIG SA

Admission to Fellowship by Election

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

Michele Anne Katrina DUFFY	TAS	Joan Irene SUTHERLAND	VIC
Joseph John Herbert SHERRIFF	NZ	Peter Michael TOLLEY	VIC

Recognition as a Specialist in Anaesthesia

The following revised Regulation 23 "Recognition as a Specialist in Anaesthesia" was approved at the recent October Council Meeting

23. RECOGNITION AS A SPECIALIST IN ANAESTHESIA

The College does not register specialists. On request, the College will provide advice regarding specialist recognition to the relevant national and State/Territory authorities in Australia and New Zealand. Applications for registration must be made to the State/Territory Medical Boards, the Australian Medical Council or the Medical Council of New Zealand.

Definition:

The **Overseas Trained Specialist Assessment Process** is not a specialist training program, but an evaluation of the suitability of an overseas trained specialist to practice in Australia or New Zealand as an unsupervised specialist anaesthetist at a comparable standard to that required of a Fellow of the College.

- 23.1 An assessment undertaken by the College on information supplied to it does not imply any recognition by the College. Such recognition will only be granted when all of the requirements set out by the College have been satisfied.
- 23.2 Support for an application for Registration as a Specialist in Anaesthesia in Australia will be automatic in the case of a graduate in Medicine from a School recognised by the Australian Medical Council who holds the Diploma of Fellowship of the Australian and New Zealand College of Anaesthetists.
- 23.3 Support for an application for placement on the Anaesthesia section of the Vocational Register of the Medical Council of New Zealand will be automatic in the case of a graduate in Medicine from a School recognised by the Medical Council of New Zealand who holds the Diploma of Fellowship of the Australian and New Zealand College of Anaesthetists.
- 23.4 For all other applicants, support in respect of an application for Registration as a Specialist in Anaesthesia in Australia, or for placement on the Anaesthesia section of the Vocational Register of the Medical Council of New Zealand requires that:
 - 23.4.1 The applicant has a basic medical qualification which is recognised by the Australian Medical Council (for Australia) or by the Medical Council of New Zealand (for New Zealand).
 - 23.4.2 The applicant has certified documentation of Registration as a Specialist in Anaesthesia (or equivalent) in the country of origin.
 - 23.4.3 The applicant has satisfied all the requirements of the Overseas Trained Specialist Assessment Process.
- 23.5 The Overseas Trained Specialist Assessment Process will be conducted by the Overseas Trained Specialist Committee and will normally require:
 - 23.5.1 A Face-to-face Assessment Interview.
 - 23.5.2 A Structured Performance Assessment.
 - 23.5.3 A Clinical Practice Assessment Period.
- 23.6 Fees for components of the Overseas Trained Specialist Assessment Process will be determined by College Council.
- 23.7 The Face-to-face Assessment Interview will be conducted by an Overseas Trained Specialist Interview Panel which will comprise three Fellows plus a community representative.
 - 23.7.1 In Australia, the Fellows will be three of: the Assessor, the Assistant Assessor, the Chairman of the General Examinations Committee, the Chairman of the Final Examination Committee, other members of the Overseas Trained Specialist Committee, and other Councillors. The panel must include a community representative. The President will not normally be a member of the panel. The Assistant Assessor (or nominee) shall be the Chairman.
 - 23.7.2 In New Zealand, the Fellows will be three of: the Assistant Assessor for New Zealand Overseas Trained Specialists, Councillors resident in New Zealand, members of the New Zealand National Committee, other New Zealand Fellows nominated by the New Zealand National Committee. The panel must include a

community representative. The Chairman of the New Zealand National Committee will not normally be a member of the panel. The Assistant Assessor for New Zealand Overseas Trained Specialists (or nominee) shall be the Chairman.

23.8 The Interview Panel will use the following criteria to assess an applicant:

23.8.1 Specialist training, including comparability with that required by the College of its Fellows with regard to duration, structure, content, curriculum, sub-specialty experience, supervision and assessment. The onus will be on the applicant to provide evidence in this regard. Assessment will take into account the College's training requirements at the time the applicant attained his/her initial post-graduate specialist qualification in anaesthesia.

23.8.2 Specialist qualifications, substantiated by certified copies of original diplomas.

23.8.3 Specialist experience, taking account of case mix, use of equipment and drugs, and compliance with standards of practice comparable with those set out in the College's Professional Documents. References from relevant professional colleagues must be provided.

23.8.4 Evidence of participation in continuing education and quality assurance activities, comparable with the participation required of Fellows by the College's Maintenance of Professional Standards Program.

23.9 The Interview Panel will make one of the following recommendations:

23.9.1 Ineligible for further consideration under the Overseas Trained Specialist Assessment Process. Such applicants may consider applying for registration as a trainee with the College's training program.

23.9.2 Eligible to proceed to Structured Performance Assessment and Clinical Practice Assessment. The Interview Panel may at its discretion recommend exemption from the written section of the Structured Performance Assessment (see Regulation 23.10.1.1).

23.10 Structured Performance Assessments will be conducted under the direction of the Final Examination Committee, and normally at the same time as the Final Examination.

23.10.1 Such Structured Performance Assessments will comprise:

23.10.1.1 A written section, emphasising general principles and evaluating knowledge fundamental to anaesthesia practice, including clinical physiology, clinical pharmacology and clinical measurement. Exemption from the written section may be recommended by the Interview Panel if it is satisfied that the applicant has an outstanding record as a specialist anaesthetist and clinical teacher.

23.10.1.2 A clinical section, evaluating applied clinical performance in a standardised setting.

23.10.1.3 An oral section, providing a structured evaluation of the applicant's applied clinical knowledge and decision-making in a wide range of sub-specialties.

23.10.2 An entry form must be submitted and the prescribed fee paid by the specified closing date.

23.10.3 Application to sit a Structured Performance Assessment may be submitted to the College at any time subsequent to the Face-to-face Assessment Interview.

23.10.4 The Chairman of the Court of Examiners for each Final Examination shall be responsible for ensuring that applicants for a Structured Performance Assessment are informed of the outcome of their assessment as soon as is practicable after a decision has been made.

23.10.5 The Overseas Trained Specialist Committee will review the cases of applicants who are unsuccessful for a second time at their Structured Performance Assessment. The purpose of such a review is to facilitate assistance.

23.11 The Clinical Practice Assessment Period serves both to familiarise the overseas trained specialist with anaesthesia practice in Australia or New Zealand, and to enable an assessment to be made of his/her personal clinical performance.

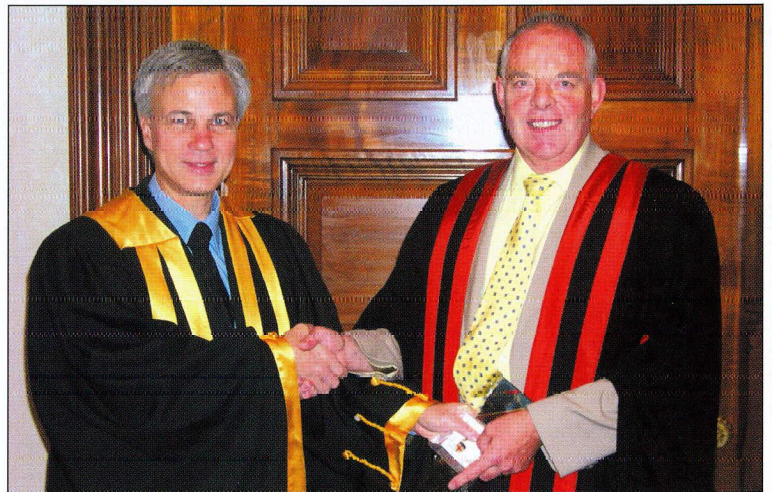
- 23.11.1 The Clinical Practice Assessment Period shall be recommended by the Interview Panel and will normally require a minimum of 12 and up to 24 consecutive months in a full-time appointment.
- 23.11.2 The appointment must be in a Department of Anaesthesia (or other organisation) in Australia or New Zealand accepted by the College as appropriate for this Assessment Period.
- 23.11.3 The appointment must satisfy any specific requirements recommended with regard to a particular applicant by the Interview Panel.
- 23.11.4 The College has no responsibility on behalf of applicants for obtaining employment in appointments suitable for assessment.
- 23.11.5 The Clinical Practice Assessment Period may commence at the earliest on the day following the Face-to-face Assessment Interview.
- 23.11.6 The Clinical Practice Assessment Period may be undertaken on a part-time basis subject to prospective approval by the Assistant Assessor (in Australia) or the Assistant Assessor for New Zealand Overseas Trained Specialists (in New Zealand).
- 23.11.7 The Overseas Trained Specialist Committee shall nominate an Applicant's Assessor to oversee each applicant's Clinical Practice Assessment Period. The Applicant's Assessor shall provide to the Assistant Assessor (in Australia) or the Assistant Assessor for New Zealand Overseas Trained Specialists (in New Zealand) proforma structured reports on the applicant's practice. These reports will be submitted after an initial three month period, at intervals on request, and at the end of the assessment period.
- 23.11.8 On the basis of the Applicant's Assessor's reports, the Overseas Trained Specialist Committee may review and modify the initial assessment requirements as recommended by the Interview Panel.
- 23.11.9 Should the Applicant's Assessor raise serious concerns regarding the adequacy of the applicant's clinical performance, the Overseas Trained Specialist Committee may recommend to College Council that the applicant be deemed ineligible to proceed further under the Overseas Trained Specialist Assessment Process. If this recommendation is accepted by Council, such applicants may consider applying for registration as a trainee with the College's training program.
- 23.11.10 The Assistant Assessor (in Australia) or the Assistant Assessor for New Zealand Overseas Trained Specialists (in New Zealand) will notify the Overseas Trained Specialist Committee of the names of applicants who have satisfactorily completed the required Clinical Practice Assessment Period.
- 23.12 Separate consideration will be given to an applicant who is seeking appointment to a Health Authority designated Area-of-Need. College support for specialist recognition will not however be granted either during or subsequent to such an appointment unless the Overseas Trained Specialist Assessment Process as set out in these Regulations has been completed satisfactorily.
- 23.13 Following satisfactory completion of all requirements specified by the College to gain its support for Registration as a Specialist in Anaesthesia in Australia, or placement on the Anaesthesia section of the Vocational Register of the Medical Council of New Zealand, including satisfactory completion of all required components of the Overseas Trained Specialist Assessment Process, applicants will be eligible to apply for admission to Fellowship of the Australian and New Zealand College of Anaesthetists. Applicants admitted to Fellowship on this basis will be deemed to have been admitted to Fellowship by Examination under Article 20(b).
- 23.14 An applicant may appeal against a College decision on a matter of process. Such an appeal will be considered according to the College's appeals procedure.

October 2003

Primary Examination July/September 2003



Dr. David Cottee with retiring Primary Examination Committee Chairman, Dr. Neville Gibbs.



Dr. Neville Gibbs (Chairman) with Dr. Paul Cartwright of the Royal College of Anaesthetists during his visit to the Primary Examination.



Court of Examiners

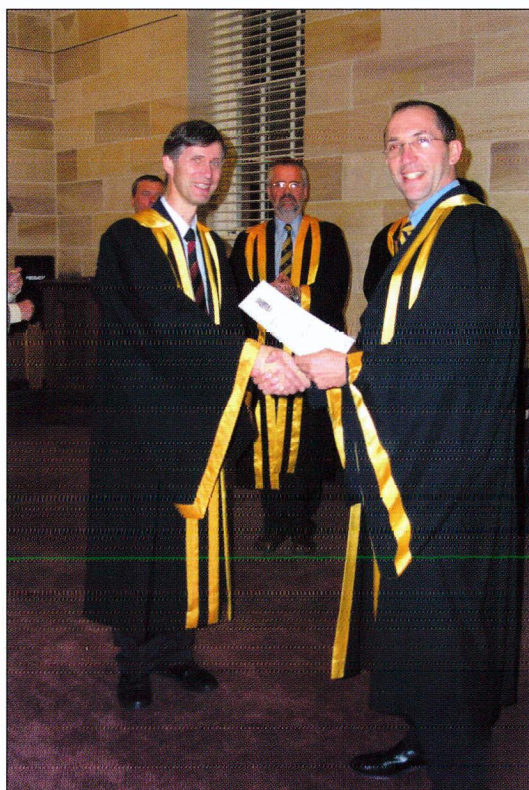
Front Row (Left to Right): Drs. Yahya Shehabi, Linda Cass, Neville Gibbs (Chairman) and Assoc. Prof. Kate Leslie

Back Row: Dr. David Story, Prof. Tony Gin, Drs. Ross MacPherson, Stephen Barratt, Steuart Henderson, John Copland, Brad Smith and Mark Langley

Final Examination September 2003



Court of Examiners

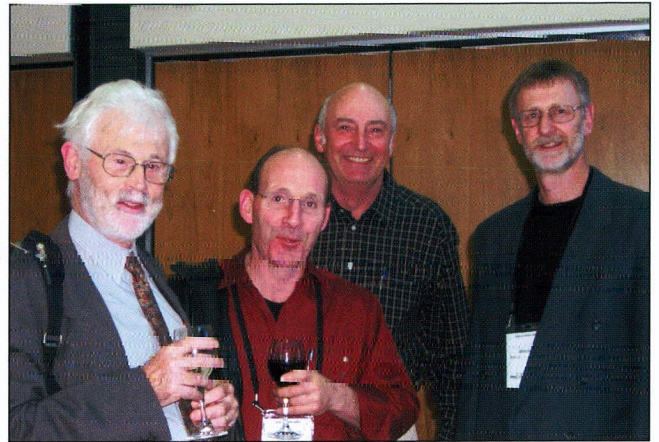


Retiring Examiner, A/Prof. David Scott with A/Prof Tony Weeks, Chairman, Final Examination Committee

The College hosted a cocktail party at ANZCA House on Friday 3 October 2003 for delegates of the ASA Congress following the AGMs of the New Zealand Society of Anaesthetists and the New Zealand National Committee, ANZCA.



Mrs Joan Sheales with Drs David Chamley and Claudia Schnieder



Prof. John Gibbs, Drs Matt Cumpbell, Vaughan Laurenson and Trevor Mitchell



The President, Dr Richard Willis with Drs Peter Cooke and Annette Turley



Dr David Fenwick presenting his sculpture "Airway" to the President, Dr Richard Willis



"AIRWAY"

The maintenance of the Oxygen Cascade is the basis of safe anaesthesia. The checking of apparatus and its application is an essential part of safety. Thus the seated figure of a young female anaesthetist is checking the inflated cuff of an endotracheal tube, while displaying a laryngoscope for its insertion and a stethoscope to check its correct position after insertion.

Photography and Anaesthesia

Mike Martyn – mmartyn@thegroup.com.au



Anaesthesia provides us with opportunities to travel and work in amazing places and with fascinating people all over the world (including at home). The ability to capture images of such places and people and share them with others is the basis of my rekindled interest in photography. As one of my mentors once said 'Anaesthesia is a fantastic hobby that helps pay for my other hobbies'. Photography has been a long standing other hobby of mine.

The move to more affordable higher quality SLR digital cameras utilising quality SLR lenses has led me to become more active again in photography. Coupled with the ability to process images digitally, with programs such as Photoshop, and easily share images over the internet makes it a much more self rewarding exercise. As well there is a vast amount of educational resources available on-line to help in developing abilities and also to get feedback.

My own personal choice earlier this year was to replace my aging Canon EOS with a Canon EOS 10D and two Canon lenses (17-40L, 28-135 IS). I have been using these

for the last three months and capturing a variety of medical and outdoor activity scenes. I am on a steep learning curve!

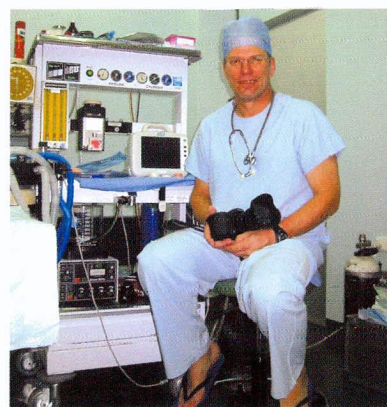
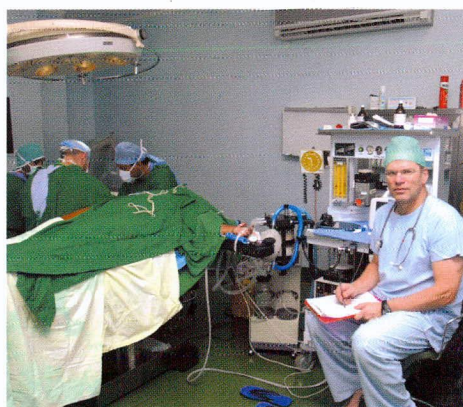
In July I was fortunate to travel to Kiribati in the Pacific as part of an Interplast Team. Such places, people and work are difficult to describe to those that haven't been there. I attempted to put together a portfolio of images that covered not only the work we did, but also gave an insight into the people and islands that we visited. These images were shown to the Australian High Commissioner, AusAID representatives, Interplast officials and published on the internet.

Photography is a long journey of awareness, knowledge and skill development. I am interested in contacting others who are on this journey.

Kiribati photos: www.pbase.com/tasmart/interplast_2003

Digital Photography Resource: www.dpreview.com

Interplast: www.interplast.com.au





Dean's Message

Neil Matthews

The ANZICS ASM in Cairns was a tremendous opportunity for me to network with Fellows and Trainees, and to explore issues of common interest at the ANZICS Board meeting. I very much congratulate David Fraenkel on his election to the ANZICS Presidency, and applaud John Santamaria for his achievements, especially during his time as President.

In Cairns, a workshop of Fellows with rural and remote practice interests vigorously and at times emotionally debated issues in support of intensive care, training and accreditation of Units. An important outcome was for an appropriate representative group to meet regularly to ensure cohesive opinions are put to the Board. The Board will need to appropriately respond to those opinions. The workshop endorsed Tony Bell as their representative on the Board, and I thank Tony for organising the workshop, maintaining appropriate discussion and achieving a good outcome. I very much welcome the Rural Focus Group's reinvigoration and for honest comment and feedback which will see us move forward.

Elsewhere in this Bulletin is a Letter from me in response to an article in the MJA proposing the development of a new, separate integrated intensive care training program. While there are issues for intensive care practice in rural settings, the problems outlined in the original article are not unique to our specialty, and will require a coordinated approach. I would welcome feedback on the issues raised in my Letter. Richard Lee, Ray Raper and myself had a preliminary meeting with the Australasian College for

Emergency Medicine to understand our varying points of view and to explore issues of common interest, and have agreed for the Executives of both groups to meet regularly.

Also in Cairns, I addressed a forum on the major workforce issues facing intensive care and the significant issues for medical students, training medical officers, rural practice and women in the workforce. Initiatives have already commenced in New South Wales by their Regional Committee, and we have formed a liaison group with ANZICS to progress these important issues. We will need to develop more appropriate forums for Trainees to have a voice on matters pertaining to them. A start is Trainee representation on our Education Committee, and the anticipated development of a Trainee Committee next year.

It has been another busy year, especially for our hard working Executive, with the development of new Regulations and our new Training Program. For me personally, it has been a stimulating and motivating year to meet with Fellows and Trainees individually and in various forums to discuss issues important to us all. On behalf of the Board, I wish you all a safe and happy new year.

A handwritten signature in black ink that reads "Neil Matthews". The signature is written in a cursive, flowing style.

N T Matthews
Dean

Admission to Fellowship of the Joint Faculty of Intensive Care Medicine

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

Robert Wilson Frengley	NZ
Mark Anthony Philip Lucey	IRELAND
Elizabeth Jane Bennett	QLD
Kush Gurunath Deshpande	SA
Mark Joseph Lennon	WA
Satyadeepak Bhonagiri	NSW
Stuart Bradley Baker	SA
Paul Brian Goldrick	QLD
Iain George Johnston	QLD

Admission to Fellowship via OTS Assessment Process

Andreas Schibler	QLD
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Rural Intensive Care

If you are involved in rural intensive care and would like to be included on an Email List, please contact the Joint Faculty office.

Appointments

SUPERVISOR OF TRAINING IN INTENSIVE CARE MEDICINE

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

Dr Emma Merry	Wellington Hospital, New Zealand
Dr Neil Widdicombe	Royal Brisbane Hospital
Dr Anne Leung Kit Hung	Pamela Youde Nethersole Eastern Hospital
Dr Paul Phipps	Royal Prince Alfred Hospital
Dr Stuart Miller	Royal Hobart Hospital
Dr Richard Lee	Royal North Shore Hospital/North Shore Private Hospital
Dr Charles Gomersall	The Prince of Wales Hospital, Hong Kong
Dr Antony Stewart	Liverpool Hospital

Items of Interest

FROM THE OCTOBER 2003 BOARD MEETING

EDUCATION AND TRAINING

The Supervisor of Training Support Kit has been revised and circulated to Supervisors, incorporating the revised training program. A range of options for acknowledging the contributions of Supervisors of Training will be explored by the Education Committee.

The Examination Committee will explore the development of a video as a training tool for examination candidates, Supervisors and examiners. To initiate this, a video prepared by the Chair of the Examination Committee Dr Peter Morley was viewed at the conclusion of the Board.

The terms of reference of the Education Committee were finalised. Representation includes a trainee, who will be appointed by a trainee committee which is currently being established. The issue of reduction of working hours and the effect on training will be addressed in collaboration with a joint ANZICS/Faculty workforce working party.

A Support Kit for Trainees to replace the current Manual on Training was approved and will be made available to Trainees registering for the revised training program in 2004. It will also be made available to current trainees via the Website.

PROFESSIONAL

Policy Documents

The Board reviewed and approved IC-11 "Guidelines for the In-Training Assessment of Trainees in Intensive Care Medicine" (reprinted elsewhere in the Bulletin). The review incorporates the requirement that in-training assessment be compulsory for all advanced training, and desirable for basic training. The ITA form will also be updated to include reference to Advanced Training.

The Board approved IC-3 "Guidelines for Intensive Care Units Seeking Accreditation for Training in Intensive Care Medicine" (published elsewhere in the Bulletin). The major amendments include the withdrawal of the S3 classification, and the requirement for C24 classified units to normally have a caseload of 750 patients per annum, a high level of illness severity and a range of specialty exposure. Policy Documents IC-1 and IC-3 have now been cross-referenced to clarify issues relating to the classification of units and training requirements.

Rural Issues

A number of initiatives are under consideration following a meeting of practitioners involved in rural practice. These include development of an email list for improved communication, the possibility of a rural representative on the Board, a face to face meeting and liaison with ANZICS.

Liaison with Australasian College for Emergency Medicine

Dialogue between the Joint Faculty and ACEM will be held to consider training and explore opportunities for collaborating on rural issues.

FINANCE

Subscription Concessions

The Board have reviewed the subscription concessions as follows:

1. Fellows over the age of 60 years, but less than 65 years 25%
2. Fellows over the age of 65 years practising any form of medicine 50%
3. Fellows under the age of 65 years practising medicine but not practising anaesthesia, intensive care medicine, pain medicine or related disciplines 50%
4. Fellows not practising any form of medicine 100%
5. Fellows working in a missionary or similar field where the income is small 100%
6. Fellows engaged in full-time College-funded or College-approved research and undertaking no more than two clinical sessions per week 50%
7. Fellows undertaking two or less sessions per week over one full year in anaesthesia, intensive care medicine or pain medicine, not practising any other form of medicine or related activity 50%
8. Fellows resident outside Australia and New Zealand 50%
9. Fellows resident outside Australia, New Zealand, Hong Kong, Singapore or Malaysia after five years of residency outside these countries 75%

It should be noted that the 80% concession for Fellows of the Australian and New Zealand College of Anaesthetists wishing to maintain their FJFICM will be rescinded from 2004.

Fees

The following fees for 2004 were struck:

1. Registration Fee for Trainees remain at A\$300 (+ GST), payable to the Melbourne Office.
2. Annual Basic Training Fee be:
Australia and Hong Kong A\$350 (+ GST where applicable). Payable to the Melbourne office
New Zealand NZ\$350 (+ NZ GST) payable to NZ office
3. Annual Advanced Training Fee:
Australia and Hong Kong A\$925 (+ GST) Payable to the Melbourne office
New Zealand NZ\$925 (+ NZ GST) payable to NZ office
4. Conditional Advanced Training Fee
Australia and Hong Kong A\$350 (+ GST where applicable) Payable to the Melbourne office
New Zealand NZ\$350 (+ NZ GST) payable to NZ office
Balance A\$575 (+ GST where applicable) NZ\$575 (+ NZ GST)
Balance payable following success at Exam and accreditation of the year as an advanced training year.
5. Fellowship Examination Entry Fee:
A\$1,900 (no GST) To be remitted to the Melbourne office.
6. Fee for non-Fellows' participation in the Maintenance of Professional Standards Program be A\$500, (+ GST where applicable).
7. That the JFICM Annual Subscription, due and payable on 1st January 2004, remain at A\$990 (+ GST where applicable), payable to the Melbourne office.
8. That the Overseas Trained Specialist Assessment Fee for 2004 remain at A\$1,300 (+ GST).
9. That the Occupational Training Visa processing fee for 2004 be increased to A\$150 (+ GST).
10. That the Area of Need Assessment fee remain at A\$250 (+ GST).

11. Fee for AON Site Visit be A\$1500 (+ GST) plus reasonable travel and accommodation costs when there is a requirement for a reviewer to attend an on-site review.

CONTINUING EDUCATION

Annual Scientific Meetings

Arrangements for the ASM in Perth are being finalised. Speakers include the Foundation Visitor from the UK, Dr Ian Roberts, Dr David Linton, Professor Michael Meisner and Dr David Burgner. Topics are based on the theme of panacea or poison, and include steroids, infection screening, oxygen, collaborative medicine and lung protection.

Professor Keith Walley was appointed as the JFICM Foundation Visitor for the Joint Faculty/ANZICS meeting to be held in Auckland in May 2005 concurrent with the ANZCA ASM.

Arrangements for the Inaugural stand alone Joint Faculty ASM were noted. This meeting will be held in Sydney in June 2005, and will be a single themed meeting on neurosciences.

The Board agreed that in future there will be continued involvement with RACP and ANZCA scientific meetings, in addition to offering a separate Joint Faculty meeting.

Maintenance of Professional Standards

The Board reviewed its current program and accepted some minor changes, to be introduced in 2004, with the implementation of an online diary. A paper diary will still be available to participants.

INTERNAL AFFAIRS

Honours and Appointments

The Board offers its congratulations to the following Fellows:

Professor G.A. Barker (Canada) – Life Time Achievement Award, The World Federation of Pediatric Intensive and Critical Care Societies

Dr Alan Duncan (WA) – Chief Editor, *Anaesthesia and Intensive Care*

Dr Peter Sharley (SA) – Order of Australia Medal, Bali Bravery Awards

Dr Di Stephens (NT) – Order of Australia Medal, Bali Bravery Awards

Revised Regulations

The Joint Faculty's Regulations have now been amended and approved by the Councils of the RACP and ANZCA. They have been revised to incorporate the changes to the training program, to take effect from December 2003. Copies of Regulation 7 relating to training and examinations are available on the Website at <http://www.jficm.anzca.edu.au/training/reg7/index.htm>

Integrated critical care: An approach to specialist cover for critical care in the rural setting

Matthews N. Integrated critical care: an approach to specialist cover for critical care in the rural setting. *MJA* 2003; 179: 511-.

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TO THE EDITOR: The article by Hore et al[1] raises many important issues for acute-care medicine in rural settings, including the need for specialists to be multiskilled and collaborate across disciplines, the lack of professional support for rural training programs and rural specialists, and the difficulty of overseeing multidisciplinary credentialling.

These issues are not unique to acute-care medicine or to the Joint Faculty of Intensive Care Medicine (JFICM). They are problems for other faculties and colleges, rural healthcare facilities and governments. Many rural specialist services in Australia and New Zealand have the benefit of considerable expertise provided by medical practitioners who are not necessarily Fellows of the relevant specialist colleges. They should be supported by collaborative efforts of the relevant colleges, which should develop initiatives to increase the numbers of specialist medical practitioners working in rural settings.

The JFICM, representing some 464 Fellows and 391 trainees, has been developing frameworks to support rural intensive care. JFICM's goals are to develop a more flexible training program to encourage rural training; to establish a rural officer on the JFICM Board; to support a rural focus group, working through rural structures with the Committee of Presidents of Medical Colleges; and to explore liaisons with other colleges.

The argument for developing a specialty of integrated critical-care medicine implies that current programs are deficient and cannot provide a holistic, integrated approach to rural acute care. Hore and colleagues

argue that "there is no formal program for training specialists for multidisciplinary rural critical-care practice". I must correct them on this point. Their proposal in fact eloquently describes the elements of the JFICM training program, which has existed since 1977. An internationally recognised and comprehensive intensive-care/critical-care training program, its status has been confirmed with its successful accreditation by the Australian Medical Council.

The authors also suggest that "critical care" is in some way different from "intensive care". This is not contemporary reality. The terms "intensive care" and "critical care" are one and the same.

Healthcare workers in rural and remote locations have collaboratively developed multidisciplinary working relationships that provide comprehensive acute and non-acute healthcare. The same approach should be used by authoritative bodies to resolve important issues for rural specialists and training programs. The issues do not require establishing a separate specialty.

The above comments notwithstanding, the suggestion by Hore and colleagues that specialties involved in acute care lead a collaborative process to strengthen clinical links is to be applauded. The discussions need to be inclusive of medical specialists working in intensive care medicine.

1. Hore CT, Lancashire W, Roberts JB, Fassett R. Integrated critical care: an approach to specialist cover for critical care in the rural setting. *Med J Aust* 2003; 179: 95-97.

Erratum

Please note that an error appears in the recently circulated Policy Document IC-1 **Minimum Standards for Intensive Care Units**. Paragraph 2.3.5 regarding 'An active research program' for Level II units should be deleted and the remaining paragraphs renumbered. An active research program for Level II units is desirable, not mandatory.

Successful Candidates – Examinations, September 2003



Back Row (from left to right): Dr Martin J. McNamara; Dr Michael F.H. Lindley-Jones; Dr Jason A. Fletcher; Dr David J.R. Morgan; Dr Stuart Baker; Dr Simon J. Morphett; Dr Christopher T. Allen.

Front: Dr P.A. Max Seet

Absent: Dr Celia M. Bradford; Dr David W. Collins; Dr Paul B. Goldrick; Dr Heike G. Koelzow; Dr Manoj K. Saxena; Dr Chai R. Soh; Dr Timothy J. Wigmore.



(From left to right) Dr Andreas Schibler and Dr Peter Rhodes completed the OTS Performance Assessment and Dr Jonathan R. Egan the Paediatric Intensive Care Fellowship Examination.



Dr Peter Morley congratulates Associate Professor Al Vedig (SA) on completion of twelve years service as an Examiner.

Retirement of Board Members

Drs Gill Bishop and Toby Thomas

Dr Neil Matthews presented tokens of appreciation to Drs Gill Bishop and Toby Thomas following their retirement from the Board in June. Both of these members had long and meritorious service to the Board of both the previous and current Faculty. They completed their terms as senior members of the Board in the positions of Rural Focus Officer and Treasurer respectively. We take this opportunity to express our thanks and to wish them well in their hospitals.



Survey on Supervision

In June, the Board of Faculty considered a Discussion Paper on the supervision of patients and trainees in Intensive Care Units accredited for training. This discussion paper was based on the survey which was circulated to the Directors of all accredited Intensive Care Units in Australia, New Zealand and Hong Kong. The Board is seeking input on this issue with a view to generating guidelines covering the supervision of trainees and patients in accredited intensive care units.

The Discussion Paper (which includes possible guidelines) is reprinted in this section of the Bulletin. One issue not canvassed in the Discussion Paper but which will likely form part of any guidelines, would be the need for out-of-hours ICU specialist availability within a specified period of time. The Board is aware that some hospitals have specific guidelines in relation to on call availability and that the SCCM and ESICM have guidelines which require availability for attendance in the ICU within either 20 or 30 minutes. Any views on this aspect of supervision would also be most welcome.

RAYMOND F RAPER
Chairman, Hospital Accreditation Committee

Survey on Supervision

The current discussion concerning trainee supervision arose out of concern for the adequacy of supervision in co-located Intensive Care Units where it was reported that ICU Specialists were simultaneously involved in the supervision of trainees in more than a single unit. This was seen to be in breach of Faculty guidelines. Concern was simultaneously raised for the adequacy of supervision in some of the larger 'mega' units. The survey was undertaken in an attempt to establish actual practice as a basis for consideration of the generation of guidelines or instructions.

Faculty Survey of Supervision and Co-location

Responses: 54 centres

Co-location: 15 (28%)

Nature of co-location:

Same floor	3
Same building	8
< 1 min	4
2- 5 min	3
> 5 min	1

Maximum patients per unit:

< 10	19
10 - 15	24
16 - 20	9
21 - 25	4
26 - 30	4
> 30	0

Maximum patients per specialist - each unit:

Patient number	Week days	Week nights
< 10	24	20
10 - 15	21	25
16 - 20	9	9
21 - 25	2	4
26 - 30	2	3
> 30	0	0

Usual number of patients per specialist - each unit

Patient number	Week days	Week nights
< 10	39	35
10 - 15	27	27
16 - 20	4	5
21 - 25	0	3
26 - 30	1	1
> 30	0	0

Co-located units with shared cover:

Week day:	2/15
Week night:	8/15
Weekends:	10/15

Maximum patients per specialist with shared cover:

Patients	Week days	Week nights	Week ends
< 10	0	0	0
10 - 15	4	0	2
16 - 20	2	2	3
21 - 25	0	1	0
25 - 30	0	3	3
> 30	0	1	1

Usual number of patients per specialist with shared cover:

Patients	Week days	Week nights	Week ends
< 10	1	0	0
10 - 15	4	1	5
16 - 20	1	2	1
21 - 25	0	1	0
25 - 30	0	2	2
> 30	0	1	1

Nature of cover:

Almost exclusively on call out of hours, on duty Monday to Friday.

Backup:

Invariably claimed. Various models

It is likely that the results are reasonably representative as responses were obtained from 46 centers in Australia (56 Intensive Care Units), 6 ICUs in New Zealand and 2 Hong Kong ICUs.

Several factors warrant consideration in the discussion of the adequacy of supervision of trainees. These include:

- The Joint Faculty has a responsibility to trainees to ensure they are adequately supervised in an appropriate environment from both a clinical and educational perspective.
- The Joint Faculty has promulgated minimum standards for Intensive Care Units and guidelines for Intensive Care Units seeking accreditation for training in Intensive Care. These standards may have a role in determining standards for appropriate patient care, independently of responsibility to trainees.
- Trainees are also employed by Health Services for the provision of services related to the care of critically ill patients. Training is not a 'full time' pursuit and the service commitment must be recognised.
- There is a considerable manpower shortage of both junior medical staff and Intensive Care Specialists. The Joint Faculty should not be setting standards which are not achievable or which might make the specialty less attractive with potentially adverse impact on future recruitment.

- The Joint Faculty has a responsibility to its Fellowship to promote working conditions that are safe and compatible with personal and professional wellbeing. (Although the Joint Faculty is not an industrial body, promulgated standards for training should be consistent with the personal and professional wellbeing of the Fellowship).
- Current practice is almost universally structured to provide close, personal trainee (and patient) supervision by day with remote supervision at night. This is reflected in the larger number of patients managed per ICU specialist out-of-hours in a caretaker role than reported for the regular hours of practice. While this practice is largely traditional, it is well established and generally accepted. A requirement for 'round-the-clock' in-house supervision of trainees by supervising specialists would likely have a significant negative impact on the specialty.
- Senior trainees require less close supervision than junior trainees and other medical staff. In fact, senior trainees actually benefit from a training perspective from the greater responsibility associated with increased autonomy.
- Several factors will impact on the ability of any Intensive Care Specialist to adequately supervise both patient care and the activities of the trainee. These include:
 - The geography of the Intensive Care Unit including associated or co-located units.
 - The proximity of associated or co-located units.
 - The number and seniority of junior doctors involved in patient care.
 - The number of patients and their case mix and severity of illness.
 - The presence of a Senior Registrar (or similar senior trainee).

Possible outcomes from this process might include:

- Maintenance of the status quo. Clearly, several Units are currently in breach of current guidelines, even if a quite broad concept of a single unit is embraced. Moreover, the distinction between these practices and those of the larger Intensive Care Units could be seen to be somewhat arbitrary.
- Removal of current restrictions concerning simultaneous rostering in multiple units. This would be retrograde, unnecessary and potentially harmful.
- Promulgation of rigid guidelines citing specific maximal numbers etc. These would be open to criticism and difficult to enforce. They would also fail to recognise locally important factors.
- Promulgation of more broad guidelines which would embrace most of current practice and which might then be used to dissuade those practices which are clearly well outside 'usual practice'.

Guidelines might include:

- The supervising specialist should usually be present within the Unit most of the time during regular hours. This requirement would preclude service provision in two separate units even if they are co-located on a single campus. As far as possible, other clinical and non-clinical undertakings should not be scheduled during clinical supervision / training time.
- No supervising specialist should be simultaneously rostered to more than a single unit unless the units are on a single, geographical campus. This implies a walking distance between units of no more than 5 minutes.
- The supervising specialist must be exclusively rostered and immediately available to attend patients within the ICU. Other clinical and non-clinical commitments which might preclude immediate availability may only be undertaken when another suitable specialist is immediately available.
- Formal cover arrangements need to be established when it is possible that the supervising specialist may not be immediately available to proceed to the ICU when required. This would include:
 - Regular hours when the rostered specialist may have other clinical or non-clinical commitments which might restrict availability.
 - Any time when the supervising specialist is rostered to more than a single unit where attendance in one unit may preclude immediate availability at the other.
- During regular hours (generally this means daylight hours, all days) ICU specialists should not routinely supervise the care of more than 15 patients. Larger numbers of patients would only be reasonable if:
 - Patient care is also supervised by a senior trainee requiring less close supervision.
 - Appropriate specialist backup is available at all times should the need arise.
 - The patients are managed within a single, geographical unit.
 - The case mix is limited.
 - The illness severity is not excessive.
- Outside regular hours, ICU specialists should not usually be responsible for the care of more than 30 patients. This number is clearly excessive for the clinical supervision of the ongoing care of critically ill patients and can only be justified if:
 - The patients are managed within a single geographical unit.
 - A senior trainee requiring less close supervision also supervises patient care.
 - There is a 'second-on-call' arrangement to cover times of greater need.
 - There is some limitation on case mix and severity of illness (ie several of the patients must be of a more predictable, or routine nature).

Joint Faculty of Intensive Care Medicine

Australian and New Zealand College of Anaesthetists
and Royal Australasian College of Physicians

ABN 82 055 042 852

Review IC3 (2003)

GUIDELINES FOR INTENSIVE CARE UNITS SEEKING ACCREDITATION FOR TRAINING IN INTENSIVE CARE MEDICINE

I. GENERAL

- 1.1 The Joint Faculty of Intensive Care Medicine classifies intensive care units into a number of categories for the purpose of its Administrative Instructions relating to training in intensive care medicine.
- 1.2 The Joint Faculty of Intensive Care Medicine expects that supervision of vocational trainees will conform to the principles of the Document IC-4 "The Supervision of Vocational Trainees in Intensive Care".
- 1.3 All specialists employed in accredited units have an obligation to teach trainees, as outlined in Document IC-2 "The Duties of an Intensive Care Specialist in Hospitals Accredited for Training In Intensive Care".
- 1.4 Intensive care units accredited for training by the Joint Faculty of Intensive Care Medicine must meet the following criteria:
 - 1.4.1 The unit must fulfil the requirements of either Level III (for C6, C12 and C24 classifications) or Level II (for C6, or occasionally C12, classification) as outlined in Document IC-1 "Minimum Standards for Intensive Care Units".
 - 1.4.2 The unit must offer trainees a wide spectrum of experience with an acceptable case load.
 - 1.4.3 The hospital should provide a comprehensive range of medical and surgical specialties.
 - 1.4.4 There must be access to a wide spectrum of investigations and therapeutic procedures.
 - 1.4.5 Trainees must work adequate hours within the intensive care unit as distinct from high dependency units or other rostered duties.

If inadequate hours are worked in intensive care, the Censor may rule that the trainee or trainees must extend the duration of their core training.
 - 1.4.6 Where trainees are involved in routine patient care in a high dependency unit, the high dependency unit should meet the criteria as described in Document IC-13 "Recommendations on Standards For High Dependency Units Seeking Accreditation For Training In Intensive Care Medicine".
 - 1.4.7 Unit policies and rosters must ensure that adequate clinical management experience (including performance of procedures) is available to trainees. If excessive numbers of trainees are considered to limit the adequacy of training for individuals, then the Censor may rule that the trainee or trainees must extend the duration of their core training.
 - 1.4.8 Safe working hours for trainees must be maintained and welfare issues addressed.
 - 1.4.9 When appointments to the specialist staff are made, the advice of a properly constituted committee capable of evaluating the qualifications of the applicants must be sought. Faculty nominees are available to committees for this purpose.
 - 1.4.10 Positions for training in intensive care units accredited by the Joint Faculty of Intensive Care Medicine must be advertised and the unit classification must be indicated in the advertisement. The selection process must conform to Joint Faculty guidelines. Selection panels for the appointment of trainees in intensive care should include a Fellow of the Joint Faculty of Intensive Care Medicine.

- 1.5 A program of education, quality assurance and research must be offered which includes a formal teaching program readily available to trainees.
- 1.6 Adequate intensive care textbooks, journals, management guidelines, protocols or clinical care pathways must be available on site, and the unit should have access to electronic medical information.
- 1.7 The hospital must have a comprehensive continuing education program for its staff and should provide adequate library facilities.
- 1.8 The hospital must be prepared for the Joint Faculty, at intervals determined by the Board, to carry out visits to the unit to assess its suitability for training. Information about caseload, staffing patterns and the rosters must be provided.
- 1.9 The training appointment must be entirely in intensive care, and should include provision for the trainee to take part in out-of-hours rosters in intensive care.
- 1.10 Supervisors of Training are nominated by the Unit and appointed by the Board of the Joint Faculty. The Supervisor is expected to carry out the duties listed in Document IC-6 "The Role of Supervisors of Training in Intensive Care Medicine".
- 1.11 The hospital must agree to notify the Board, through its Supervisor of Training, of any changes that might affect training. Changes such as a reduction in the workload, a significant change in casemix or acuity or a reduction in the number of specialist staff working in the unit are regarded as important.
- 1.12 Applications for a change in classification will be received by the Board, and may necessitate re-inspection of the unit.

2. CLASSIFICATION OF UNITS

- 2.1 Subject to criteria being met, the number of training posts in a unit accredited for training is unrestricted and determined by workplace practices in the unit, unless otherwise specified. All accredited units are suitable for core training, elective training and, unless otherwise specified, the intensive care component of anaesthesia training.
- 2.2 The duration of core training is determined by the classification of the unit as outlined below.

2.2.1 C24: Unrestricted core training

This classification is granted only to Level III units and Paediatric Units, where in addition to the Level III status the Board deems it would be appropriate for a trainee to spend the whole of their core training in intensive care. C24 accredited units will be major intensive care units in tertiary

referral hospitals and usually have more than 3 Specialists who are Fellows of the JFICM and who have at least a 50% involvement in the unit. The patients will have a high level of illness severity. The case mix will be diverse, normally including five of the following six specialties: trauma, general medicine, general surgery, cardiac surgery, acute cardiology and neurosurgery. Exposure to burns, spinal injuries and transplant services is desirable. Total case numbers will usually exceed 750 patients per annum with at least a 40% ventilation rate. Trainees are required to spend at least one year of core intensive care training in a unit with a C24 classification.

2.2.2 C12: Twelve months core training

This classification is granted to Level III units and Paediatric Units, and occasionally to Level II units, where the caseload and casemix are adequate, but where the Board considers it would be unsuitable for a trainee to spend the whole of their core intensive care training. C12 accredited units will usually have more than 2 Specialists who are Fellows of the JFICM and who have at least a 50% involvement in the unit. The case mix will be diverse including general medicine, and general surgery and may also include, acute cardiology cardiac surgery, trauma and neurosurgery. Total case numbers will usually exceed 500 patients per annum with at least a 40% ventilation rate.

2.2.3 C6: Six months core training

This classification is granted to Level II, Level III or Paediatric Units where the case load, case mix, supervision or facilities are limited, such that the period of core training in that unit should be restricted to six months. This is not a reflection on the quality of care in that unit. The C6 classification is also designed to encourage rotations to such units from other units. Normally, not more than one period of C6 training in a given unit is allowed during core intensive care training. A second period of C6 training in another unit requires prior approval of the Censor and will only be granted if specific benefit in training will be achieved.

2.3 Criteria for determining classification of units

The determination of a unit's classification will be made with regard to points listed in paragraph 1 above, the unit's case load, case mix, severity of illness of patients, range and frequency of

procedures, supervision of trainees and facilities of the unit.

3. TEACHING AND RESEARCH

3.1 There must be a formal, documented and demonstrable program of teaching provided for trainees. This teaching will include:

3.1.1 Tutorials

3.1.2 Daily review of patients with the intensive care specialist on duty for the unit.

3.1.3 Case presentations and review sessions.

3.1.4 Mortality and morbidity sessions.

3.2 The unit should have an active, documented and demonstrable research program to which trainees are encouraged to contribute in a significant way.

3.3 The unit should have adequate clerical, data collection and secretarial support. Trainees are expected to take part in routine unit data collection (eg. patient demographic data, APACHE II scoring data, morbidity and mortality data).

3.4 The unit should have active quality assurance (QA) and quality improvement (QI) programs. Trainees are expected to take part in these activities.

These guidelines should be interpreted in conjunction with the following Documents of the Joint Faculty of Intensive Care Medicine, Australian and New Zealand College of Anaesthetists and the Royal Australasian College of Physicians:

IC-1 *'Minimum Standards for Intensive Care Units'*

IC-2 *'The Duties of an Intensive Care Specialist in Hospitals Accredited for Training in Intensive Care'*

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

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

IC-7 *'Secretarial Services to Intensive Care Units'*

IC-8 *'Quality Assurance'*

IC-13 *'Recommendations on Standards for High Dependency Units Seeking Accreditation for Training in Intensive Care Medicine'*

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

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

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

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Joint Faculty Website: <http://www.jficm.anzca.edu.au/>

Promulgated: February 1994

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Joint Faculty of Intensive Care Medicine

Australian and New Zealand College of Anaesthetists
and Royal Australasian College of Physicians

ABN 82 055 042 852

Review IC11 (2003)

GUIDELINES FOR THE IN-TRAINING ASSESSMENT OF TRAINEES IN INTENSIVE CARE MEDICINE

1. Introduction

In-training assessment (ITA) of Trainees in Intensive Care Medicine is an essential part of the Trainees' education. It complements other methods of evaluation, such as examinations. ITA is a joint process of evaluation and goal setting by the Trainee and the Supervisor of Training (SOT), and requires active participation by the Trainee. It is essential that the assessment is conducted in accordance with sound educational principles, and that the principles of natural justice are observed.

Assessment may be formative or summative. Formative assessment is personal and aims to be supportive of the Trainee. Summative assessment is an external validation of the trainee's development measured against objective criteria, for example by examination. The Faculty's ITA is mainly a formative process, but does have some summative aspects.

2. Objectives

The objectives of ITA are to:

- 2.1 Assess and assist with the Trainee's progress towards appropriate goals.
- 2.2 Provide regular feedback to Trainees.
- 2.3 Develop any remedial activities for the Trainee that may be required.

However, the failure to fully achieve the objectives will not invalidate the process.

3. Process

Each Trainee must maintain a training portfolio throughout their training. It should include originals or copies of formal documents related to training and courses passed, as well as voluntary documentation such as a log-book. It **MUST** contain a copy of the signed ITA form from each final assessment with an SOT, and should contain all self evaluation performance forms. It may be necessary for the trainee to produce the copies of final assessment forms when undergoing future assessments.

- 3.1 During the **Advanced Training Years** or **Core Years** formal assessment meetings **MUST** occur between the SOT and each Trainee at the end of each six month period (or sooner if the attachment is less than six months). Additional meetings between the Trainee and SOT should occur as appropriate. An interview at the beginning of the period is highly desirable. The purpose of such an early interview is to review the Trainee's previous performance, and set appropriate goals for the next training term. This may involve review of the Trainee's Training Portfolio. The agreed goals need to be written down and kept in the portfolio.

There should also be regular group meetings between the SOT and the Trainees together with the Head of Department if appropriate. Any Trainee experiencing difficulty should bring this to the attention of the SOT as early as possible.

During the **Basic Training Years**, ITAs are not mandatory for the Trainee for the purposes of accreditation, although it is highly recommended. However ITAs may be necessary for other programs, and if the Trainee is working in ICM as a Basic Trainee it is desirable that they should undergo formal assessment and feedback.

- 3.2 At the final assessment interview, the SOT and Trainee will review and discuss performance during the completed attachment.
- 3.3 The formal assessment of the Trainee's performance over the previous attachment should be based upon:
 - 3.3.1 An assessment by the three senior staff who are best placed to provide that assessment. Each must complete section B and C of the ITA form, and/or:
 - 3.3.2 An assessment by a consensus meeting of the senior staff of the Department in writing using the ITA form.

The SOT should use this information to complete the definitive ITA form. Prior to the final interview, the Trainee may be asked to complete section C of an ITA form as self evaluation. This information can be used to discuss the past term and to establish goals for the next one. The completed final ITA form must be signed by the Trainee and the SOT, after the Trainee has had an opportunity to add comments.

If the Trainee is continuing at the same institution for the following six months, then the final interview can be joined with the initial interview for the next term.

3.4 Destination of forms:

3.4.1 The signed original copy of the ITA form should be submitted to the Faculty Executive Officer by the SOT within two weeks of the assessment. These forms will become part of the Trainee's central record and will be reviewed by the Censor.

3.4.2 A copy of the signed ITA form will be retained by the Trainee, along with any self evaluation forms the Trainee completed, and should be retained in the Trainee's portfolio.

3.5 The following points may assist senior staff and SOTs in situations where the Trainee's performance is not at the level indicative of a satisfactory assessment.

3.5.1 If there is a performance less than that 'consistent with level of experience' in any of the skills/attitudes/abilities listed on the ITA form (indicative of a consensus view of the senior staff involved), then this matter must be discussed with the trainee with a view to establishing remedial strategies. An isolated 'unsatisfactory' attribute does not necessarily constitute an unsatisfactory assessment.

3.5.2 A consistent unsatisfactory attribute over more than one assessment or multiple unsatisfactory attributes on the one occasion must be discussed with the Trainee and remedial strategies drawn up. The Trainee should be told in writing that his/her future performance will be specially monitored and planning for the next term should take that requirement into account.

3.5.3 Continued performance during serial assessments which is globally less than 'consistent with level of experience' may be indicative of a situation which should be discussed with the Head of Department, and reported to the Executive Officer of the Faculty.

3.5.4 Advice as to remedial strategies can be obtained from the Education Officer or from the Education Unit via the Faculty Executive Officer.

4. Unsatisfactory ITA Performance

When a Trainee consistently performs at a level which is considered to be below that to be acceptable for a developing intensive care medicine specialist, not withstanding repeated documented attempts at correction, then the provisions outlined in the ANZCA College Document TE18 *Guidelines for Assisting Trainees with Difficulties* section 7 or the RACP Independent Review of Training should be considered. This will require that processes in addition to In-Training Assessment are invoked. Advice can be obtained from the Education Officer or the Faculty Executive Officer.

Trainees may appeal against a JFICM decision on a matter of process. The appeal will be considered according to the appeal procedure of ANZCA.

These guidelines should be interpreted in conjunction with the following documents:

ANZCA Professional Document TE18 - *Guidelines for Assisting Trainees with Difficulties*

RACP Document - Independent Review of Training

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

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Joint Faculty of Intensive Care Medicine

ABN 82 055 042 852

POLICY DOCUMENTS

- IC-1 (2003) Minimum Standards for Intensive Care Units *Bulletin August 2003, pg 69*
- IC-2 (2000) The Duties of an Intensive Care Specialist in Hospitals with Approved Training Posts *Bulletin November 2000, pg 53*
- IC-3 (2003) Guidelines for Intensive Care Units Seeking Accreditation for Training in Intensive Care Medicine *Bulletin November 2003, pg 61*
- IC-4 (2000) The Supervision of Vocational Trainees in Intensive Care *Bulletin March 2000, pg 57*
- IC-5 (1995) Duties of Regional Education Officers in Intensive Care *Bulletin November 1995, pg 50*
- IC-6 (2002) The Role of Supervisors of Training in Intensive Care Medicine *Bulletin September 2002, pg 36*
- IC-7 (2000) Secretarial Services to Intensive Care Units *Bulletin March 2000, pg 58*
- IC-8 (2000) Quality Assurance *Bulletin November 2000, pg 55*
- IC-9 (1997) Statement on the Ethical Practice of Intensive Care Medicine *Bulletin November 2002, pg 57*
- IC-10 (2003) Minimum Standards for Transport of Critically Ill Patients *Bulletin March 2003, pg 29*
- IC-11 (2003) Guidelines for the In-Training Assessment of Trainees in Intensive Care Medicine *Bulletin November 2003, pg 64*
- IC-12 (2001) Examination Candidates Suffering from Illness, Accident or Disability *Bulletin November 2001, pg 63*
- IC-13 (2002) Recommendation on Standards for High Dependency Units Seeking Accreditation for Training in Intensive Care Medicine *Bulletin June 2002, pg 68*
- PS38 (1999) Statement Relating to the Relief of Pain and Suffering and End of Life Decisions *Bulletin June 1999, pg 93*
- PS39 (2003) Minimum Standards for Intrahospital Transport of Critically Ill Patients *Bulletin June 2003, pg 90*
- PS40 (2000) Guidelines for the Relationship Between Fellows and the Healthcare Industry *Bulletin March 2000, pg 55*
- PS45 (2001) Statement of Patient's Rights to Pain Management *Bulletin March 2002, pg 72*
- PS48 (2003) Statement on Clinical Principles for Procedural Sedation *Bulletin March 2003, pg 73*
- PS49 (2003) Guidelines on the Health of Specialists and Trainees *Bulletin August 2003, pg 88*

13 May 2003



Dean's Message

Leigh Atkinson

Conjoint Meetings

Gathering Support for Pain Medicine

There should be no doubt in any of our minds that the needs of the pain patient are not being met in our communities. The burden of pain has been identified. But while our national budgets are fat with economic prosperity, this wealth has not been transferred to patient-care in our hospitals, nursing homes and clinics.

Politicians are deaf to the issue. Clinical Colleges are consumed by bureaucratic controls and protocols. University medical schools seem to have lost contact with their mission. Hospital administrators must focus on their budgets or be sacked. The medical workforce is not meeting the demands. Our medical colleagues wonder what Pain Medicine has to offer.

Your Board is sensitive to the frustrations and complacency that we face in advancing Pain Medicine in Australia and New Zealand. Our Faculty is now well established with its Fellowship, examinations, education and accreditation process. We await the Australian Medical Council's response to our submission for specialty status. It is time to raise our advocacy for our patients with acute, chronic and cancer pain. We must start with our colleagues in our sister Colleges and our Societies.

Over the next three years we plan to actively promote Pain Medicine with conjoint meetings. Already we have had successful joint sessions with the neurosurgeons at the Brisbane Annual Scientific Meeting of the Royal Australasian College of Surgeons in May this year. Henrik Kehlet was the Foundation Guest in Hobart and he continued on the subject of surgical pain at the neurosurgeons meeting in Brisbane.

On 30th September and 1st October, Colin Goodchild convened a conjoint meeting of the ANZCA Acute Pain SIG,

the Australian Society of Anaesthetists, the New Zealand Society of Anaesthetists and the Faculty. Two hundred registrants included pain medicine specialists, general practitioners and nurses. The meeting was well received.

In 2004 we will expand these meetings. At the ANZCA ASM in Perth, Stephan Schug will convene the conjoint scientific meeting and Ralph Baron, as the Foundation Guest, will introduce a strong flavour of neurology into the program while Christoph Stein will speak on opioids. Prior to that meeting, again in Perth, our Faculty Fellows will meet with the geriatric and rehabilitation medical group to explore the multidisciplinary aspects of Pain Medicine.

In the absence of the neurosurgeons at the RACS ASM in Melbourne, we are negotiating to include Pain Medicine speakers involved in the topics of military medicine, oncology and general surgery. The interaction between our Faculty and the surgeons needs persistent attention. Graham Rice has liaised with the RANZCP to have our Faculty Fellows, Bob Large, Mike Butler and David Jones involved in their ASM program.

Already we are advanced in arrangements for the conjoint meeting in Auckland with ANZCA in 2005. Our Foundation Guest will be Mark Sullivan with Bob Large and Mike Butler convening the meeting.

The World Congress on Pain to be staged by the International Association for the Study of Pain in Sydney should prove another opportunity to highlight research and advances in the care of pain patients around the world. This will be held in Sydney from 21st to 26th August, 2005.

Already in 2006 the Faculty has been invited to join with the Australian Pain Society and ANZCA to present a joint meeting in Adelaide with our special involvement between 3rd and 7th May. Tim Semple will be convening the Pain Society section and we look forward to progressing this event.

Our specialty numbers remain small compared to the clinical demands. We need to attract more trainees and, in particular, more women graduates to Pain Medicine. An increased presence at the conjoint meetings with our sister Colleges is a real opportunity to promote Pain Medicine. Your Faculty calls on each Fellow in the individual Colleges to assist us in this project of advancing the needs and the management of acute, cancer and chronic pain patients.



Leigh Atkinson
Dean

Maintenance of Professional Standards

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

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

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

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

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

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

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

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

Highlights from the Board Meeting

HELD ON JULY 31, 2003

Rob Helme was welcomed to his first Board Meeting since his election to the Board.

Visitors to the meeting were:

Professor Michael Ashby, President, Australian and New Zealand Society of Palliative Medicine and the first Chair of the Chapter of Palliative Medicine's Education Committee, joined the Board for discussions on issues relevant to both palliative medicine and pain medicine. This was a very valuable discussion and it was concluded that there are many areas where we can work more closely together.

Mr Ronald Walker AO, CBE gave a presentation to the Board. The Dean, on behalf of the Faculty, thanked Mr and Mrs Walker for their generous support to the Faculty through the Barbara Walker Award for Excellence in Pain Management.

Stephan Schug, the 2004 scientific convenor, was linked in by telephone to discuss the 2004 ASM.

Education

A teleconference meeting of the Education Committee was held on July 21 and the following issues were discussed:

Psychosocial Assessment of Chronic Pain Patients

This document now only requires copyright issues to be finalised. Faiz Noore and Frank New were thanked for their work in the production of this document.

Pain Orientated Physical Examination

A trial video has been completed and discussions in relation to financial support for the production of the CD will now commence.

Objectives of Training and Reading List

A major revision of this document is to be undertaken. Fellows are encouraged to submit new reference material. The document can be viewed on the web page.

American Academy of Pain Medical – Pain Medicine Journal

Fellows are continuing to receive this journal on-line. An assessment of this journal will be undertaken in due course.

Regional Education Meetings

A small working group will discuss a framework for these meetings and report to the next Board Meeting.

Research

It was agreed that Fellows and Trainees be made aware of the ANZCA Research Grants. This could be mentioned in the next issue of *Synapse*.

Multicentre Clinical Trials

It was noted that there is an article in the August 2003 Bulletin on multicentre trials. Fellows should be made aware of this College initiative.

Evidence Based Management of Acute Musculoskeletal Pain

It was noted that this document, produced by the Faculty of Health Sciences, University of Queensland, has now been finalised. The Board agreed that the Faculty endorse this document.

2003 Examination

The Examination Committee met on July 30. It was noted that the dates for this examination had to be altered due to the World Rugby Cup matches in Brisbane. The dates are revised to October 28 and 29. The examination registration deadline is September 12.

Pre-Examination Short Course

P Briscoe commented that the program and facilitators for this two day course in September at Royal Adelaide Hospital are finalised.

Professional Documents

PM2 *Requirements for Multidisciplinary Pain Centres Offering Training in Pain Medicine*. This document remains under revision.

PS31 *Recommendations on Checking Anaesthesia Delivery Systems*. The Board noted this revised document and agreed that it be updated on the Faculty list of Professional Documents.

PS40 *Guidelines for the Relationship Between Fellows (2000) and the Healthcare Industry*. The Board agreed that this document be drawn to Fellows' and Trainees' attention.

Intercollegiate Forum

The Dean advised the Board that a decision had been made to postpone this meeting. This meeting date seemed to clash with meetings at some of the participating Colleges.

Paediatric Pain Medicine

It was noted that Meredith Craigie has agreed to Chair the Paediatric Pain Medicine Working Party.

National Institute of Clinical Studies

Jane Trinca has kindly agreed to represent the Faculty on the NICS Pain Management Project. A report was provided following her attendance at a recent meeting.

2004 Refresher Course Day

This meeting will be held on April 30, 2004 at the Duxton Hotel, Perth. The Education Committee is presently planning the program.

Annual Scientific Meetings

Perth 2004

Stephan Schug reported to the Board that the program is underway for the meeting. He had been in contact with the Foundation Visitor, Professor Ralf Baron, and the Faculty's Second Speakers Professor Christoph Stein and Professor Bob Large regarding their sessions.

Participating Colleges/Faculty ASMs

The Dean reported he had received positive feedback from the convenors of the participating Colleges' ASMs for the Faculty to hold sessions during their ASMs. Discussions will continue.

2004 Annual Dinner

The Faculty's Annual Dinner will be held on April 30 at The Old Swan Brewery, Perth.

Combined Acute Pain SIG/FPM Meeting, Melbourne

This program has now been circulated.

Web Site

The Faculty's web site has been redesigned. An Editorial Committee of L Atkinson, M Cohen and R Helme were appointed to continue work on developing this site. It was agreed to urge Fellows to provide information for inclusion on the web site.

Research Committee

The terms of reference were finalised for the newly created Research Committee. They are:

- To promote research in the field of Pain Medicine amongst Faculty Fellows and Trainees
- To develop key questions for the ANZCA multicentre trials.

J Fleming will Chair this Committee and members will now be appointed.

Admission to Fellowship of the Faculty of Pain Medicine

By training and examination:

Stephan Peter Willi Neff SA

By election:

Geoffrey Keith Gourlay SA

René Gaston Pols SA

Saxby Arthur Pridmore TAS

Andrew Michael Singer NSW

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

The Faculty's application to the AMC was submitted in June 2003. We recommend all Fellows and Trainees view this submission on the Faculty's web site www.fpm.anzca.edu.au This is an informative document and it is recommended that all Fellows and Trainees read our submission. There is also an excellent list of references.

The Portrait Unveiling of the Founding Dean, Professor Michael Cousins

at 'Ulimaroa' on 30 July 2003



Prof. Michael Cousins with the Dean, A/Prof. Leigh Atkinson



(Left to Right): Drs Greta Palmer, Will Howard, Carolyn Arnold, Ray Garrick, A/Prof. Milton Cohen and Prof. Michael Cousins

Faculty of Pain Medicine

Australian and New Zealand College of Anaesthetists

ABN 82 055 042 852

PM2 (2003)

GUIDELINES FOR PROGRAMS OFFERING TRAINING IN MULTIDISCIPLINARY PAIN MEDICINE

1. INTRODUCTION

- 1.1 These guidelines establish the recommended standards for Programs offering training in Multidisciplinary Pain Medicine for **Fellowship of the Faculty of Pain Medicine** of the Australian and New Zealand College of Anaesthetists.
- 1.2 A Multidisciplinary Pain Medicine Program is one that enables all requirements for training for Fellowship in Pain Medicine to be met, either at a single Multidisciplinary Pain Centre or at several centres that are collectively able and agree to offer equivalent training and experience. The Multidisciplinary Pain Medicine Program must be prospectively approved by the Board of the Faculty of Pain Medicine for training purposes.
- 1.3 A Multidisciplinary Pain Medicine Program must include practitioners from three or more medical specialties and from other relevant allied health professions. These individuals specialise in interdisciplinary 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'.
- 1.4 The staff of a Multidisciplinary Pain Medicine Program must be able to use a biopsychosocial assessment and appropriate treatment approach for patients with pain.
- 1.5 The Multidisciplinary Pain Medicine Program must include rehabilitation services, cancer/palliative care services and access to an Acute Pain Service¹.
- 1.6 A session is a notional period of 4.0 hours devoted exclusively to Pain Medicine.

2. ADMINISTRATIVE STRUCTURE AND STAFFING

- 2.1 Funding for a training position(s) remains the responsibility of the centre or centres involved.

- 2.2 All medical practitioners involved in the Multidisciplinary Pain Medicine Program must be accredited by their institutions for the duties and procedures they perform.
- 2.3 If the Multidisciplinary Pain Medicine Program is a single Multidisciplinary Pain Centre, the Director of that Centre must be a Fellow of the Faculty of Pain Medicine. There must also be a Deputy Director and Supervisor of Training.
- 2.4 If the Multidisciplinary Pain Medicine Program is one that enables the requirements for training for Fellowship in Pain Medicine to be met at several centres, there must be a Director of the educational program and a Supervisor of Training to oversee the training of the trainee. The Director must be a Fellow of the Faculty of Pain Medicine. There must also be a Deputy Director.
- 2.5 There must be input equivalent to at least four (4) sessions per week into the Multidisciplinary Pain Medicine Program by medical practitioners holding Fellowship of the Faculty of Pain Medicine.
- 2.6 There must be a minimum of eight (8) scheduled medical specialist sessions provided in the Centre or across the Program and available to the trainee each week (excluding sessions allocated to the Acute Pain Service).

Regularly scheduled specialist sessions are essential from:

- 2.6.1 **Anaesthesia**
- 2.6.2 **Psychiatry**
- 2.6.3 **Rehabilitation Medicine**
- 2.6.4 Regularly scheduled specialist sessions are highly desirable from: **Rheumatology, oncology, neurology, neurosurgery, orthopaedic surgery, palliative medicine, drug and alcohol and other appropriate medical specialties**
- 2.6.5 Specialist supervision appropriate to the level of clinical experience of the trainee must be available.

- 2.7 The following disciplines should also form an integral part of staffing:
- 2.7.1 **Nursing staff:** senior registered nurse exclusively attached to the centre(s) involved. (Nursing staff for an Acute Pain Service: see 2.19)
 - 2.7.2 **Clinical Psychologist:** a minimum of five (5) sessions weekly
 - 2.7.3 **Physiotherapist/Physical Therapist:** a minimum of five (5) sessions weekly
 - 2.7.4 Regular clinical input from these disciplines is highly desirable:
 - 2.7.4.1 **Occupational Therapy**
 - 2.7.4.2 **Social Work**
 - 2.7.4.3 Other Allied Health disciplines such as Rehabilitation/Occupational Counselling, Dietetics and others may be associated with the Centre.
- 2.8 Centres participating in training must establish regular contact with the patient's General Practitioner.
- 2.9 Centres participating in training should also offer expertise in the following areas:
- 2.9.1 Review of medical records
 - 2.9.2 History taking and physical examination relevant to Pain Medicine
 - 2.9.3 Psychological assessment and treatment including cognitive behavioural approaches
 - 2.9.4 Referral for other medical consultation
 - 2.9.5 Medical management
 - 2.9.6 Physical therapy
 - 2.9.7 Interdisciplinary meetings
 - 2.9.8 Vocational assessment and counselling
- 2.10 Regularly scheduled staff education sessions are essential.
- 2.11 Involvement in undergraduate and postgraduate medical, nursing and allied health education is essential.
- 2.12 Regularly scheduled quality improvement/peer review activities are essential.
- 2.13 An active research program related to Pain Medicine is highly desirable.
- 2.14 A comprehensive patient record system is essential.
- 2.15 A computerised data review system for both diagnosis and treatment is highly desirable.
- 2.16 Documentation of treatment protocols and procedures for patients together with a statement of their rights and responsibilities is essential.
- 2.17 Secretarial assistance to the Centre(s) of one full-time equivalent or more is essential.
- 2.18 Allocated of RMOs is highly desirable.
- 2.19 The Acute Pain Service within the Multidisciplinary Pain Medicine Program must have:
 - 2.19.1 at least one (1) specialist anaesthetist session allocated each week day.
 - 2.19.2 a specialist anaesthetist should be available for consultation 24 hours a day.
 - 2.19.3 at least one (1) registered nursing session allocated each week day.
 - 2.19.4 It is highly desirable that there are regularly scheduled administrative sessions allocated for the Acute Pain Service and the Chronic and Cancer Pain Services.
- ### 3. PHYSICAL COMPONENTS OF THE FACILITIES
- 3.1 Appropriate consulting and examination rooms are essential.
- 3.2 Access to procedure rooms with adequate equipment and staffing is essential. Staffing includes nurses, technicians and radiographers as required.
 - 3.2.1 Anaesthesia and resuscitation equipment must comply with ANZCA College Professional Document T1 (2000) *Recommendations on Minimum Facilities for Safe Anaesthesia Practice in Operating Suites.*
 - 3.2.2 Recovery facilities and procedures must comply with ANZCA College Professional Document PS4 (2000) *Recommendations for the Post Anaesthesia Recovery Room.*
- 3.3 Suitable office space for permanent staff and trainees is essential. See ANZCA Professional Document TE1 (2003) *Recommendations for Hospitals seeking College Approval for Vocational Training in Anaesthesia.*
- 3.4 Access to in-patient beds:
 - 3.4.1 Is mandatory.
 - 3.4.2 Designated Multidisciplinary Pain Medicine in-patient beds are highly desirable.
- 3.5 Access to a library including major pain medicine books and access to bibliographic databases for journal publications are mandatory. Access must be available to all recommended major texts, journal articles and reviews as listed in the Faculty Objectives of Training and Reading List.

4. CLINICAL WORKLOAD AND STANDARDS FOR A MULTIDISCIPLINARY PAIN MEDICINE PROGRAM FOR TRAINING

- 4.1 There must be enough new patients per annum² to provide the trainee with exposure to:
- 4.1.1 Acute perioperative/medical/trauma
 - 4.1.2 Chronic non-cancer pain
 - 4.1.3 **Cancer pain**
 - 4.1.4 **Out-patient medical specialist sessions:** minimum five (5) per week.
- 4.2 **Formal interdisciplinary case conferences:** where after discussion among a number of health professionals who have seen the patient in consultation, a treatment plan is drawn up. At least once per week, preferably three to five per week.
- 4.3 **Procedural sessions:** One or more procedural sessions (eg: diagnostic and therapeutic nerve blocks) per procedural specialist per week, to provide adequate exposure for all trainees.
- 4.4 **In-patient rounds:** There must be regular scheduled attendances to inpatients under the care of the centre(s) participating in training. For patients under the care of the Acute Pain Service, daily rounds are required. There must be medical specialist input to the rounds.
- 4.5 There must be medical specialist cover for participating centres 24 hours per day through the year. This must include scheduled out of hours rounds.
- 4.6 **Radiology:** There must be regular review sessions.
- 4.7 **Non-invasive treatments:** must be included in the Centre's activities.

- 4.8 **Psychiatry and Psychology therapy sessions:** trainees must gain adequate exposure.
- 4.9 **Audit and clinical review sessions:** must be held at least monthly and include documentation of results.
- 4.10 All centres participating in the Multidisciplinary Pain Medicine Program must comply with all current Faculty Professional Documents.

1. The Acute Pain Service must attend to approximately 1000 new patients per annum.
2. Recommended numbers of patients per trainee per year approximate: acute 500, chronic non-cancer 250 and cancer 50.

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

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

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

Promulgated: 2001
Date of Current Document: October 2003

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FPM Website: <http://www.fpm.anzca.edu.au>

Faculty of Pain Medicine

ABN 82 055 042 852

PROFESSIONAL DOCUMENTS

P = Professional

PS = Professional standards

- PM1 (2002) Guidelines for Trainees and Departments Seeking Faculty Approval of Posts for Training in Pain Medicine
- PM2 (2003) Requirements for Multidisciplinary Pain Centres Offering Training in Pain Medicine
- PM3 (2002) Lumbar Epidural Administration of Corticosteroids
- PS3 (2003) Guidelines for the Management of Major Regional Analgesia
- PS40 (2000) Guidelines for the Relationship Between Fellows and the Healthcare Industry
- PS41 (2000) Guidelines on Acute Pain Management
- PS45 (2001) Statement on Patients' Rights to Pain Management
- PS48 (2003) Statement on Clinical Principles for Procedural Sedation
- PS49 (2003) Guidelines on the Health of Specialists and Trainees

COLLEGE PROFESSIONAL DOCUMENTS ADOPTED BY THE FACULTY:

- PS4 (2000) Recommendations for the Post-Anaesthesia Recovery Room (Adopted February 2001)
- PS7 (1998) The Pre-Anaesthesia Consultation (Adopted February 2001)
- PS8 (1998) The Assistant for the Anaesthetist (Adopted February 2001)
- PS9 (2001) Guidelines on Conscious Sedation for Diagnostic, Interventional Medical and Surgical Procedures (May 2002)
- PS10 (1999) The Handover of Responsibility During an Anaesthetic (Adopted February 2001)
- PS15 (2000) Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery with amendment to the title to read Recommendations for the Perioperative Care of Patients Selected for Day Care Procedures (Adopted February 2001)
- PS18 (2000) Recommendations on Monitoring During Anaesthesia (Adopted February 2001)
- PS20 (2001) Recommendations for Responsibilities of the Anaesthetist in the Post-Operative Period (Adopted February 2001)
- PS31 (2003) Recommendations on Checking Anaesthesia Delivery Systems (Adopted July 2003)

Special Interest Groups Annual Reports

Diving and Hyperbaric Medicine

EXECUTIVE

The SIG Executive composition is as follows:

Dr Robert Wong (Chairman)	WA
Dr Mike Bennett	NSW
Dr Alistair Gibson	NZ
Dr David Griffiths	QLD
Dr Brian Spain	NT
Dr Margaret Walker	TAS
Dr David Wilkinson	SA

Co-opted Members:

Dr Simon Mitchell	South Pacific Underwater Medicine Society
Dr David Smart	ANZ Hyperbaric Medicine Group

FORMAL QUALIFICATION IN DIVING AND HYPERBARIC MEDICINE

A formal qualification in Diving and Hyperbaric Medicine has been established by ANZCA. The College Council has granted the Award of a Certificate in Diving and Hyperbaric Medicine. A call for applications for the Foundation Certificate was promulgated in the College Bulletin on page 21, Vol 11, No 4 November 2002. Seventeen applicants satisfied the criteria. Apart from Fellows of ANZCA, there were applicants from the Australasian Faculty of Occupational Medicine and the Australasian College for Emergency Medicine. Two overseas applications were received after the closing date and these applicants have been invited to present for the Certificate examinations if they fulfil all the pre-requisites.

The Certificate in Diving and Hyperbaric Medicine is essentially for practitioners in Australia and New Zealand. The Executive Committee had not envisaged foreign practitioners wishing to acquire the qualification. This issue will be raised with the ANZCA Certificates Committee.

Accreditation of facilities seeking approval for Vocational Training in Diving and Hyperbaric Medicine took place in May 2003 during the ASM ANZCA when the Royal Hobart Hospital's Hyperbaric Unit was inspected. It has been recommended that this department be approved for training towards the ANZCA Certificate in Diving and Hyperbaric Medicine, and the period of accreditation is for a period of 5 years in the first instance. Other Departments that have applied for accreditation are the Prince of Wales

Hospital, Randwick, NSW and the Fremantle Hospital, Fremantle, WA.

Council Citation – those not in active clinical practice but who would have otherwise fulfilled the criteria to be awarded the Foundation Certificate were discussed. Initially, titles such as Emeritus Consultants or Honorary Foundation Certificate Holders had been suggested and were rejected.

It had been agreed by the SIG Executive Committee that practitioners who are no longer in active practice but have made major contributions in this specialty be recommended for the award of a Council Citation.

At the AGM of the SIG held in Hobart in May 2003, four practitioners were suggested for this award.

DIVING AND HYPERBARIC MEDICINE COURSE

The two-week full-time course continues into its fourth year in 2003, and was conducted in March at the Alfred Hospital in Melbourne. This is one of the two requisite courses for training in the Certificate in Diving and Hyperbaric Medicine.

STANDARDS AUSTRALIA

Members of the SIG Executive Committee continued to contribute Standards Australia. In 2002, the SF/046 was published as AS4774 WORK IN COMPRESSED AIR AND HYPERBARIC FACILITIES. Part 2:AS 4774.2 HYPERBARIC OXYGEN FACILITIES. Part 1 on tunnelling work, having received public comments, was published in 2003 – WORK IN TUNNELS, SHAFTS AND CAISSONS.

ANNUAL GENERAL MEETING

An AGM is usually held during the ASM ANZCA. In 2004, due to the great effort put in by the organising committee headed by Dr Mike Bennett, the ASM of the Undersea and Hyperbaric Medical Society (UHMS) will be held for the first time in Sydney, Australia. In view of the number of members of the SIG who usually also attend the UHMS, it has been decided to hold the AGM during the UHMS in May 2004.

SCIENTIFIC MEETINGS

The SIG held a scientific meeting at the ASM of ANZCA in Hobart in May. Members also contributed to other national and international scientific meetings during the year eg meetings of the Undersea and Hyperbaric Medical Society (UHMS); South Pacific Underwater Medicine Society (SPUMS); European Underwater and Baromedical Society (EUBS) and the Australasian Hyperbaric Meeting hosted by the Hyperbaric Technicians & Nurses Association

(HTNA). The Australian and New Zealand Hyperbaric Medicine Group (ANZHMG), a subcommittee of SPUMS, also holds the AGM during this meeting.

SIG CONSTITUTION

With the amended SIG Constitution, SIG Associate Members holding the ANZCA Certificate in Diving and Hyperbaric Medicine will now be eligible to become full members.

RETIREMENT

Dr John Knight who has contributed greatly to the SIG, having represented SPUMS and later as the Victorian Representative has retired. We wish him a healthy, happy and fulfilling retirement.

PUBLICATIONS

Members of the SIG have been active in writing papers for publications.

Dr Mike Bennett has eleven publications during the year 2002.

Dr Simon Mitchell has four publications, two as co-author in book chapters in the text-book Bennett & Elliott's Physiology and Medicine of Diving 5th Ed, Ed Brubakk AO and Newman TS.

Others who have made contributions to various publications include Drs David Doolette, J Lehm, Connor D, Trytko B, McKay R. Dr R Wong also contributed to a book chapter in Bennett and Elliott's Physiology & Medicine of Diving.

HONOURS, AWARDS AND APPOINTMENTS

The Chairman and the Executive Members of the SIG extend their congratulations to those members who have received awards or have been honoured/ appointed to the

various diving & hyperbaric organisations.

Dr Chris Acott was elected Vice President of the Undersea and Hyperbaric Medical Society Inc (UHMS) USA.

Dr David Doolette was awarded the Oceaneering International Award at the UHMS Annual Scientific Meeting held in Quebec.

Dr Simon Mitchell was awarded the Australasian Diving Technologies Industrial Support Award for Support of Technical Diving in Australasia at the September 2002 Conference. He also received the Leo Ducker Award for Outstanding Support of Diving in New Zealand at the New Zealand Underwater Federation Annual Conference in June 2003.

The Editor of SPUMS Journal is Dr Mike Davis of Christchurch who has made changes and improvements to the Journal.

Dr David Smart continues to serve as Chairman of the Australian & New Zealand Hyperbaric Medicine Group (ANZHMG) and Dr David Wilkinson as the Honorary Secretary.

Dr Simon Mitchell still serves on the Editorial Board of the Journal of Undersea and Hyperbaric Medicine. He is also the Member at Large of the Executive Committee of the Undersea and Hyperbaric Medical Society Inc USA and continues to be a member of the Adjunctive Therapy Committee of the same organisation.

Dr Mike Bennett continues to serve on the Hyperbaric Oxygen Therapy and Education Committees of that organisation.

Robert M Wong
Chairman

Professional Documents Under Review

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

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

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

Acute Pain SIG

EXECUTIVE

The Executive composition is as follows:

Dr Grant Turner (Chair)	WA
Dr Mary Cardoso	MALAYSIA
Dr Meredith Craigie	SA
Dr Lachlan Doughty	TAS
Prof Colin Goodchild	VIC
Dr Richard Halliwell	NSW
Dr Martina Meyer-Witting	QLD
Dr James Sartain	QLD
Prof Stephan Schug	NZ

The current SIG Executive has completed a term of office and nominations have been called for interested members to serve on the Executive. It is anticipated that there will be a nomination from New Zealand.

The term of the current Chairman is due to expire and a new chairman will be elected at the first Executive meeting following the AGM.

Change in Executive Membership

Dr Martina Meyer-Witting (Qld) and Dr Meredith Craigie were co-opted on to the SIG Executive during the past 18 months.

Dr Pam Macintyre regrettably tendered her resignation as the South Australian representative after many years of service. Her contributions to the work of the AP SIG are acknowledged.

CONTINUING EDUCATION ACTIVITIES

ANZCA ASM Brisbane 2002

Drs Sartain and Meyer-Witting convened the SIG session at the ASM in Brisbane. The theme was based on Acute Pain Problems in the Real World and was well attended and received.

ANZCA ASM Hobart 2003

The SIG was fortunate to have Prof Kehlet present at the SIG session. His presentation addressed the next challenge Acute Pain Services have in maximising the benefits to be obtained from good pain management in a coordinated way with changes in surgical thinking. Dr Steve Jones complemented Prof Kehlet's talk with a review of NSAIDs.

CME Meeting Melbourne October 2003

Prof Goodchild has organised what promises to be a groundbreaking meeting in Melbourne in October 2003. This meeting is a combined meeting with the Faculty of Pain Medicine and is designed to reach out to anaesthetists, pain nurses and GPs. The theme of 'Crossing Boundaries' is very apt.

ONGOING ISSUES

This CME meeting marks a new direction for the SIG in reaching out its educational activities to a wider audience. Further similar ventures may be considered after review of the success of this one.

The benefits of further standardising of APS Data Collections around the region to enable pooling and comparison of data are apparent. However the attainment of this remains elusive. The SIG is investigating and experimenting with various data collection protocols and devices to achieve this goal.

Grant Turner
Chairman

Obstetric Anaesthesia SIG

EXECUTIVE

The SIG Executive composition remains unchanged as:

A/Prof Michael Paech (Chair)	WA
Dr David Elliott	NSW
Dr Genevieve Goulding	Qld
Dr Steven Katz	NSW
Dr Alison Lilley	VIC
Prof Warwick Ngan Kee	HK
Dr Andrew Ross	VIC
Dr Graham Sharpe	NZ
Dr Scott Simmons	SA
Co-opted Members:	
Dr David Crooke	NSW
Dr Stephen Gatt	NSW

ADMINISTRATION

The 2003 Annual General Meeting was held on 5 May 2003, during the ANZCA Annual Scientific Meeting in Hobart. Minutes have been circulated. Matters discussed included liaison with other like-minded organisations; representation on the National Maternal Mortality Committee (see below); the pending ANZCA Multicentre Trial Secretariat; and National Obstetric Anaesthesia Audit.

CONTINUING EDUCATION

The SIG continued its involvement in plenary sessions of major national scientific meetings, including both the 2002 ASA NSC in Adelaide and the 2003 ANZCA ASM in Hobart. My thanks to colleagues involved in the organisation and presentation of these sessions. The SIG is committed to organisation of plenary sessions at the October 2003 ASA National Scientific Congress, Melbourne, and the May 2004 ANZCA Annual Scientific Meeting in Perth.

Victorian SIG Members, Drs Maggie Wong, Andrew Ross and Vangy Malkoutzis organised a very successful one-day Obstetric Anaesthesia Symposium, *The Good, the Bad and the Ugly of Obstetric Anaesthesia* at ANZCA House in Melbourne in June 2003. The meeting attracted 117 registrants and was videoconferenced to 17 sites throughout Australia and New Zealand. As a result of the positive feedback, it is proposed that this become a regular biennial meeting in Melbourne.

In addition, Dr Graham Sharpe is convening an independent SIG conference, planned for 13-15 November 2004, prior to the Wellington CECANZ meeting, in Blenheim, New Zealand. Dr David Bogod of the UK has accepted the SIG Executive's invitation to be the invited overseas speaker. Information is available through the ACECC website.

Another 'Newsletter', similar to that distributed in 2002, summarising some of the relevant presentations from the Hobart ASM, is being written.

OTHER AREAS OF SIG INVOLVEMENT

Through the initiative of the SIG, A/Prof Michael Paech was recently appointed through the College to the AIHW National Advisory Committee on Maternal Mortality and the first teleconference has been held. This Committee will be preparing reports for the triennia of 1997-1999 and subsequently 2000-2002. We believe the involvement of an anaesthetist on this Committee for the first time is an important initiative.

Three members of the SIG Executive (Drs Alison Lilley and Graham Sharpe and A/Professor Michael Paech) are currently members of a joint RANZCOG/ANZCA/RACGP/ACRRM working party preparing a position statement on the provision of obstetric anaesthetic services.

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

Michael Paech
Chairman

RECOMMENDATIONS ON THE PRE-ANAESTHESIA CONSULTATION

1. INTRODUCTION

Consultation by an anaesthetist is essential for the medical assessment of a patient prior to anaesthesia in order to ensure that the patient is in an optimal state of health, anaesthesia management can be planned, and appropriate discussion and consent of the anaesthesia and related procedures can take place.

2. GENERAL PRINCIPLES

2.1 The processes involved in delivering safe and effective pre-anaesthesia consultations will vary with the type of practice and environment in which the anaesthetist works.

2.2 A pre-anaesthesia consultation must be performed by the anaesthetist who is to administer the anaesthetic even if an assessment has already been performed previously by some other person.

2.3 The use of written or computer-generated questionnaires, screening assessments by appropriately trained nurses and pre-admission clinics may be used so long as the requirement of 2.2 is followed.

2.4 The consultation must take place at an appropriate time prior to anaesthesia and surgery in order to allow for adequate consideration of all factors. This is especially important to be as early as possible where there is significant co-morbidity, major surgery is planned and/or there are specific anaesthesia concerns.

2.5 The difficulties inherent in adequately assessing patients admitted on the day of surgery must be recognised. Ideally such patients should be assessed prior to admission. Otherwise admission times, list planning and session times must accommodate the extra time required for pre-anaesthesia consultations. (see PS15 *Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery*).

2.6 In some circumstances, early consultation will not be possible (e.g. emergency surgery) but the consultation must not be modified except when

the overall welfare of the patient is at risk.

2.7 Pre-anaesthesia consultation facilities must include appropriate equipment and space to allow for a consultation and clinical examination in privacy. An appropriately equipped consulting room or single bed hospital room is most appropriate.

3. GUIDELINES

The pre-anaesthesia consultation should include:

3.1 Identification and introduction of the anaesthetist to the patient.

3.2 An appropriate medical assessment of the patient including medical history (which may be assisted by a questionnaire and/or review of available patient notes), clinical examination, review of any medications, the results of any relevant investigations and arrangement for any further investigatory or therapeutic measures which are considered necessary. This medical assessment may lead to delay, postponement or even cancellation of the planned anaesthesia.

3.3 Consultation with professional colleagues if required.

3.4 A discussion with the patient (or guardian) of those details of the anaesthetic management which are of significance to the patient. This would usually include the anaesthetic procedure, pain management, potential complications and risks, an opportunity for questions and provision of educational material. This material may be in the form of written pamphlets, video recordings or audiotapes (see PS26 *Guidelines on Providing Information about the Services of an Anaesthetist*).

3.5 Obtaining of informed consent for anaesthesia and related procedures. This should include consent regarding the type of anaesthesia, any invasive procedures, pain management and other medication plan and, where appropriate, informed financial consent.

3.6 The ordering of any medications considered necessary.

3.7 A written summary of the consultation which should become part of the medical record of the patient. (see PS6 *Recommendations on the Recording of an Episode of Anaesthesia Care*).

RELATED ANZCA DOCUMENTS

- PS6 *Recommendations on the Recording of an Episode of Anaesthesia Care*
- PS15 *Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery*
- PS26 *Guidelines on Providing Information about the Services of an Anaesthetist*
- PS41 *Guidelines on Acute Pain Management*

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.

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

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

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

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

Australian and New Zealand College of Anaesthetists

ABN 82 055 042 852

Review PS8 (2003)

GUIDELINES ON THE ASSISTANT FOR THE ANAESTHETIST

The presence of a trained assistant for the anaesthetist during the conduct of anaesthesia is a major contributory factor to safe patient management. The assistant must have undertaken appropriate training in order to provide effective support to the anaesthetist. The guidelines that follow are therefore stated in general terms to establish both the practical and educational responsibilities of a competent assistant to the anaesthetist.

1. PRINCIPLES

- 1.1 The presence of a trained assistant for the anaesthetist is essential for the safe and efficient conduct of anaesthesia.
- 1.2 This requires:
 - 1.2.1 The presence of an assistant during preparation for and induction of anaesthesia. The assistant must remain under the immediate direction of the anaesthetist until instructed that this level of assistance is no longer required.
 - 1.2.2 The presence of an assistant at short notice if required during the maintenance of anaesthesia.
 - 1.2.3 The presence of an assistant at the conclusion of anaesthesia.
- 1.3 These principles apply wherever anaesthesia or sedation is administered by an anaesthetist.
- 1.4 Institutions in which anaesthetics are given must provide a service which ensures the availability and maintenance of anaesthesia equipment in accordance with College policy documents on recommended minimum facilities for safe anaesthetic practice. The relevant College Policy Documents are:

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

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

PS31 *Recommendations on Checking Anaesthesia Delivery Systems*

- 1.5 Staff employed for the above purposes must be trained as defined below for this role.

2. DEPLOYMENT OF ASSISTANTS

- 2.1 The deployment of assistants in accordance with 1.2, should be specified by management protocols.
- 2.2 The nature and workload of the anaesthesia service will determine the number and status of assistants.
- 2.3 The duties of an assistant should be specified in an appropriate job description.
- 2.4 Whilst assisting the anaesthetist, the assistant is wholly and exclusively responsible to that anaesthetist.
- 2.5 The assistant is an essential member of the staff establishment in all locations where anaesthetists are required to administer anaesthesia or sedation.
- 2.6 There must be appropriate staffing establishment and rosters for assistants.
- 2.7 Where a number of assistants are employed, an appropriately trained senior member of a group of anaesthesia assistants should be designated as being the supervisor.

3. EDUCATIONAL REQUIREMENTS FOR ASSISTANTS

An adequately trained assistant to the anaesthetist must have attended and completed a training course which has as a minimum the following criteria:

- 3.1 Eligibility
 - 3.1.1 Those without previous health sector experience must have the Higher School Certificate or its equivalent.
 - 3.1.2 Those with nursing experience must hold a certificate as a Registered Nurse (Registered Nurse Division 1) or as an Enrolled Nurse (Registered Nurse Division 2), or their equivalents.
 - 3.1.3 Registered Nurses, Division 1 or 2 or their equivalents must be in current clinical

employment or have been so employed within one year of acceptance into a training course.

3.2 Course of Instruction

The course should be developed and administered by an appropriate Institute of learning. A distance learning course is appropriate when conditions demand this.

At a minimum the course will include:

- 3.2.1 A course of lectures that will be provided either full-time or part-time. There will be continuous employment as a trainee anaesthetic assistant during any part-time components of the course.
- 3.2.2 A course of lectures of at least 150 hours in accordance with a curriculum into which anaesthetists have input and in which a significant amount of the lecture material must be prepared and delivered by anaesthetists.
- 3.2.3 Practical instruction supervised by trained anaesthetists, which should be documented in a log book as a record describing the type of instruction received and competencies demonstrated.
- 3.2.4 Completion of assignments appropriate to the curriculum which are suitable for presentation to trainees and supervisors.
- 3.2.5 Successful completion of internal assessments including competencies and designated examinations.

3.3 Duration of the Course

- 3.3.1 For those without previous hospital experience, three years full-time employment comprising study and work as a trainee anaesthesia assistant.
- 3.3.2 For those with Registered Nurse Division 2 qualifications or similar hospital experience, two years full time employment comprising study and work as a trainee anaesthesia assistant.
- 3.3.3 For those with Registered Nurse, Division 1 qualifications, one year full time employment comprising study and work as a trainee anaesthesia assistant.
- 3.3.4 The course should not exceed three years.
- 3.3.5 Study may be undertaken in part-time courses or in full-time blocks.

4. FURTHER EDUCATIONAL ACTIVITIES

The anaesthesia assistant will maintain and upgrade his or her knowledge and skills with regular continuing education activities.

5. The Addendum outlines recommended minimum content for Australian courses.

ADDENDUM

RECOMMENDED CONTENT OF TRAINING COURSES FOR THE ASSISTANT TO THE ANAESTHETIST

Basic Sciences

Instruction will include appropriate elements of:-

- Physics
- Chemistry
- Pharmacology
- Anatomy
- Physiology
- Clinical Measurement
- Microbiology

as these apply to the practice of anaesthesia.

Anaesthesia

In the following areas, in depth understanding of the various topics is necessary. This must be reinforced by appropriate practical experience obtained while providing assistance to anaesthetists.

Anaesthetic Equipment

This will include the care, use and servicing of equipment in normal use.

- Anaesthesia delivery systems and ventilators
- Monitoring equipment
- Airways devices including fiberoptic instruments
- Intravascular devices

- Cleaning and sterilisation of equipment
- Infection control issues for staff, equipment and patients

- Pollution prevention

Safety

- Electrical safety
- Gas cylinders and pipelines
- Hazards in anaesthetising locations
- Patient safety
- Staff safety

Anaesthesia Techniques and requirements in all areas of perioperative practice in both theoretical and practical terms.

Invasive Techniques applicable to anaesthesia including insertion of intravenous, central venous and pulmonary artery catheters and arterial lines as well as their ongoing management. Other techniques such as intercostal tube drainage, red cell salvage and endoscopy of the airways.

Local Anaesthesia including all commonly used techniques for regional blockade.

All Drugs, Fluids and Other Therapeutic Substances administered during anaesthesia.

Emergency Care including provision and care of necessary equipment

- Crisis Management including appropriate algorithms
- Cardiopulmonary resuscitation
- Airway management including difficult airway management
- Cardiac defibrillation and cardioversion
- Blood transfusion

Postoperative Pain including management and equipment required.

Management

- Rostering
- Budgetary matters
- Anaesthesia standards and protocols
- Incident monitoring
- Workplace, Occupational Health & Safety Regulations
- Communication
- Privacy Protection
- Interfaces with other healthcare workers
- Legal responsibilities
- Interpersonal relationships

COLLEGE PROFESSIONAL DOCUMENTS

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This document is intended to apply wherever anaesthesia is administered.

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Australian and New Zealand College of Anaesthetists

ABN 82 055 042 852

Review TE11 (2003)

FORMAL PROJECT GUIDELINES

1. INTRODUCTION

Every trainee registered with the College is required to complete a Formal Project before the Diploma of FANZCA can be awarded. This project is not a prerequisite for presenting for either the Primary or the Final examinations and may be undertaken at any time. To avoid delay in awarding the Diploma of FANZCA, the trainee must submit the project well before the completion of approved vocational training.

A trainee should prospectively register the project with his/her Regional/National Committee (or Training Committee in South East Asia) Formal Project Officer and seek advice **prior to commencing work on the project**. This Professional Document relates to all Formal Projects presented from the commencement of the 1999 training year.

2. OBJECTIVES

The objectives of the Formal Project are:

- 2.1 To advance skills in self-directed continuing education and scientific enquiry.
- 2.2 To develop an understanding of evidence-based medicine.

The objectives are intended to advance skills in trainees by requiring them to gain experience, for example, in how to:

- Develop an idea or concept into a topic for evaluation.
- Derive a question or hypothesis on the topic for the project to answer.
- Perform a literature search on the topic using libraries, books, journals, the internet, *Index Medicus*, Medline, and other forms of information technology.
- Evaluate what information is useful and relevant to the question or hypothesis.
- Collect data from the literature search and relevant investigations.
- Analyse information and data collected, and apply relevant statistical analyses.

- Review past work and publications on the topic, especially with respect to the question or hypothesis.
- Determine one's results with reference, where applicable, to evidence-based reports.
- Decide how to best present one's findings – if publication is intended, decide on the most appropriate journal.
- Write up the project to demonstrate scholarship, i.e. clear, logical, critical and analytical thinking.

3. THE FORMAL PROJECT

The Formal Project is the submitted material of the trainee's work. With the exception of published papers and written dissertations for a qualification (see below 5.3.1 and 5.3.2), a project must include a written report of at least 1,500 words (excluding references) on the work undertaken. This will include a critical review and an evidence-based approach to the specific topic. The trainee should show that he/she has assessed background data relating to the project and objectively weighed up the validity of relevant information obtained from the scientific literature and other sources. The project must be conducted in major part by the trainee (except if the trainee participates in multi-centre research (see below 3.4)).

Examples of Formal Projects are:

- 3.1 A case report of interest or clinical significance.
- 3.2 A review of a topic relevant to anaesthesia, intensive care or pain medicine.
- 3.3 A meta-analysis of published work on a topic relevant to anaesthesia, intensive care or pain medicine.
- 3.4 A research project. This may be conducted mainly by the trainee or be a multi-centre trial. When the trainee participates in multi-centre research, a log book of involvement should be presented which has been signed off by the trainee's supervisor.
- 3.5 Documentation of activity resulting from a period of research prospectively approved by the Assistant Assessor. In general, this will require a period equivalent to three months full-time

research. The trainee must have an appropriate supervisor. A statement from the supervisor to validate the trainee's work must be submitted with the trainee's written report.

- 3.6 Any other project which has value from a clinical, scientific or educational perspective, such as a quality assurance project, a project submitted for a higher qualification relevant to anaesthesia, or an instructional video or computer program.

4. GUIDELINES ON COMPLETING A FORMAL PROJECT

The usual steps undertaken to complete a Formal Project are:

- 4.1 Decide on a topic and propose a question, problem or hypothesis to analyse.
- 4.2 Define terms used in discussions on the topic.
- 4.3 Search for published and other relevant literature on the topic.
- 4.4 Collect other information or data if the project is a research study.
- 4.5 Analyse the scientific evidence in published and/or collected data that is relevant to the question, problem or hypothesis.
- 4.6 Derive conclusions from the analysis of one's information and data. When the trainee has participated in multi-centre research, analysis of the results may not be possible. The trainee should describe the proposed analyses in depth.
- 4.7 Propose solutions and answers to one's question, problem and hypothesis.
- 4.8 Complete the project, e.g. record videos, finish posters, prepare graphics etc.
- 4.9 Write up work undertaken.

5 ASSESSMENT OF PROJECTS

- 5.1 Each Regional/National Committee and Training Committee in South East Asia will appoint a Formal Project Officer, who will certify to the Assessor that each trainee has completed a Formal Project. Except for projects deemed to have met the requirements of the Formal Project (see below 5.3), all projects must be assessed by at least two people nominated by the Formal Project Officer, one of whom may be himself/herself.
- 5.2 For projects which need to be assessed, the Formal Project Officer may accept a project, may require it to be revised or may reject it. The Formal Project Officer will refer rejected projects to the Assistant Assessor. The Assistant Assessor will chair a Formal Projects Panel appointed by Council to reassess these projects.
- 5.3 Completion of the following projects will be deemed to have met the requirements of the

Formal Project without requiring further assessment:

- 5.3.1 A paper published in a refereed journal listed with *Index Medicus*. Letters to Editors are excluded.
- 5.3.2 A qualification relevant to anaesthesia conferred by an educational or professional institution, which requires examination of a written dissertation. Diplomas of FFICANZCA and FPPMANZCA are considered as approved Formal Projects. A qualification relevant to anaesthesia awarded before the trainee commences vocational training may also be accepted as a Formal Project. Acceptance of pre-vocational training and other qualifications requires approval by the Assistant Assessor.
- 5.4 An oral or a poster presentation at an ANZCA ASM, ASA NSC, Regional ANZCA/ASA CME Meeting, CECANZ Meeting, ANZCA Registrars Meeting, or a meeting approved by the Assistant Assessor, may be accepted as a Formal Project without further assessment. However, a written report must be submitted as stated in 3 for any oral or poster presentation submitted as a Formal Project.
- 5.5 Formal Project assessors should consider the following aspects when reviewing a Formal Project:
 - 5.5.1 The project's topic is relevant to anaesthesia, intensive care or pain medicine.
 - 5.5.2 The report has a minimum of 1,500 words.
 - 5.5.3 The trainee conducted a major part of the project or that adequate involvement in multi-centre research has been documented.
 - 5.5.4 The trainee achieved the Formal Project objectives or demonstrated an awareness of the objectives.
 - 5.5.5 The trainee derived a question, problem, or hypothesis for the project to resolve.
 - 5.5.6 The trainee conducted an up-to-date critical review of the project's topic from published and other relevant literature, using an evidence-based approach.
 - 5.5.7 The trainee used (or described) a valid approach or relevant methodology.
 - 5.5.8 The trainee objectively analysed information derived from the project with reference to evidence contained in the literature.

5.5.9 The trainee, where relevant, followed conventional standards applicable to scientific work (e.g. research ethics, honesty of reporting and authorship)

5.6 Formal Project Officers should consult the Assistant Assessor on problems with any project. A trainee whose Formal Project is rejected by a Formal Project Officer and the Assistant Assessor may lodge a formal appeal to the College.

6 CERTIFICATION

Upon compliance with the above, the Formal Project Officer will certify to the Assessor that the trainee has completed an appropriate Formal Project. The College will notify the trainee of its acceptance.

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- PS26 (1999) Guidelines on Providing Information about the Services of an Anaesthetist *Bulletin November 1999, pg 63*
- P28 (1995) Policy on Infection Control in Anaesthesia *Bulletin March 1995, pg 38*
- PS29 (2002) Statement on Anaesthesia Care of Children in Healthcare Facilities without Dedicated Paediatric Facilities *Bulletin November 2002, pg 80*
- PS31 (2003) Recommendations on Checking Anaesthesia Delivery Systems *Bulletin August 2003, pg 85*
- PS37 (1998) Regional Anaesthesia and Allied Health Practitioners *Bulletin March 1998, pg 79*
- PS38 (1999) Statement Relating to the Relief of Pain and Suffering and End of Life Decisions *Bulletin June 1999, pg 93*
- PS39 (2003) Minimum Standards for Intrahospital Transport of Critically Ill Patients *Bulletin June 2003, pg 90*
- PS40 (2000) Guidelines for the Relationship Between Fellows and the Healthcare Industry *Bulletin March 2000, pg 55*
- PS41 (2000) Guidelines on Acute Pain Management *Bulletin November 2000, pg 80*
- PS42 (2000) Recommendations for Staffing of Departments of Anaesthesia *Bulletin March 2001, pg 63*
- PS43 (2001) Statement on Fatigue and the Anaesthetist *Bulletin March 2002, pg 69*
- PS44 (2001) Guidelines to Fellows Acting on Appointments Committees for Senior Staff in Anaesthesia *Bulletin March 2002, pg 71*
- PS45 (2001) Statement on Patients' Rights to Pain Management *Bulletin March 2002, pg 72*
- PS46 (2002) Recommendations for Training and Practice of Diagnostic Perioperative Transoesophageal Echocardiography in Adults *Bulletin November 2002, pg 73*
- PS47 (2002) Guidelines for Hospitals Seeking College Approval of Posts for Vocational Training in Diving and Hyperbaric Medicine *Bulletin November 2002, pg 82*
- PS48 (2003) Statement on Clinical Principles for Procedural Sedation *Bulletin June 2003, pg 97*
- PS49 (2003) Guidelines on the Health of Specialists and Trainees *Bulletin August 2003, pg 89*

November 2003

Australian And New Zealand College Of Anaesthetists

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PROFESSIONAL DOCUMENTS

P = Professional

T = Technical

EX = Examinations

PS = Professional Standards

TE = Training and Educational

- TE1 (2003) Recommendations for Hospitals Seeking College Approval for Vocational Training in Anaesthesia
Despatched with August 2003 Bulletin
- TE2 (2003) Policy on Vocational Training Modules and Module Supervisor *Despatched with August 2003 Bulletin*
- TE3 (2003) Policy on Supervision of Clinical Experience for Vocational Trainees in Anaesthesia *Despatched with August 2003 Bulletin*
- TE4 (2003) Policy on Duties of Regional Education Officers in Anaesthesia *Despatched with August 2003 Bulletin*
- TE5 (2003) Policy for Supervisors of Training in Anaesthesia *Despatched with August 2003 Bulletin*
- TE6 (2000) Guidelines on the Duties of an Anaesthetist *Bulletin July 2000, pg 86*
- TE7 (1999) Secretarial and Support Services to Departments of Anaesthesia *Bulletin November 1999, pg 69*
- TE8 (2003) Guidelines for the Learning Portfolio for Trainees in Anaesthesia *Despatched with August 2003 Bulletin*
- TE9 (1999) Quality Assurance *Bulletin June 1999, pg 94*
- TE10 (2003) Recommendations for Vocational Training Programs *Despatched with August 2003 Bulletin*
- TE11 (2003) Formal Project Guidelines *Bulletin November 2003, pg 92*
- TE13 (2003) Guidelines for the Provisional Fellowship Program *Despatched with August 2003 Bulletin*
- TE14 (2001) Policy for the In-Training Assessment of Trainees in Anaesthesia *Bulletin November 2001, pg 84*
- TE17 (2003) Policy on Advisors of Candidates for Anaesthesia Training *Despatched with August 2003 Bulletin*
- TE18 (2000) Guidelines for Assisting Trainees with Difficulties *Bulletin March 2001, pg 76*
- EX1 (2001) Policy on Examination Candidates Suffering from Illness, Accident or Disability *Bulletin November 2001, pg 75*
- T1 (2000) Recommendations on Minimum Facilities for Safe Anaesthesia Practice in Operating Suites *Bulletin March 2001, pg 68*
- T2 (2000) Recommendations on Minimum Facilities for Safe Anaesthesia Practice outside Operating Suites *Bulletin March 2001, pg 72*
- PS1 (2002) Recommendations on Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia *Bulletin November 2002, pg 78*
- PS2 (2001) Statement on Credentialling in Anaesthesia *Bulletin March 2002, pg 65*
- PS3 (2003) Guidelines for the Management of Major Regional Analgesia *Bulletin March 2003, pg 70*
- PS4 (2000) Recommendations for the Post-Anaesthesia Recovery Room *Bulletin November 2000, pg 72*
- PS6 (2001) Recommendations on the Recording of an Episode of Anaesthesia Care (the Anaesthesia Record)
Bulletin November 2001, pg 77
- PS7 (2003) Recommendations on the Pre-Anaesthesia Consultation *Bulletin November 2003, pg 87*
- PS8 (2003) Guidelines on the Assistant for the Anaesthetist *Bulletin November 2003, pg 89*
- PS9 (2001) Guidelines on Conscious Sedation for Diagnostic, Interventional Medical and Surgical Procedures
Bulletin June 2001, pg 88
- PS10 (1999) The Handover of Responsibility During an Anaesthetic *Bulletin November 1999, pg 62*
- PS12 (2001) Statement on Smoking as Related to the Perioperative Period *Bulletin November 2001, pg 79*
- PS14 (1998) Guidelines for the Conduct of Major Regional Analgesia in Obstetrics *Bulletin November 1998, pg 81*
- PS15 (2000) Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery *Bulletin November 2000, pg 75*
- PS16 (2001) Statement on the Standards of Practice of a Specialist Anaesthetist *Bulletin November 2001, pg 81*
- PS18 (2000) Recommendations on Monitoring During Anaesthesia *Bulletin November 2000, pg 78*
- PS19 (2001) Recommendations on Monitored Care by an Anaesthetist *Bulletin November 2001, pg 82*
- PS20 (2001) Recommendations for Responsibilities of the Anaesthetist in the Post-Operative Period *Bulletin November 2001, pg 83*
- P21 (2003) Guidelines on Conscious Sedation for Dental Procedures *Bulletin June 2003, pg 93*
- P24 (1997) Sedation for Endoscopy *Bulletin May 1997, pg 78*