

Australian and New Zealand College of Anaesthetists

ABN 82 055 042 852

Faculty of Intensive Care
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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President's Message

Teik E Oh, MD, PANZCA

Being Collegiate

Recently a Fellow wrote to "resign" from the College. This is a rare occurrence and one to cause me much concern. I rang him and he told me of his irritations with the College, all of which were of a minor nature. He finished by saying that he did not feel "collegiate" to part with his 2001 subscription. As FANZCA will be withdrawn, he would toss in a qualification that he earned through hard grind and one that he needs as a professional bread-winner. Why would he do that? He gave no reason that I could understand. Troubled by this, I wondered what being collegiate is all about. Perhaps this can be addressed through three questions.

Question 1. *What is the College all about?* ANZCA is more than a training body. The College's core business concerns education and standards. The education umbrella spans training, teaching, learning, assessments, peer review, and continuing professional development (CPD). Professional standards and certification underpin professional practice. Every professional body must establish standards on which excellence is achieved and performance is based. These set professionals apart from charlatans. ANZCA's education and guidelines are corner stones of practice standards in our disciplines in Australia, New Zealand and parts of Asia-Pacific. Our College exists to serve our patients safe and quality care. Being collegiate is being a Fellow of our College.

Question 2. *What can the College do for me?* The College provides Fellows with the professional means and culture to deliver safe and quality care, foremost examples being certification and CPD. FANZCA certification provides recognition as a specialist anaesthetist with its resultant clinical privileges. The College may look to widen the latter. Some Fellows are involved in a few areas of clinical medicine outside of mainstream anaesthesia and FANZCA training (ie. which are not anaesthesia procedures or subspecialties). Certification

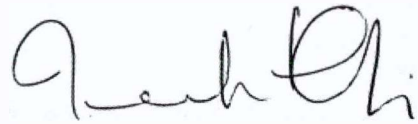
in such an area of expertise will establish safer standards of practice and provide our Fellows with appropriate clinical privileges, which could otherwise be denied them. Since College processes respect procedural fairness and natural justice, no anaesthetist need fear discrimination if they meet peer-established standards. The big benefits of College certification are the promotion of safe and quality care for our patients and the establishment of clinical privileges for Fellows.

CPD is a responsibility of all medical practitioners. The College is developing a series of CPD programs for Fellows. Other than CME meetings, these will include modules for self-learning and self-development, in print and interactive form on the web. Our new Director of Education, Dr Russell Jones PhD, and his deputy, Dr Mary Done, a Fellow herself, will provide much guidance in this. More CPD programs will help Fellows fulfil the MOPS program, which will itself undergo refinement. The Australian Medical Council has signalled an intention to recertify specialists, using compliance with MOPS as a determinant. Recertification is in line with other countries and is already in practice in New Zealand. The College's efforts in CPD and other new initiatives will assist Fellows to comply with recertification. Much time is expended by College officers, your peers, with Commonwealth and State officials and sister medical colleges in the interests of patients and Fellows. Being collegiate is being privileged with the professional entitlements of Fellowship.

Question 3. *What can I do for myself?* JF Kennedy in his Presidential Inaugural Address (1961) said "...ask not what your country can do for you - ask what you can do for your country". We need not explore patriotic sentiments here, but what can Fellows do for the College and thus for themselves? Work for the College *pro bono* as a Councillor, member of Regional and College committees, examiners, hospital reviewers etc. involves some degree of personal sacrifice. This

selfless work is akin to that done by "honoraries", those teaching hospital visiting specialists before the 1970s who gave unpaid time to teach and attend to public patients. It is a worthy pursuit to give something back to the system that rewards us and to invest in the future of our specialties. If we don't, who will? Who pays the ferryman? There are no free rides. I urge every Fellow to become involved in *your* College. Redress wrongs, redirect priorities, plant ideas, cultivate advances, reap progress, and achieve satisfaction. Help your

patients, help your peers, and help yourself. Be passionate about being the best. Be the best. Being collegiate is being involved.

A handwritten signature in black ink, appearing to read "Andrew Shi". The signature is written in a cursive, flowing style with a large initial 'A' and 'S'.

Highlights of Council

FROM THE FEBRUARY 2001 COUNCIL MEETING

WELCOME

In accordance with College policy to invite two Regional/National Committee Chairmen to attend Council Meetings, the President welcomed Dr Frank Moloney (NSW) and Dr Margaret Wiese (SA) to the meeting.

Professor Richard Smallwood AO, Commonwealth Chief Medical Officer, presented Council with a most interesting and varied presentation with regard to current issues in medicine and those perceived for the future.

INTERNAL AFFAIRS

Election of President-Elect

Professor Teik Oh was re-elected President to continue this office following the forthcoming Annual General Meeting in May.

ANZCA Prize

The ANZCA Prize is available to a final year student with the best overall performance in the anaesthesia module of the clinical curriculum of Australasian Medical Schools.

In Western Australia, the Australian Society of Anaesthetists awards the "Gilbert Troup" Prize to the best medical student in anaesthesia in the University of Western Australia Medical School.

At the request of the West Australian anaesthetists to continue this tradition, Council agreed that in future, the College and the Society each donate \$150 towards this Prize and retain the name of "Gilbert Troup" in the Prize.

Library

Primary Exam Textbooks

Council agreed to a core collection of text books for the Primary Examination being housed in the office of the New Zealand National Committee for ease of access to examination candidates.

EDUCATION

5th National Forum on Prevocational Education held 16-17 November 2000

Dr Steuart Henderson, Education Officer, attended the recent Forum. Items of interest from the Forum were highlighted as follows:

- Formative versus summative assessment with regard to ITA was considered. The general view of the forum had been that using ITA for summative assessment is not a reliable method.

- It was noted that the issue of logbooks had been raised and that their use has been decreasing and has now been abandoned virtually everywhere in North America.
- Encouragement for trainees to undertake rural rotations was considered and supported.

The Forum concluded by passing the following resolutions:

1. This Meeting opposes separation of teaching and training from clinical practice, as this will affect continuing medical education, quality improvement and risk management.
2. This Meeting supports the provision of medical education by practising clinicians who have appropriate support from professional educators, and access to professional development of teaching skill.
3. This Meeting recommends that each primary allocation centre should develop at least one rotation to a community or rural practice.
4. This Meeting resolves to promote increasing involvement of junior doctors in all aspects of postgraduate medical education.

Director of Education

Dr Russell Jones commenced his appointment as Director of Education with the College in January. Dr Mary Done took up her role as Assistant Director of Education in February. These appointees are available to all Fellows and trainees and are anxious to assist with all educational matters.

The following items were highlighted by Dr Jones for development and educational input:

Supervisors of Training	In-Training Assessment	MOPS
Modular Training	Web-based CME	Rural Issues
Assessment and Exams	Research	
Communication	Education of the Public	
Asia Pacific Education	New FANZCA Program	

Dr Jones advised that he was compiling an initial report encompassing each of these topics which would be circulated to Council for feedback in due course.

Dr Jones will conduct a Workshop for Supervisors of Training during the CSM in Hong Kong and has plans to visit the Regions and New Zealand.

Anaesthetics Framework for PGY1 and 2 Trainees

The amended document setting out guidelines for educational opportunities in anaesthesia for PGY1 and 2 medical practitioners was accepted and will be forwarded to the Postgraduate Medical Council in Queensland as the approved College version.

Performance Assessment

A document on Performance Assessment was accepted in principle by Council. Prior to formal approval by Council, this document has been forwarded to the CPMC for consideration.

New Zealand National Matters

It was advised that the joint NZ National Committee/NZSA/CECANZ website has been established.

ELECTION TO FELLOWSHIP

Council endorsed the following principles for eligibility for Election to Fellowship without Examination:

- That OTS resident in Australia and New Zealand before January 1996 who have been assessed and supported for specialist recognition by ANZCA, and have subsequently practised anaesthesia or related specialties for at least five years, are eligible for consideration for election to Fellowship under Regulation 6.3.1. The criteria and process

for consideration will follow principles and guidelines endorsed by Council.

- That OTS who enter Australia or New Zealand from 1 February 2001 and who do not pass the ANZCA OTS Assessment Process are not eligible for consideration for election to Fellowship under Regulation 6.3.1.
- That OTS resident in Australia or New Zealand who entered after January 1996 and who did not pass ANZCA specialist assessment under Regulations pertaining from January 1996 to 1 February 2001 will not be eligible for consideration for election to Fellowship under Regulation 6.3.1

PROFESSIONAL

Professional Documents

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

PS43 *Statement on Fatigue and the Anaesthetist*

As a result of the promulgation of T2 *Recommendations on Minimum Facilities for Safe Anaesthesia Practice Outside Operating Suites* in December 2000, the following professional documents have been withdrawn:

- PS33 (1999) *Recommended Minimum Facilities for Safe Anaesthetic Practice for Electro-Convulsive Therapy (ECT)*
- T3 (1995) *Recommended Minimum Facilities for Safe Anaesthetic Practice in Organ Imaging Facilities*
- T5 (1995) *Recommended Minimum Facilities for Safe Anaesthetic Practice in Dental Surgeries*
- T6 (1995) *Recommended Minimum Facilities for Safe Anaesthetic Practice in Delivery Suites*



Law Report

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

The Corridor Consultation

I am often asked about the potential liability of the doctor who provides general advice to a colleague, junior doctor or trainee. The notorious 'corridor consultation' is a pervasive and important part of training and encouragement of junior doctors and is an important part of the collegiate manner in which many doctors conduct their practices, whether private or public.

The 'corridor consultation' is usually one in which the problems of the patient are discussed in generalities, the practitioner offering advice has not seen the patient or their records and the advice given may explore options and possibilities rather than any definitive view.

The question might be put as follows:

'The doctor who has not seen the patient in question is consulted by another doctor, who may proceed to take action on the basis of the advice given. What is the liability of the first doctor?'

One would expect that, in these circumstances, commonsense will prevail.

Certainly in its purest form the 'corridor conversation' should not entail any liability for the advising doctor. Where a doctor, who has no relationship with the patient in question, is not responsible for the supervision of the consulting doctor and who is only advising in generalities, should have no liability to the patient.

On the other hand, a doctor who may be the senior consultant for a department, who has general responsibility for a patient

in the department, and is responsible for the supervision of the consulting doctor and who gives relatively detailed advice or instruction, may be liable notwithstanding that the doctor would not assume that his or her advice was intended to be a 'directive' for treatment.

These are obviously two extreme situations, where the outcome might be considered clear. There will, however, be many instances that fall between these two and constitute an area of 'grey', where liability may or may not arise.

Duty of Care

The doctor owes a duty of care to all those who he or she could reasonably expect to be affected by his or her actions. The extent to which the doctor could expect others to be affected by his or her advice, depends on the extent to which the advice is likely to be followed. If it is taken as a directive or a clear instruction, then the doctor may have liability for the advice. If the advice is merely an exchange of ideas, consideration of options (without formal consultation) then liability should not flow.

The liability, where it arises, might be to the patient who receives the treatment in relation to which the doctor's advice is given. The liability could also be to the consulting doctor, who acts and relies upon the doctor's advice.

Factors which might influence the likelihood of liability include:

- The nature of perceived seniority and the relationship between the two doctors - the advice of a supervising consultant to a junior colleague will carry more weight than the shared opinions of two colleagues of equal seniority.

- The formal role of the doctor as a contractor - is the doctor in charge of the department? Is the doctor a supervisor of treatment for this patient or ward? Is the doctor a specialist in this particular area?
- The circumstances in which the advice is given - an exchange of views in the corridor, a formal question on rounds, a formal consultation in the doctor's office, etc.

If the advising doctor is generally perceived to have a high level of expertise, then he might expect the advice that he gives is likely to be carried out, and may have a duty of care towards the ultimate patient.

Similarly, if the role of the advising doctor is as a supervising consultant, then advice might be construed as being given in his official function as an adviser, and may attract a duty of care towards the patient.

However, if the advising doctor is consulted by one of equal seniority, or is consulted as a colleague rather than in any formal sense, then it is clearly unlikely that a duty of care would apply. In those cases, it would not be reasonably expected that the advice or suggestion would be taken as directives and carried out.

The context and manner in which the advice is given is important. Obviously the doctors involved will be well aware of the fact that the consulting doctor has not seen the patient in question, not seen the patient's records and is relying on an abbreviated description of the symptoms/problems.

Clearly if the advice is framed in such a way which makes it clear that it is of general application or is a consideration of options, or is subject to further tests or investigation, then liability is less likely.

The courts have, and we assume will, adopt a commonsense approach to an examination of these circumstances. There have been few occasions where a doctor, giving general advice of this nature, has been sued, let alone attracted liability.

Nonetheless, it would be prudent for doctors giving general advice of this nature to make it clear that it is of a general nature, is merely a discussion of options or is subject to further investigation or review by the doctor seeking the advice.

Standard of care

If a duty of care is found, the standard of care required of the advising doctor, to discharge that duty, would be to take all reasonable care in giving the advice that would be expected of a person with his or her expertise.

A doctor with greater experience and seniority will be required to bring that skill and seniority to the consultation.

In some high risk circumstances, an advising doctor might be required to see a patient personally and review the patient's

record, before giving any definitive advice which might be relied on by the doctor seeking the advice.

Obviously liability issues could be avoided completely if the advising doctor made a policy of seeing each patient as a formal consultation - although this would be impractical. Alternatively, the advising doctor could make it clear that his or her advice was given in general circumstances and should not be relied upon or acted upon, in the absence of a more formal consultation, further investigation or review, etc.

Conclusion

'Corridor consultations', are an every day part of hospital life and collegiate work. In all of our professions, we often consult and provide general advice to our colleagues on a range of issues or matters. None of us would regard them as circumstances in which legal liability should apply.

The courts will recognise that these types of consultations will occur, and are an important part of professional life. There is great value generally in ensuring that consultations of this nature can take place, without fear of litigation or liability.

This article merely serves to send a warning that liability may apply in circumstances where the 'corridor consultation' takes on the appearance and circumstances of a formal consultation, where there may be reliance on the advice given and where treatment of patients might follow. The more likely it is that the advice will be relied upon, and that a patient will be treated accordingly, then the more likely that liability may attach.

In those circumstances where you may be concerned about liability, then it may be important to keep a general note of the conversation and circumstances. There are, of course, practical limits.

One doctor recently mentioned to me:

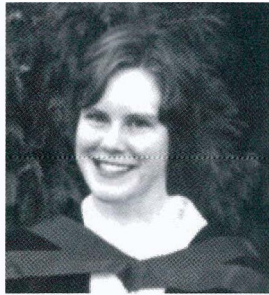
'For myself, I never keep records of such conversations. I do not know the identity of the patients and, in general, I do not hear the outcome unless the patient is subsequently referred. Obviously, over a period of time, we get to know the referring doctors and whether we can rely upon them. Some are so unreliable that I, as a rule, would suggest the patient be referred for a personal assessment, but I do not have any serious concerns about giving advice to help them out.

'To keep records of conversations like this, to insist on obtaining the patient's name, or to insist on seeing every patient personally, would make the job impractical...'

There is obviously some fear that liability may attach to these types of consultations and advice. The above factor should therefore be borne in mind.

I am grateful for the assistance of Anthony Massaro in the research and preparation of this article.

Undergraduate Prize In Anaesthesia



The recipients of the 2000 ANZCA Prize for the University of Tasmania were Dr Elisabeth Spurr (above) and Dr Michael Lumsden-Steel, who were presented with their awards at the University's Graduation Ceremony held on 13 December 2000.



Dr Denzil Gill received the 2000 ANZCA Prize for the Christchurch Clinical School of Medicine, University of Otago.

Admission To Fellowship

BY EXAMINATION

AGIUS	Erika Veronika	NSW	LIM	Soo-Im	WA
BARIC	Amanda	VIC	LO	Kevin Shing	HK
BENNETT	Elizabeth Jane	QLD	MACLEOD	Iain Cameron	SA
BLUM	Philip Georgeson	NT	MAFFEY	Simon Charles	QLD
CAIN	Adrian Gerard	IRE	MANN	Timothy John	WA
CAPONAS	George	NSW	MCDONALD	Andrew John	NSW
CHANDRASEKARA	Sisira Dishan Parakrama	VIC	MCFARLAN	Charles Stuart	NZ
CHANG	Geoffrey Wai Ming	NSW	MCGIRR	Anthony Gerard	NSW
CHEUNG	Pearl	QLD	MCILROY	David Richard	VIC
CHIRNSIDE	Robyn Frances	NZ	MCLEAN	Richard John	QLD
CHU	Ming Chi	HK	MISSO	Sonia Louise	UK
CLUNIES-ROSS	Penelope Jane	VIC	MOHLER	Thomas	VIC
COLBY	Anthony Craig	QLD	MOLNAR	Adam Robert Louis	VIC
COLE	Claire Michelle	WA	MOORE	Brendan Joseph	QLD
COOPER	James Peter	VIC	MURRAY	Catriona Louise	NSW
COOREY	Anthony Neville	QLD	NEWELL	Patricia Anne	VIC
DUNCAN	Matthew Kevin	QLD	NG	Man Wai, Vivian	HK
EGAN	Mark Kenneth	NSW	ORFORD	Neil Ronald	VIC
EMERICK	Darren Robert	QLD	PEARCE	Stephen Geoffrey	NZ
FANSHAWE	Michael Peter	QLD	ROBINSON	Andrew William Eldon	TAS
FERGUSON	Sarah Jane	NSW	SCHNEIDER	Andrew Carl	VIC
FOREMAN	Ross William	NSW	SHEN	Judith	HK
FORTIER	Karen Patricia	QLD	SINCLAIR	Paul	NSW
GARRETT	Wesley Mark	QLD	STANDEN	Jane Catherine	NSW
GIRDLESTONE	Peter Thomas Joseph	VIC	STEELE	Raymond Geoffrey	VIC
GROSSI	Antonio	VIC	STELLIOS	John	NSW
HASTIE	Cameron Robert	QLD	SUE	Graham	WA
HEARD	Gaylene Claire	VIC	SWAINSBURY	Vandna	QLD
HEWITSON	Erica Helen	SA	VELTMAN	Michael George	NSW
HILL	Jack Simon	WA	WATSON	William Robert	VIC
HO	Sue-Chen	VIC	WILSON	Michael David	UK
IMISON	Andrew Robert	WA	WONG	James Siew Hua	NSW
JAMES	Christopher Richard		WORBOYS	Stephen James	VIC
	Maldwyn	VIC	YUEN	Shiu Tim Timmy	HK
JOHNSON	Fiona Jane	VIC	By Examination through the OTD System		
KEAVY	Denise Joanne	NSW	HONG	Debbie Kim	ACT
KONTROBARSKY	Yuri	VIC	WAKEFIELD	Martin Lawrence	QLD
LANG	Robert Alexander	ACT			
LEONG	Samuel Wen-Fei	VIC			

Director of Education



Dr Russell W Jones has commenced his appointment as the Director of Education for the College. The creation of this new position reflects the increasing emphasis placed by the College on education. Dr Jones holds a research-based Doctorate specialising in evaluative and research methods from the University of Massachusetts. In addition he has extensive experience in the development, implementation and evaluation of a broad range of educational programs, adult education, teaching and training, research, quality assurance and standard setting. Dr Jones has held academic appointments at Melbourne University, Boston College and the University of

Massachusetts. He has consulted widely for educational bodies and multi-national corporations including the International Association for the Evaluation of Educational Achievement, UNESCO, Reed International, the National Assessment Governing Board USA, the World Bank, the Institute for International Research and the International Assessment of Educational Progress. Dr Jones is looking forward to bringing his knowledge, skills and experience to the role of Director of Education at the College.

In addition to a Ph.D. Dr Jones holds a Bachelor of Science degree, Post Graduate Diploma in Education and a Bachelor of Education degree with first-class honours. He was awarded these qualifications from the University of Western Australia, along with the Cecil Andrews Prize in Education and the Bertha Houghton Prize in Education. Subsequent awards include the John W Turnbull Memorial Fellowship awarded by Educational Testing Service of Princeton in 1991 and the Psychometric Methods Fellowship USA for the pursuit of evaluation and assessment interests in psychometric issues and practice awarded in 1990-91, and again in 1991-92 and 1992-93.

Dr Jones' primary role is one of leadership in the development and implementation of the educational programs of the College. These programs include training and accreditation, continuing assessment and examination, and professional development. Dr Jones would welcome the opportunity to discuss all aspects of education within the College. His e-mail address is DirEduc@anzca.edu.au.

Admission to Fellowship

BY ELECTION

Under Regulation 6.3.1 (a)

BOLSIN	Stephen	VIC
POWER	Ian	SCOTLAND

Under Regulation 6.3.1 (b)

ALLEN	Philip William	QLD
AMARASENA	Lakshman Sunil	QLD
BELLUM	Nanda Gopal	NZ
BUKOFZER	Mark	NZ
CARTER	Martin Louis	NT
DOMINY	Clive Bruce	NZ
DONAHUE	Peter Latham	QLD
HOOD	Gillian M	SA

MEYER-WITTING	Martina	QLD
MITCHELL	Angus	NSW
ROSE	John Andrew	NZ
SRI RAGAVAN	Ponniah	NZ
STEPHENS	Peter Hugh	QLD
STORRS	John Alastair	QLD
VAN AMMERS	Pieter Max	NZ
VROON	Johan Anton	NZ
WALLACE	Marianne	VIC

Under Regulation 6.3.1 (e)

LOW	John	HK
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Comment on Prevention of Venous Thrombo-Embolism

Recent publicity in the lay press has focussed attention on the vagaries of the coagulation system. The first of these reports outlined the death of a young British tourist en route from Australia to England following development of a deep venous thrombosis and subsequent fatal pulmonary embolism, the so-called 'economy class syndrome'. The second related to the near blinding of a patient following minor ocular surgery.

The problem in this case was a severe retro-orbital haemorrhage as a result of the ingestion of garlic tablets, which have anti-coagulant properties. Organic supplements of this nature are common and possess myriad physiologic modifications of which anaesthetists should be aware or, at least, suspicious.

The peri-operative area is, however, the concern of most anaesthetists. In recent times the medico-legal system has begun to hone in on instances where appropriate anti-coagulation is in question. Plaintiff lawyers thrive on issues that are contentious especially where doctors cannot agree amongst themselves as to what constitutes an acceptable protocol and where the medical literature or its internet counterpart produce conflicting information. How should an anaesthetist respond and where do his or her responsibilities lie when it comes to avoidance of legal action?

Whilst nothing is concrete in law, it is reasonable to assume that the surgeon bears primary responsibility for the individual patient. If an anaesthetist is to notate the chart with an anti-coagulant protocol it should only be after confirmation with the surgeon. Not all surgeons are diligent in this regard and, where appropriate, the anaesthetist should bring his colleague's attention to the need for anti-coagulant therapy. Furthermore, in the various journals of the surgical subspecialties each have variable regimens, which may differ from those appearing in anaesthetic data. Some orthopaedic surgeons, for instance, prefer low molecular weight heparins whilst others commence an immediate warfarin regimen. Compression stockings and calf stimulators are also part of a complex equation.

It is not the purpose of this commentary to summarise the current status of debate but rather to draw attention to the need for consensus and to adopt a policy that will at least give some protection in the unfortunate circumstance of a serious complication. A recent article in the *Australian and New Zealand Journal of Surgery* (1999), Vol 69, summaries the outcome of a working party entitled 'A National Working Party for prevention of DVT and Chronic Venous Insufficiency'. Of most relevance

to anaesthetists is the association of intraspinal anaesthesia and the potential for catastrophic haemorrhage into the epidural space. In this article the authors conclude that 18-24 hours should be the recommended time between any intraspinal procedure and administration of a low molecular weight heparin. In common practice 12 hours is usually accepted as a reasonable compromise provided there are no other anti-platelet drugs in use. An excellent summary of this subject, which covers most situations, is obtainable at the American Society of Regional Anaesthesia website:

<http://www.asra.com/consensus/>

Table 1. Risk assessment and deep vein thrombosis prophylaxis for surgical patients.

Risk category	Surgical patient	Prophylaxis
High	Orthopaedic surgery of pelvis, hip or lower limb Major surgery, age > 60 years Major surgery, age 40-60 years with cancer or history of DVT/PE or other risk factors Thrombophilia	LMWH or unfractionated heparin + GCS ± SCD
Moderate	Major surgery, age 40-60 years or other risk factors Minor surgery, age > 60 years or age 40-60 years with history of DVT/PE or oestrogen therapy or other risk factors	Unfractionated heparin or GCS
Low	Major surgery, age < 40 years Minor surgery, age < 60 years	Consider GCS

DVT, deep vein thrombosis; PE, pulmonary embolism; LMWH, low molecular weight heparin; GCS, graduated compression stockings; SCD, sequential compression device.

From Fletcher, K.P. et al, "Prevention of Venous Thrombo-Embolism", *Australian and New Zealand Journal of Surgery*, (1999) Vol 69, reproduced with permission.

Obituary

Dr Peter William Padbury

Victoria – FFARACS 1979, FANZCA 1992

Peter was born in Perth 51 years ago, moving to Adelaide when aged 16 to complete his major schooling at St Peter's College. His first year in Medicine at the University of Adelaide resulted in several academic prizes. The following year, 1968, his father Bill, a director at Elders, was transferred to Melbourne, and so Peter completed his undergraduate years at Monash University Medical School, taking several prizes on the way. He graduated with Honours in 1972, and his resident and anaesthetic registrar years were spent mainly at the Alfred Hospital. His special ability in Anaesthetics was recognised early in his registrar years. He married Caroline in 1973, and they were to have three children, Sarah, Stuart and Robert.

1979 was an important year for Peter – he was awarded his FFARACS and was quickly snapped up by the Melbourne Anaesthetic Group.

As the years passed, Peter's anaesthetic skill and knowledge and his personal manner ensured he was very successful in his private practice, and he was always in demand.

Peter was very proud of belonging to the Melbourne Anaesthetic Group and over the past few years had involved himself in the office management, being quite at home discussing the legal or accounting business of the Group. His administrative qualities were also put to use at some of the hospitals he attended.

Peter was also well known for his quirky, Pythonesque sense of humour. His e-mail address began with 'sandman' and for many of us he will remain the mythical, ideal anaesthetist. He was punctual, courteous and efficient, with compassion for his patients and concern for their post-operative comfort.

We will all miss him in our own ways. Within the wider hospital community in which he worked, there is a sense of sadness and loss. His wise counsel, easily given, will be sorely missed. He was special to all who knew him. The hearts of his family and close friends will long hang heavy. He was a man of the finest principles and integrity, a man of honour, and an expert anaesthetist. And he was a great mate.

Michael Rozen

Deaths

Council noted with regret the death of:

Dr Arthur Barclay Bull (South Africa) – FFARACS 1977, FANZCA 1992

Dr Peter William Padbury (Vic) – FFARACS 1979, FANZCA 1992

Dr William James Pryor, OBE (NZ) – FFARACS 1955, FANZCA 1992

Dr Annie Winifred Wall, OAM (SA) – FFARACS 1955, FANZCA 1992

Open Letter to the Australian Medical Profession

The Hon Daryl Williams, AM, QC, MP
Attorney-General

I wish to bring to your attention an issue that I consider to be of concern to readers of this journal. That issue is the need for authorisation from an appropriate court or tribunal prior to undertaking a sterilisation procedure on a minor unless as a by-product of surgery appropriately carried out to treat malfunction or disease.

I am bringing this to your attention as a lack of awareness among some professionals may be leaving children without the protection of the law. Professionals who perform unauthorised procedures are at risk of liability.

In 1992 the High Court of Australia, in a case referred to as *Marion's Case*, decided that the right to consent to the sterilisation of a child is not within the ordinary scope of parents' or guardians' powers, except in limited circumstances. The High Court considered that where certain special medical procedures, including sterilisation, were to be undertaken, the decision to do so should be made by an objective, independent decision-maker. The Family Court of Australia and the Federal Magistrates Service are appropriate bodies to decide such matters.

It has come to my attention that some sterilisation procedures are being undertaken on children without the proper authorisation. Though I believe the number of these unauthorised procedures to be small, I also believe that the legal obligation to obtain court authorisation may not be widely known among medical professionals.

In November 1998, the Medicare Benefits Schedule was amended to include advice that:

(i) It is unlawful throughout Australia to conduct a sterilisation procedure on a minor (under 18 years of age) which is not

a by-product of surgery appropriately carried out to treat malfunction or disease (eg malignancies of the reproductive tract). Parents/guardians have no legal authority to consent to such sterilisation procedures.

(ii) Practitioners may be subject to criminal and civil liability if the sterilisation procedure is not authorised by the Family Court of Australia or a Court or Tribunal with jurisdiction to give such authorisation.

Revised Commonwealth Priorities and Guidelines for Legal Assistance in Respect of Matters Arising Under Commonwealth Law have also been approved. The revised Guidelines reflect the Government's policy of encouraging parents to act lawfully and seek a court order for special medical procedures (such as sterilisation), by making legal aid more accessible and clarifying eligibility, particularly for parents.

The Guidelines provide that legal assistance should be granted for the separate representation of a child in any court case relating to special medical procedures. The means test is not applied in such cases, and a legal aid commission must not try to recover any of the costs of the child's representation from the child's parents, whether they are legally assisted or not. Legal aid must also be provided to the parents of a child in any court case relating to special medical procedures where the parents meet the means test. More information on the Guidelines can be obtained from Legal Aid Commissions in all States and Territories.

If you have any questions with regard to procedures for obtaining authorisation for a sterilisation procedure on a minor, you should contact the Family Court in the relevant State or Territory.

Yours sincerely

Daryl Williams

Fellow's Profile

DR IAN MCDONALD

Reproduced with the permission of the Melbourne Cricket Club's MCC News " 'Doc' kept batsmen watchful and his patients quiet"

The slightly built medico, whose peak athletic statistics in the pre-decimal era were 5ft 7in and 10st 5lb, played cricket for our first, second and club eleven teams (1947-53) and represented Victoria as wicketkeeper (1948-53).



Sixty years after joining the club as a junior member, Dr Ian McDonald, 77, was accorded Honorary Life Membership at the annual general meeting on 16 August. Few people in the MCC's 162-year history have made such a varied contribution to the clubmanship of our extremely broadly based institution.

He founded the MCC Hockey Section in 1960, was playing chairman for 10 years and in 1986 received the Hans Ebeling Award for services to the MCC Sporting Sections. The MCC's XXIX Club (The Twenty-Niners to non-Latin scholars) was conceived by this busy little bee in 1956, when selectors were suspected of giving low priority to those who had reached the age of 30.

McDonald, with contemporaries Jack Daniel, Jack Green, Clive Fairbairn, Max Haysom and others, were in the danger zone, so they made the decision that they would never be older than 29 – at least in spirit – and would continue to play the game, at whatever level.

Lindsay Hassett was guest speaker at the Twenty-Niners' inaugural dinner in 1957 and its rostrum has been adorned ever since by Australian and overseas cricket dignitaries. On the field, the XXIX club banner since has been flown in UK, Asia, Canada, Denmark and Central Australia.

Apart from this major contribution to the social life and culture of the club, Ian McDonald was on the MCC committee for 10

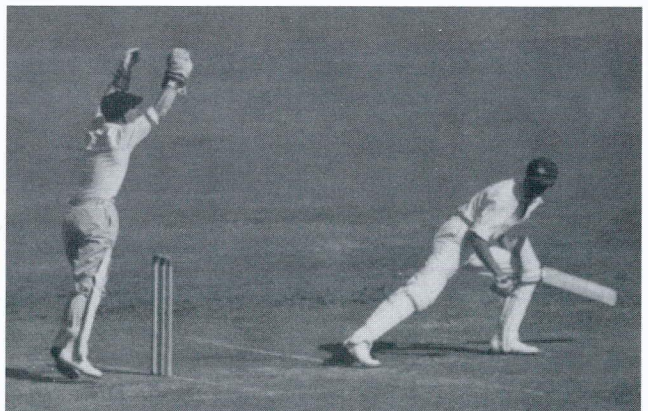
years from 1958, noting without any hint of criticism that 'they were very elderly' (President Charlie Simmonds was 91 when he stood down in 1965).

'Doc' McDonald was surprised and somewhat embarrassed at his elevation to the life membership honour board. He accepted the ultimate MCC accolade with the blushing humility of a century-maker receiving a standing ovation after being missed three times in the nineties.

Actually no century came McDonald's way in either VCA pennant or Shield cricket, but getting in to the eighties during a club record partnership with Mac Holten is a pleasing 'one off' recollection. And being chosen for 'an Australian XI' against South Africa at Sydney in 1952 was a career highlight.

So how did our man become a wicketkeeper sufficiently proficient to play at state level, effect six dismissals in an innings against SA and briefly harbour aspirations of a trip to England as a second 'keeper in 1953?

Maybe we should defer to the infallible logic of the six-year-old kids at Glen Iris State School who worked out that their 'Skeeter' was too short to bowl fast or run fast in the field so there was nowhere else to go but behind the sticks. Good thinking. He thereafter kept through Scotch College and University (1941-45) en-route to MCC then state selection in 1948, the same year as younger brother and Test opener Colin. Of a host of first class cricket memories, McDonald unhesitatingly nominates Keith Miller and Ray Lindwall as Victoria's greatest opponents. Lindsay Hassett and Neil Harvey were the Victorian greats of his era.



Ian McDonald's first Shield wicket – Queensland's Ken Archer caught off Doug Ring.

Unsurprisingly, he names Jack (Big Jake) Iverson as the most sensational entrant to big cricket and certainly an MCC all-time superstar with his unorthodox and undetectable finger-flipping spin, impeccable length and unusually high bounce combining to bamboozle batsmen at all levels of the game.



Former president and fellow life member Donald Cordner with 'Doc', his wife Dorothy, Bruce Church and Ian's brother Colin.

Iverson's first class figures will continue to delight generations of statisticians but McDonald points to the MCC honour board as the best justification for the man's reputation as 'the mystery spinner'.

'He won four bowling averages in six seasons of VCA cricket, improving from 12 per wicket in the first season, through 11, nine, then 6.6 in the last season. To me, those numbers convey that, unlike just about every other bowler in history, he was never mastered in pennant cricket. He just kept getting better.'

It is a tribute to modest McDonald's ability that he was able to read Iverson's spin accurately. But he kept wickets poorly (his own assessment) in 1952-53, missed the second wicket-keeping berth to England and retired from serious cricket.

A medical graduate, he had chosen anaesthesia as his discipline basically because it offered flexibility in time off to play cricket for Victoria! However, two years at Oxford on a Nuffield Fellowship had confirmed that anaesthesia, emerging from the 'rag and bottle' stage, was evolving into an exciting new life-saving era. Inevitably, it assumed top priority in Ian's life.

'Doc's' current sporting activities are social golf, where hundreds come easily, and fly fishing, where he gleefully accepts all catches. Contemporary hockey player and recent

MCC tour guide Lew Jenkins described McDonald as a great organiser, with ideas, energy and a talent for recruiting the right people.

'He won the support of the club committee, all of who came to the Hockey Section's annual dinner. That was some feat!'

As a footnote to this article which appeared in the *MCC News* of December 2000, Ian wishes to say that much as he appreciated the great honour accorded him by MCC (there are only four other living life members), and the very delightful article reporting the conferring of that award, he would perhaps, rather be remembered by his anaesthetic colleagues for initiating prolonged naso-tracheal intubation at the Royal Children's Hospital, Melbourne, reporting the first series of cases in association with the remarkable and dearly remembered John Stocks. John of course, was the man who continued the developmental hard labour, and who, particularly with our Adelaide paediatric colleagues, produced a life-saving tool of world-wide significance.

He also points out that he owes a great debt of gratitude to his anaesthetic and non-anaesthetic friends at the Royal Children's who covered for him during interstate cricket commitments over six years, at a time when the rag and bottle was giving way to the methods which were the fore-runners of today's somewhat more precise routines. The decision to embark upon a career in anaesthesia therefore, was not only one of flexibility in lifestyle as suggested in the *MCC News*, but was also due to the burgeoning demand for exponents of the new technology. Ian was indeed the first anaesthetic registrar appointed to the RCH in 1951.

It is of some interest to recall that in 1947 Brian Dwyer (ex Dean of Faculty) and Ian were opposing captains in a New South Wales v Victoria 2nd XI game at the MCG, where an horrific accident befell Richie Benaud; but that is another story. Extraordinarily they next met when they found themselves in partnership at the Nuffield Department of Anaesthetics, Radcliffe Infirmary, and the City Cricket Club in Oxford in 1953/54. So there appears to be some association between cricket and anaesthesia. Anaesthetists and wicket-keepers have much in common. They must consult closely with the captain (and sometimes stand in for him), take the hard ones, and recognise the googlies. Both are vital cogs in what should be close-knit teams.

The Melbourne – Munster Exchange



Dr Robert Grauer, Mr Paul O'Sullivan (Australian Ambassador) Dr Hugo Van Aken and Dr Richard Walsh met together recently when Ambassador O'Sullivan officially visited The Department of Anaesthesia at Westfalische Wilhelms University.

One of the great things about anaesthesia is that we can go all over the world and work in our specialty. Traditionally anaesthetists would go and practice in the UK or USA to gain extra experience both in anaesthesia and life. However other parts of Europe have a great deal to offer and it was with this in mind that we developed an exchange between St. Vincent's Hospital in Melbourne and the Westfalische Wilhelms University in Munster Germany. Dr. Robert Grauer spent a year in Munster gaining many new skills in anaesthesia and appreciated being exposed to a different style of anaesthesia practice. The Department of Anaesthesia at Westfalische Wilhelms University is headed by Professor Hugo Van Aken and is considered to be one of the best academic departments in Germany. Robert rotated through most of the anaesthetic subspecialties and gained valuable skills with peripheral nerve blocks, massive transfusion for orthopaedic tumour surgery, induced hypotension and wake up during scoliosis surgery. He was able to increase his experience in obstetrics and about a third of his patients were children. Robert gained a greater understanding of how a major academic department was

structured and made a number of friends amongst his German colleagues which he hopes to maintain for life. Overall it was a great experience.

Michael Booke came to Melbourne with his wife and child and enjoyed his exposure to both Australian anaesthesia and Australia a great deal. Michael was also exposed to the many anaesthetic subspecialties including cardiac, neuro, vascular and major orthopaedics. Forty one percent of his work was utilising regional anaesthesia which he appreciated a great deal. Michael was also involved with our teaching and research and made valuable contributions in these areas. Perhaps the most important thing was that he made many friends from the Department and I am sure many will want to visit him now that he has returned to Munster.

This exchange was a great success and we would recommend it to any anaesthetist who is able to speak some German.

Associate Professor Michael Davies
Director of Anaesthesia
St Vincent's Hospital Melbourne

Errata

Obstetric SIG

In the previous *Bulletin*, a photo of Dr Michael Paech, Chairman of the Obstetric Anaesthesia SIG was incorrectly published beside the Neuroanaesthesia SIG Annual Report. Apologies to Dr Paech and to Dr Stephen Swallow, Chairman of the Neuroanaesthesia SIG.



Simulation and Skills Training SIG

Assoc Prof. Harry Owen is the SA Representative on the Executive of the Simulation and Skills Training SIG. Apologies to Professor Owen for the misspelling of his name in the November *Bulletin*.

ANZCA Workforce 2000

Australian Fellows

In December 1999, 2327 questionnaires were sent out with ANZCA annual subscription notices to all Australian Fellows whose status was "active".

Questionnaires were returned by 1409, a response rate of 60.5%. (*The response rate to the 1994 ANZCA Survey was 63%*). 23 of the respondents indicated that they had now retired from practice. Analysis of the remaining 1386 questionnaires from active Fellows gives the following results. (Not all respondents answered all questions).

DEMOGRAPHIC DATA

Gender

80.6% (1117) of respondents were male, and 19.4% female (269). Comparing the male:female ratio of respondents with that from the ANZCA database gives a very similar percentage (82% males and 18% females).

Age

Active respondent Fellows are relatively young, with only 10% aged more than 60 years, and nearly 60% being aged less than 50 years.

	< 30	30-39	40-49	50-59	60-69	> 70
Fellows	0	286	523	393	131	3
%	0	21	38	28	9	0.2

We are also a young and growing speciality – well over half (60%) of Australian Fellows have obtained their FANZCA since 1985.

	< 1970	1970-	1975-	1980-	1985-	1990-	1995-
		74	79	84	89	94	99
Fellows	67	117	167	198	215	284	328
%	5	8	12	14	15.5	20.5	23.5

Qualifications

All Australian respondents (1379) had FANZCA; there were 112 respondents who had the diploma of FICANZCA, and 35 the diploma of FFPMANZCA.

12% had the diploma of FRCA, 3% of FFARCSI, 1.5% the American Boards Examination, and 5% the FRCPC. 12% had other diplomas.

Region of practice

The percentage return from the survey when classified by State and Territory agrees well with figures obtained from the ANZCA database. We conclude that responses are likely to be representative of the views and work patterns of active ANZCA Fellows.

RESPONSES

			ANZCA database
ACT	1.7%	24	1.6%
NSW	33.0%	458	34.0%
NT	0.5%	7	0.3%
QLD	17.7%	245	16.5%
SA	9.7%	134	10.0%
TAS	2.4%	33	2.5%
VIC	26.0%	359	25.0%
WA	9.1%	126	9.3%

Hospital Type

60% of Australian Fellows (47% male, 13% female) work in large metropolitan or tertiary institutions.

15% (12% men, 3% women) work in peripheral metropolitan hospitals. 19% work in large regional centres, and 2% in small regional centres. 1% work in "other" locations.

WORK STATUS

Active/retired

98.5% of Australian respondents are practising; and 1.5% (23) are retired. For those not yet retired, the intended age of retirement is as follows:

40-49	0.2%	3
50-54	1.4%	20
55-59	13.0%	187
60-64	33.0%	451
65-69	37.0%	513
70+	8.0%	115
No answer	8.0%	109

Of those who have not retired, 48% intend to retire by 65 years of age, and most (85%) intend to retire before the age of 70. In future surveys, it will be appropriate to track age and intended age of retirement as this would be important as one factor in planning future workforce needs.

Non-retired Fellows by age and state

	30-39	40-49	50-59	60-69	70+	Totals
ACT	2	10	3	6	1	22
NSW	100	159	130	50	1	440
NT	2	4	0	0	0	6
QLD	48	93	75	20	1	237
SA	23	49	43	16	0	131
TAS	8	12	8	3	0	31
VIC	77	144	97	29	0	347
WA	26	52	37	7	0	122
Totals	286	523	393	131	2	1335
	21%	38%	28%	9%	0.02%	

PRACTICE PROFILES (see tables 1 & 2)

Full/part time

Full Time

1161 (84%) of Australian Fellows work full time. The average number of anaesthesia sessions worked by all those in full time work is 7.25/week.

87% (1014) of male respondents and 55% (147) of female Fellows work full time.

Of the 1014 male Fellows working full time, 141 (14%) intend to change to part time work in the next five years, while 47 of the 147 female Fellows now working full time intend to work part time in the future.

There has been a slight apparent drop (from 87% to 84%) in the number of respondents in full-time practice since 1994.

Part Time

204 Fellows (15%) work part time. The average number of anaesthesia sessions worked per week by all those in part time work is 5.1.

84 (7.5%) men (average 5.4 sessions per week) and 121 (45%) women (average 5.1 sessions per week) work part time. 26 of the 121 women (21%) intend to change to working full time in the next five years. Only seven of the men working part time now intend to change to full time work in the future.

A majority of those working part time (77%) were satisfied with their current workload.

188 (16%) of those currently working full time intend to change to working part time in the next five years.

Private Practice – Clinical

81% (1126) of Australian Fellows work in private practice at least one session per week. The average sessions per week (private and public work) provided by Fellows are shown in table 1.

Those who work at least 50% of their time in private practice average 8 clinical sessions per week.

Anaesthetists working in rural areas (outside the capital cities) provide an average of 4.9 private sessions/week. Male respondents provide on average 5.1 private clinical sessions/week and spend on average 47% of their time in this type of work. Female respondents provide an average of 3.7 sessions/week and spend 34.5% of their time in private clinical work.

Public Practice - Clinical

1166 (84%) Australian Fellows provide services for the public sector. The average sessions per week (private and public work) provided by such Fellows are shown in table 1.

Male respondents work on average 4.5 public sessions/week, spending 43% of their time in this type of practice, while female respondents provide an average of 4.6 sessions/week, and spend 52% of their time in public clinical work.

The average sessions per week per anaesthetist in public clinical work are 4.5.

Anaesthetists working in rural areas (outside the capital cities) provide an average of 4.5 public sessions/week.

Anaesthesia

62% of Fellows work in anaesthesia; the total anaesthesia sessions provided by respondents are 6076/week. 684 male respondents provide 5038 of these sessions weekly (83%), and women 1033 (17%). The average sessions per week per anaesthetist are 7.1.

Of the 112 FFICANZCA respondents, 52 (46%) work an average of 4.5 anaesthesia sessions per week each; these Fellows provide overall 4.1 private clinical sessions/week and 5.9 public clinical sessions per week.

Of the 35 responding Fellows of the Faculty of Pain Medicine, 24 provide an average of 4.9 anaesthesia sessions per week each.

Anaesthetists working outside the capital cities provide an average of 7.5 anaesthesia sessions per week.

Intensive Care

14% of Fellows (184) provide intensive care services, an average of 4.4 sessions per week.

78 (70%) of the 112 FFICANZCAs work an average of 6.3 sessions each.

Anaesthetists working in rural areas provide an average 2.8 intensive care sessions/week.

Preoperative assessment

19% of Fellows (270) perform 308 preoperative assessment sessions weekly, averaging 1.1 sessions per week.

64 female respondents provide 25% (77) of the preoperative sessions per week (average 1.2 each) while 77% (229) of these sessions are provided by 204 men (average 1.1 each).

Anaesthetists working in rural areas provide an average 1.1 preoperative assessment sessions/week.

Hours per week on call

19% of Fellows (10% rural) were on call less than 10 hours per week; 27% (21% rural) did 10-19 hours, and 23% (33% rural) did 20-29 hours per week.

A further 11% (12% rural) did 30-39 hours while 8% (12% rural) were on call 40-90 hours per week.

5% of all Fellows did over 90 hours per week on call. Men spent an average of 33 hours per week on call, and women 25 hours.

Australian anaesthetists in private practice are on call an average of 32 hours per week.

Hours per week working out of hours

62% of Fellows (58% rural) worked less than 10 hours per week out of hours; 24% (29% rural) worked between 10-19 hours per week out of hours. 5% (6% rural) did 20-29 hours extra work; very few did more than 30 hours per week.

56 (4%) respondents either did no out of hours work or did not answer the question.

Men worked out of hours on average 12 hours/week, and women 8 hours/week.

Anaesthetists in private practice work an average of 11 hours/week out of hours.

Weeks per year worked

The great majority of Australian Fellows (88%) work 40-49 weeks per year. A higher percentage (91%) of rural anaesthetists worked 40-49 weeks per year. A small number of Fellows (7.5%) work 50 weeks or more. Male and female anaesthetists, as well as those in private practice, worked on average 46 weeks/year.

Workforce opinions

Satisfaction with current workload

Less than 1% (11 respondents) would like much more work, and 7% (101) would like more work. Of the rural anaesthetists, 8% would like more work.

The majority of respondents (67%), but fewer rural anaesthetists (61%), think that their workload is about right.

22% (302) would like less work, and 2% (26) would like much less work. 28% of rural anaesthetists would like less work, and 3% would like much less work.

Opinions on the number of anaesthetists in practice

The number of anaesthetists in practice is seen to be too few by 16% (228) respondents. The majority - 64% (888) - think the number is about right, while 12% (172) think there are too many anaesthetists in practice.

Rural opinions: 30% believe that there are too few anaesthetists, 55% think the numbers are about right, while 11% think there are too many anaesthetists.

RURAL

City/rural by hospital type

- 60% of Australian Fellows (47% male, 13% female) work in large metropolitan or tertiary institutions.
- 15% (12% men, 3% women) work in peripheral metropolitan hospitals.
- 19% (17% men, 2% women) work in large regional centres.
- 2% (22 men and 3 women) work in small regional centres.
- 1% (10 men and 3 women) in other locations.

City/rural by non-capital city

24% (330 Fellows, 25% of all male respondents and 13% of all female respondents) work outside the capital cities of Australia.

Australian Rural Fellows' responses were collated in these two groups; there were 330 who worked outside the capital cities, and 308 who worked in large and small regional centres, or "other". The responses from the two groups were similar.

The workload and sessions per week of rural Fellows were similar to city anaesthetists, although they provided less intensive care sessions.

The distribution of the 330 Fellows who worked outside the capital cities is as follows:

QLD	31%
NSW	43%
SA	1%
TAS	4%
VIC	18%
WA	2%

SUMMARY

The ANZCA Workforce 2000 survey generated an acceptable response rate (60%). There was, disappointingly, no improvement over the 1994 survey.

The College intends to conduct a regular biennial workforce questionnaire; the data obtained in this pilot 2000 Workforce Survey will be a useful baseline with which to compare data from surveys in forthcoming years.

In subsequent editions of the *Bulletin* there will be reports on the Workforce 2000 data from the following respondent groups of ANZCA Fellows: New Zealand, Intensive Care, Pain Medicine, Asia, other geographical locations, female, male, and those working full time and part time.

The work of Juliette Mullumby and Karen Monette at ANZCA in organising the survey, scanning the returned questionnaires and collating the data is very much appreciated.

The College wishes to thank those who returned completed questionnaires. Those Fellows who did not return the survey are again reminded of the importance and value of their input.

We need data from each and every one of you, to enable more accurate workforce planning, and to ensure a solid future for our specialty.

Dr Diana C Strange Khursandi
Chair, ANZCA Workforce Committee
February 2001

Table 1: Practice Profiles – Average sessions per week (Australia)

	All Fellows (1386)	Females (269)	Males (1117)	Rural by hospital type (308)	Fellows doing private work (1126)	Fellows doing public work (1166)	Fellows working full time (1161)	Fellows working part time (205)	FFIC ANZCA (112)	FFPM ANZCA (35)
Private Clinical	4.86	3.7	5.1	4.9	4.8	4.3	5.1	3.2	4.1	3.5
Public Clinical	4.5	4.6	4.5	4.5	4.0	4.5	4.7	3.5	5.9	6.0
Anaesthesia	7.1	6.2	7.3	7.5	7.5	7.1	7.25	5.1	4.5	4.9
Pain Medicine	3.0	2.8	3.0	2	3.1	2.9	3.1	1.9	2.3	4.8
Intensive Care	4.4	4.5	4.4	2.8	4.1	3.3	4.5	3.2	6.3	1.7
Preoperative Assessment	1.1	1.2	1.1	1.1	1.1	1.1	1.1	1.35	1.2	1.0
University/ Postgraduate	1.7	1.6	1.6	1.5	1.6	1.7	1.5	3.25	1.9	1.7
Administration	1.7	1.6	1.7	1.6	1.5	1.7	1.7	1.2	2.0	1.4
Other professional duties	1.6	1.5	1.4	1.2	1.3	1.4	1.3	2	1.6	1.5

Active Fellows only

Table 2: ANZCA Fellows – Average sessions per week (Australia)

	0	1	2	3	4	5	6	7	8	9	10	Fellows doing sessions	Total sessions	Average / Fellow
Private - Clinical	(40)	181	107	93	110	89	104	103	128	73	42	1030		
Sessions Worked	0	181	214	279	440	445	624	721	1024	657	420		5005	4.86
Public – Clinical	(25)	131	164	112	143	125	116	128	84	25	31	1059		
Sessions Worked	0	131	328	336	572	625	696	896	680	225	310		4799	4.5
Anaesthesia	(23)	14	28	37	48	74	101	115	158	142	138	855		
Sessions Worked	0	14	56	111	192	370	606	805	1264	1278	1380		6076	7.1
Pain Medicine	(151)	58	23	13	9	6	5	3	5	2	7	131		
Sessions Worked	0	58	46	39	36	30	30	21	40	18	70		388	3.0
Intensive Care	(142)	47	29	19	11	17	10	15	12	8	20	188		
Sessions Worked	0	47	58	57	44	85	60	105	96	72	200		824	4.4
Preoperative Assessment	(99)	241	24	2	2	1	0	0	0	0	0	270		
Sessions Worked	0	241	48	6	8	5	0	0	0	0	0		308	1.1
University / Postgraduate	(155)	63	12	8	2	4	0	1	1	0	0	91		
Sessions Worked	0	63	24	24	8	20	0	7	8	0	0		154	1.7
Administration Sessions	(92)	276	93	40	15	10	3	0	2	0	0	439		
Sessions Worked	0	276	186	120	60	50	18	0	16	0	0		726	1.7
Other Professional duties	(90)	262	67	11	8	0	1	2	1	1	0	353		
Sessions Worked	0	262	134	33	32	0	6	14	8	9	0		569	1.6

Recent Activity in Australian Standards

College members contribute to many aspects of standards development. This report highlights the contribution by Dr Bob Wong of the Hyperbaric Medicine SIG.

Australian Standards Committee SF/46 deals with diving and hyperbaric standards. Recently it has been revising AS CA12-1970 – known as the 'SAA Compressed Air Code' which has now been renamed 'Non-Diving Work in Compressed Air and Hyperbaric Treatment Facilities'. There are two parts to this standard: Part 1 is 'Work in tunnels and caissons' and Part 2 is 'Hyperbaric Oxygen Treatment Facilities'.

The impetus of this came from the 'Hyperbaric Oxygen Therapy Facilities Industry Guidelines' – known as the 'HOTFIG' Document initiated by the Hyperbaric Technicians and Nurses Association, published in 1998.

Members of this technical committee are drawn from divergent groups representing Institute of Engineers Australia, WorkCover of NSW, Hyperbaric Technicians and Nurses Association, Hyperbaric Engineering Industry Forum, Australian Industry Group, South Pacific Underwater Medicine Society, Australian Medical Association, Australian and New Zealand Hyperbaric Medicine Group and the Australian and New Zealand College of Anaesthetists.

After several meetings in 1999 and 2000, a final two-day meeting was convened in Melbourne on 18 and 19 December 2000 to finalise the Draft Australian Standard DR 00249 Work in Compressed Air and Hyperbaric Facilities (AS4774). The comments from the public review of this draft standard have now been discussed. The new draft will be circulated to the Executive Committee Members prior to release early in the 2001 year.

A considerable contribution was made by Fellows of the College. The Chairman of the Committee was Dr John Knight, whilst the Australian and New Zealand Hyperbaric Medicine Group (ANZHMG) was represented by Dr Mike Bennett, and Dr Robert M Wong represented ANZCA. The other medical officer present was Dr Ian Millar FAFOM representing the AMA. Pertinent to the SIG in Diving and Hyperbaric Medicine of the Australian and New Zealand College of Anaesthetists is the adoption by the Standards Australia of the categorisation and qualifications of hyperbaric physicians.

The SIG recommended the following categories of Hyperbaric Physicians.

1. Hyperbaric Medical Officers – these are trainees or those in non-training posts occupying hyperbaric medical posts.
2. Hyperbaric Physicians – these are physicians
 - a. who have a fellowship of a College or in possession of a university higher qualification such as MD/PhD in a relevant field;
 - b. with a Diploma in Diving and Hyperbaric Medicine (DipDHM) awarded by the South Pacific Underwater Medicine Society (SPUMS). To qualify for the Diploma, a candidate is required to have attended an examinable course of 60 hours of instruction (either in diving or in hyperbaric medicine), and have a minimum of six months experience in a recognised hyperbaric department. The candidate is further required to have performed a research project approved by the Education Officer and the Board of Censors of the South Pacific Underwater Medicine Society, and that the research is suitable and acceptable for publication in a journal.
3. Senior Hyperbaric Physician – are those, who in addition to the qualifications of (2) above, have attended an additional examinable course of instruction of 60 hours (if the initial course was in diving medicine, then this second course must be in hyperbaric medicine and vice versa), and have accumulated a minimum of 18 months experience in the field of diving and hyperbaric medicine and have completed a 'Task Book' of the SIG in order to achieve the award of the 'Certificate of Diving and Hyperbaric Medicine' of the SIG of ANZCA. (Note that the title of 'senior' rather than 'specialist' is used here, as it is accepted that currently, there is no specialist qualification in this branch of medicine.)

The recommendation is supported and applauded by all the committee members that at long last a formal qualification under the auspices of the Australian and New Zealand College of Anaesthetists is available, and that there are training courses and positions in this field of medicine. The timing of the Certificate in Diving and Hyperbaric Medicine of the SIG is appropriate, as the US has had a subspecialty in Undersea Medicine since 1993 (with a name change to Undersea and Hyperbaric Medicine in 1999), and in September 2000, the European College of Baromedicine was launched.

New Senior Medical Appointments for the Australian Defence Force

The Chief of the Defence Force, Admiral Chris Barrie, AO, RAN, announced the following promotions of three senior Reserve Health Officers. Two of the appointed officers are Fellows of the Australian and New Zealand College of Anaesthetists. These senior health officers have long Australian Defence Force (ADF) service and have completed overseas deployments on active service to areas including Vietnam, Malaysia, Persian Gulf, Rwanda, Bougainville and East Timor.

Air Commodore **Bruce Short** RFD, FRACP was appointed the Surgeon General ADF on 1 January 2001 in the rank of **Air Vice-Marshal**. Air Vice Marshal Bruce Short, of New South Wales, was the Assistant Surgeon General ADF (Air Force) and also held the positions of Consultant in General Medicine to both the former Director General of Air Force Health Service and to the Surgeon General ADF. Air Vice-Marshal Short commenced his service with the ADF in 1960. He continues as the inaugural editor of *The Journal of the Australian Defence Force Health Service* devoted to the disciplines of military medicine, surgery, anaesthesia, dentistry and nursing. Air Vice-Marshal Short practices as a specialist general physician in Sydney.

Air Vice-Marshal Short succeeds Major General John Pearn AM, RFD, FRACP on his retirement. Major General Pearn, of Queensland, was the inaugural Reserve Surgeon General ADF following his appointment in June 1998. Major General Pearn has a long and distinguished career in the Army Reserve completing a total of 36 continuous years of service with overseas active duty in the Arctic, Europe, Vietnam, Papua New Guinea and Rwanda.

Commodore **Peter Habersberger**, AM, RFD, FRACP, RANR, of Victoria, is the **Assistant Surgeon General ADF (Navy)** whose previous appointments include the Principal Medical Officer (Victoria) and Director Reserve Health Support. He commenced Royal Australian Navy Reserve service in 1968 and is the Consultant in Cardiology to the Surgeon General ADF. Commodore Habersberger practises as a consultant cardiologist in Melbourne and is recently retired from the College Panel of Examiners.

Colonel **Brian Pezzuti** of New South Wales was promoted to the rank of Brigadier on 11 November 2000 and appointed Assistant Surgeon General ADF (Army). Brigadier The Honourable Brian Pezzutti, RFD, FFARACS, FANZCA, MLC, RAAMC, practices as an anaesthetist and formally held the position of Director Health Services, Army, New South Wales. Brigadier Pezzutti enlisted in the Army Reserve in 1965.

Group Captain **Roger Capps**, AM, RFD, FFARACS, FANZCA, of South Australia, was promoted to the rank of **Air Commodore** on 1 January 2001 and appointed Assistant Surgeon General ADF (Air Force) succeeding Air Vice-Marshal Short. Air Commodore Capps was the Principal Reserve Medical Officer, South Australia. He has served in the RAAF Specialist Reserve (Medical) since 1975 and presently holds an unrestricted private pilot's licence. Air Commodore Capps is the consultant in anaesthetics and resuscitation to the Surgeon General ADF and is senior consultant in the Department of Anaesthesia and Intensive Care at the Royal Adelaide Hospital.

Call for Nominations for the Simulation and Skills Training Special Interest Group Executive

The Simulation and Skills Training Special Interest Group has been formed under the Special Interest Group Constitution developed by the Australian and New Zealand College of Anaesthetists, the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists. This Constitution is available for viewing on the ANZCA Website www.anzca.edu.au. The Constitution proposes that the Executive be nominated and elected by the membership of the Special Interest Group.

Accordingly, members of the Simulation and Skills Training SIG are invited to forward nominations for the Executive Committee. Each nomination must be signed by two SIG Members and contain a consent to act, if elected, by the person nominated, who must also be a Member of the SIG. The Executive Committee of the SIG comprises of up to nine (9) full members, to represent each state of Australia and the ACT, New Zealand, and the Asia Pacific region.

Notice is given that elections will take place at the Annual General Meeting, to be held during the ANZCA ASM in Hong Kong. The current Interim Executive Committee comprises:

- Dr Stephen Bignell (Qld)
- Dr Brent Donovan (WA)
- Dr Sandy Garden (NZ)
- Dr Richard Morris (NSW)
- Dr Harry Owen (SA)
- Dr Richard Waldron (Tas)
- Members of the Interim Executive eligible for election

Nomination forms have been circulated to all Simulation and Skills Training SIG Members. Additional nomination forms are available from Helen Morris at the ANZCA office in Melbourne. Nominations must be in the hands of the Administrative Officer, Continuing Education before 5pm on 30 March 2001.

Brendan Flanagan
Chairman
Simulator and Skills Training SIG

How Many Anaesthetics Did You Give Last Year? Using a Logbook to Document Personal Training Experience

Dr Wayne Morriss, FANZCA

Department of Anaesthesia and Pain Management, Alfred Hospital, Melbourne, Victoria, Australia
(Current address: Fiji School of Medicine, Private Mail Bag, Suva, Fiji)

SUMMARY

There are many reasons for the individual anaesthetic trainee to keep a logbook; these include accurate documentation of case numbers and procedures, identification and correction of deficient areas of training, collection of data for audit and research, and documentation of interesting cases, problems and complications. I used a personal anaesthetic computer logbook to document my experience as an anaesthetic registrar in New Zealand and Australia from December 1993 to January 1999. During 5 years of anaesthetic training, I managed 3528 cases. Sub-specialty experience, level of supervision and out of hours work conformed to guidelines published by the Australian and New Zealand College of Anaesthetists. These results illustrate the type of information that can be obtained from a relatively simple computer logbook and also provide data for comparison by other trainees or consultants. In my opinion, a logbook is essential for monitoring personal training experience.

INTRODUCTION

How many anaesthetics did you give last year? This is a difficult question to answer unless a personal logbook is kept. From personal observation, it is easy to overestimate actual case numbers and procedural experience. In addition, automated or manual hospital data collection systems may not accurately capture training information because of variability of data input and different data collection objectives. I decided to set up a computer logbook when I commenced anaesthetic training in 1995 so that I could accurately and consistently collect this data.

There is little published information on the number and type of anaesthetic cases managed by Australasian or other trainees. A survey of anaesthetic workforce in Australia and New Zealand estimated that the average number of anaesthetics (total of general and local anaesthetics) administered by each fulltime specialist anaesthetist or registrar was 1000 during 1994¹. Surprisingly, there are no published data detailing the individual experience of Australasian trainees.

Monitoring of case numbers and procedural experience is not compulsory during anaesthetic training in Australia and New Zealand, however, ANZCA strongly advises trainees to keep a logbook of sub-specialty experience². In the United Kingdom, logbooks became mandatory in April 1996. The Society for

Computing and Technology in Anaesthesia (SCATA) and the Royal College of Anaesthetists (RCA) jointly launched a computer anaesthetic logbook during the same year, and this form of logbook has gained widespread acceptance in the United Kingdom and with some trainees in other countries.

This paper presents data from a complete record of 5 year's anaesthetic training experience to illustrate the type of information that can be obtained from a relatively simple computer logbook. The relevance of this data to training is discussed, along with other advantages that became apparent during my time as a registrar.

METHODS

With fairly rudimentary computer knowledge, I designed a database using Access 2.0 (Microsoft). Raw data were collected in paper notebooks and entered in form view on a personal computer (Figure 1). The database design allowed entry of optional details for noteworthy cases.

Criteria for inclusion in the logbook were not always straightforward. Inclusion depended on my level of involvement, especially in pre-operative assessment and planning. I did not include cases where I was only peripherally involved or had taken over from another anaesthetist unless the duration of my involvement was for the majority of the

Figure 1
Form view for data entry

The screenshot shows a form view for data entry with the following fields and values:

- Date: 26/02/98
- Time of Day: In Hours (8 to 5)
- Operation: Bilat lung transplant
- Duration: > 5 hrs
- Speciality: Thoracic
- Supervision: Cat 1: One to One
- First Anaesthetist:
- Technique: GA-RA, GA, Epid, LA, Spinal, CSE, Sed
- Blocks: Epid (Thoracic)
- Procedures: AL, CVP (IJV), PAC, DLT
- Optional Details: Flag
- Comments: Methylpred, dopamine, adr, GTN, L DLT, FOB toilet
- Assessment: Bronchiectasis
- Complications: Panc vs midaz error, AF/VT/VF/inferior ischaemia

case. Patients who were cancelled before an operative procedure was performed were not included even if they had involved a great deal of assessment and planning time. Procedures performed during two intensive care training periods were not included.

Logbook data were retrieved by designing queries using the Access program. Numbers of cases logged during 5 months in 1998 were compared with anaesthetic department audit numbers to assess completeness of data collection. Where appropriate, data were compared with training guidelines published by ANZCA.

RESULTS

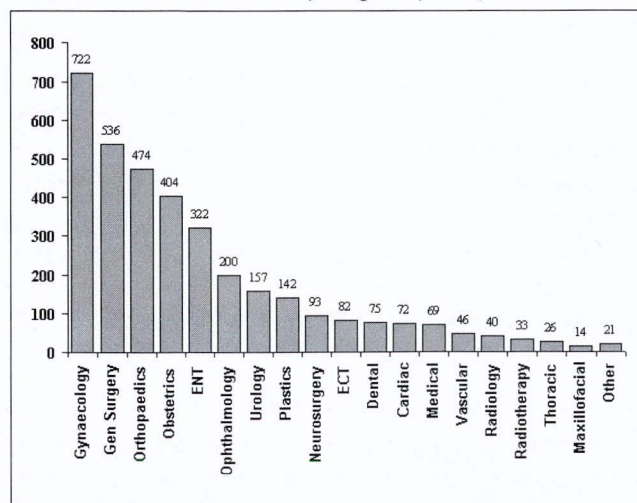
The data from 5 years of anaesthetic training (December 1993 to January 1999) in New Zealand and Australia were analysed. This comprised 6 months of intensive care and 54 months of clinical anaesthesia. The first three years of training were based in Christchurch (Christchurch Hospital, Christchurch Women's Hospital, Burwood Hospital and Timaru Hospital), the fourth year in Melbourne (Royal Children's Hospital, Sunshine Hospital and Royal Women's Hospital), and the Provisional Fellowship Year was spent at the Alfred Hospital and Royal Victorian Eye and Ear Hospital.

Number of anaesthetics

The total number of cases was 3528 or, on average, 780 per year of clinical anaesthesia training. During the five months to June 1998, 288 cases were recorded in my logbook. In comparison, 273 were entered in the Alfred Hospital anaesthetic audit database, a difference of 5%.

Surgical specialty data are presented in Figure 2. Surgical specialty was defined as the specialty of the main operative procedure in cases where more than one surgeon was involved.

Figure 2
Case numbers by surgical specialty



ENT = ear, nose and throat
ECT = electroconvulsive therapy

ANZCA guidelines

Logbook data conformed to ANZCA guidelines on sub-specialty experience², with the exception of pain cases (Table 1). Minimum supervision and out of hours work during years 1-4 of training (Table 2, n = 2783) also met ANZCA guidelines³. Logbook data in this table are derived from case numbers and do not take case duration, and therefore total anaesthetic time, into account.

Table 1
Sub-specialty training guidelines and case numbers

	ANZCA minimum recommendation	Number of cases from logbook
Neurosurgical	25 intracranial procedures	50
Thoracic and cardiac	25 intrathoracic cases 15 cases involving the use of a double lumen tube 10 cardiac bypass cases	82 18 57
Paediatric	100 cases aged < 4 years 200 cases aged 4 - 10 years	301 386
Obstetric analgesia and anaesthesia	150 cases of more than 24 weeks gestation	404
Pain	100 patients with postoperative pain 25 with chronic non-cancer pain 25 with cancer pain	Not recorded Not recorded Not recorded

Table 2
Supervision and out of hours work

	ANZCA guideline	Logbook cases
Category 1 or 2 supervision	At least 25%	49%
Category 4 supervision	Not greater than 30%	25%
Out of hours work	Between 25 - 50%	30%

ANZCA supervision categories³:

- Level 1: One consultant to one registrar, in theatre
- Level 2: One consultant to two registrars, in theatre
- Level 3: Consultant available in theatre suite or hospital
- Level 4: Consultant available at home

Out of hours work was defined as all work done outside normal working hours (0800-1700 hours, Monday to Friday)

Patient details

The ratio of females to males was 62 to 38.34% of all cases were emergencies (defined as unscheduled cases). Age and ASA data are presented in Figures 3 and 4.

Anaesthetic technique, blocks and procedures

General anaesthetic or combined general-regional techniques accounted for 80% of all anaesthetics (Table 3). Peripheral blocks were successful blocks where minimal or no sedation was used during surgery. Table 3 includes some cases where

Figure 3
Case numbers by ASA classification

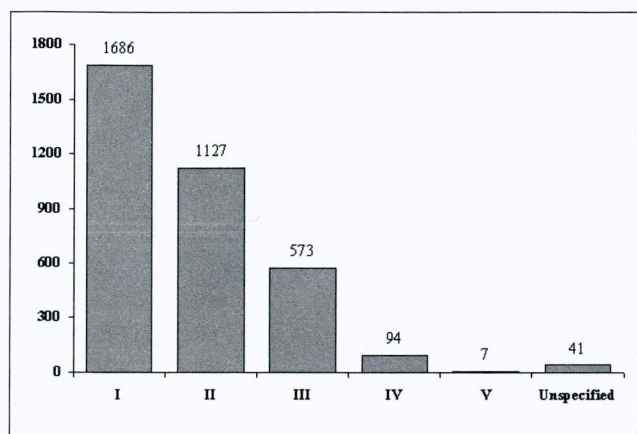
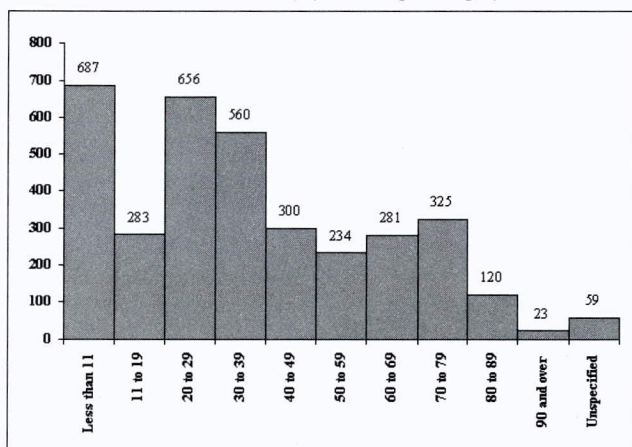


Figure 4
Case numbers by patient age category



the regional technique was performed by a supervising anaesthetist, while Table 4 lists only successful regional or peripheral nerve blocks performed by the trainee. The table includes blocks for anaesthesia alone, anaesthesia combined with a general anaesthetic and blocks for analgesia, eg, labour epidural analgesia. Successful technical procedures are listed in Table 5.

Table 3
Anaesthetic technique

Anaesthetic technique	Number of cases	
General	2669	(75.7%)
Combined general-regional	149	(4.2%)
Epidural alone	249	(7.1%)
Spinal alone	233	(6.6%)
Combined spinal-epidural	7	(0.2%)
Peripheral block	163	(4.6%)
Sedation or monitored anaesthetic care	58	(1.6%)

Table 4
Numbers of regional and peripheral blocks

Type of block	Number performed successfully
Epidural (lumbar)	235
Spinal	199
Caudal	53
Peribulbar / retrobulbar	84
Epidural (thoracic)	31
Arm block (axillary)	17
Ilio-inguinal	13
Arm block (supraclavicular)	5
Intercostal	5
Dorsal penis	5
Other	27
Total	674

Table 5
Numbers of technical procedures

Procedure	Number performed successfully
Arterial cannulation	129
Central venous catheterisation	
• Internal jugular	53
• Subclavian	8
• Antecubital	13
Pulmonary artery catheterisation	41
Fibreoptic intubation	
• Asleep	6
• Awake	5
Double lumen tube insertion	18

DISCUSSION

Logbook results

These results represent one ANZCA trainee's experience. They provide a snapshot of training in Australasia and demonstrate a broad-based training programme with good exposure to subspecialty cases and appropriate supervision. The results illustrate the value of maintaining a computer logbook for monitoring experience and also provide data for comparison by other trainees and consultants.

It is very difficult to put this report in context because of a lack of published data. The 1994 Australasian anaesthetic workforce survey¹ estimated that each fulltime equivalent anaesthetist (staff specialist, visiting medical officer or registrar) administered, on average, 815 general anaesthetics during 1994; this figure increased to 1000 anaesthetics when local anaesthetics were taken into account. Importantly, these numbers assumed that registrars were working as solo practitioners.

My average annual caseload during 4.5 years of clinical anaesthesia training was 780. This number appears low especially when one considers that it includes many cases that were supervised at a category 1 level. However, case numbers taken in isolation may be a poor indicator of workload.

Cases were only included when the patient underwent an operative procedure and my involvement was substantial. In addition, the numbers do not take into account duration or difficulty of anaesthesia.

Sub-specialty experience, in general, conformed to ANZCA guidelines². The logbook did not include pain cases and it is impossible to know whether I was involved with the management of the recommended number of pain patients. The guidelines state that the recommended sub-specialty experience should be obtained during the first four years of training so that there is an opportunity to correct any areas of deficiency during the Provisional Fellowship Year. My logbook was an indispensable tool for identifying deficiencies and targeting experience in these areas.

During the first four years of training, supervision at category 1 and 2 levels was very high, however it is important to note that the definition of the supervision categories only requires that the supervising consultant is *available* to the registrar or registrars, and his or her in-theatre involvement may be very limited. Recording the seniority of the supervisor and the actual level of direct in-theatre supervision has been suggested for the SCATA/RCA electronic logbook⁴. ANZCA guidelines do not make provision for a senior registrar supervising a junior registrar.

There are no ANZCA recommendations for numbers of regional techniques or technical procedures. Numbers obtained from my logbook were relatively small and fewer than I would have estimated from recall. Because only successful procedures were logged, it is possible that some valuable, but unsuccessful, experience was not included. In addition, procedures performed during two intensive care attachments were not included. It is important to note that numbers taken in isolation may be misleading and do not necessarily correlate with technical competency.

The above results provide only a small sample of the information that can be obtained from a relatively simple computerised logbook. Using the same data, answers to many questions are easily obtainable using database queries; eg, supervision during individual years of training, numbers of regional procedures in children, types of anaesthesia administered for Caesarean section, and comparative numbers of open heart procedures (coronary artery bypass graft versus valve replacement operations).

Logbook design

A detailed discussion on logbook design is beyond the scope of this paper. It is important to note that collection of too much information may make data entry and analysis difficult, and the most interesting and useful information can be obtained from a relatively small number of fields. The use of checkboxes and drop-down menus wherever possible simplifies and

standardises data entry, and reduces input errors. A possible list of fields might be:

- Date
- Surgical or medical specialty
- Patient age
- ASA score
- Emergency/non-emergency
- Time of day
- Level of supervision
- Duration
- Anaesthetic technique
- Regional or local blocks performed
- Technical procedures performed
- Optional field or fields for comments or recording other information

Collection of other information, eg, type of airway, patient sex, and operative procedure, may arguably be of interest, but, from personal experience, this information is seldom used. I avoided entering patient names or numbers because of possible legal concerns relating to patient privacy.

Compared with a paper logbook, the main advantage of a computer logbook is easy data analysis. Designing a simple personal logbook is possible even with limited computer knowledge. Alternatively, a ready-made program can be used. The SCATA/RCA Electronic Anaesthetic Logbook is available for download as freeware from either the RCA website (www.rcoa.ac.uk) or SCATA website (www.scata.org.uk). Programs are based on a common minimum dataset⁵ and have been developed for hand-held and desktop computers. It is therefore possible to enter data directly into a hand-held computer in the operating theatre and then to transfer the information to a personal or departmental desktop computer.

The SCATA/RCA logbook is necessarily more complicated than a simple personal logbook. The larger number of fields may be more than required for a basic training record, and there are differences between definitions used by the ANZCA guidelines and the RCA/SCATA minimum anaesthetic dataset. It is, nevertheless, a tried and tested logbook that could potentially be adapted by individual trainees in Australia or New Zealand.

Reasons for keeping a logbook

It is likely that there is a tendency for trainees to overestimate their clinical workload. A computer logbook allows the individual to maintain a record of experience that can be easily retrieved. This information is not only interesting; it can be used to identify and correct areas of deficiency during training. A number of other reasons for maintaining a logbook became apparent during my training (Table 6). The inclusion of optional data fields allows description of different anaesthetic techniques, equipment and surgical requirements, or collection of data for quality assurance or research.

Table 6
Reasons for keeping a logbook

Accurate record of case numbers and procedures
Identification of deficient areas in training
Documentation of trainee supervision
Development of computing and typing skills
Record of different anaesthetic techniques and "recipes"
Collection of data for audit or specific research questions
Record of interesting cases for discussion
Record of problems and complications
Record for patient follow-up
Data for job interviews or curriculum vitae
College assessment of trainees (potential)
Comparison of training institutions (potential)
Development of experience and supervision guidelines (potential)

Hospital theatre records may over or underestimate the number of cases done by an individual anaesthetist. Comparison of my data with complete Alfred Hospital anaesthetic audit numbers showed that hospital records missed 5% of cases. In addition, hospital records frequently collect information which is different to that required for an audit of personal experience.

In my opinion, a computer logbook is an essential tool for the individual trainee but what are the potential applications for ANZCA and training institutions? At this stage, logbooks are not compulsory for trainees in Australasia. In comparison, trainees in the United Kingdom have been required to keep a logbook (paper or electronic) throughout training since April 1996. The trainee may be required to present and discuss the results of the logbook at his or her annual review; data from this has been used to assess clinical experience and the training performance of the hospital concerned⁶. The RCA does not specify minimum case numbers. The development of a standardised logbook format has allowed pooling and comparison of large amounts of data, however there is no information in the medical literature examining the usefulness of this data.

There are some potential problems if logbooks were to be made compulsory. If a logbook is used to assess the adequacy of a trainee's clinical experience, who will assess the data and what criteria will be used? Verification of data may be difficult; inaccurate or fraudulent data entry becomes an important issue if minimum numbers of cases or technical procedures are set by ANZCA. To maximise trainee compliance and allow valid comparisons between trainees and institutions, it would be essential to standardise data fields and collect the bare minimum of information for analysis.

Case and procedure numbers by themselves are not necessarily indicative of competency or exposure to quality training; the development of clear definitions and methods for scoring performance are necessary. Cusum (cumulative summation) analysis has been used as a basis for assessing competency in anaesthesia⁷ and cardiac surgery⁸. The Queensland Regional

Committee of ANZCA is currently undertaking a trial of logbooks looking specifically at sub-specialty experience and procedural competency (Peter Moran, personal communication); a similar trial based on Cusum methodology is being undertaken at Geelong Hospital, Victoria (Steve Bolsin, personal communication).

CONCLUSIONS

My relatively simple computer logbook allowed easy retrieval of data and demonstrated a broad-based training programme with good exposure to sub-specialty training and appropriate supervision. In my opinion, a personal logbook serves as a powerful audit of anaesthetic training and allows better targeting of experience and education.

ACKNOWLEDGMENTS

I wish to thank Grant Chirnside for his help with modifications to the database, and Paul Myles for his help with preparation of the manuscript.

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Past Office Bearers

FACULTY OF ANAESTHESIA, ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Elected	Dean	Vice Dean	Elected	Dean	Vice Dean
1953	D G Renton	H J Daly	1973	T R O'Rourke-Brophy	B E Dwyer
1954	D G Renton	H J Daly	1974	B E Dwyer	W J Watt
1955	R H Orton	L G Travers, MBE	1975	B E Dwyer	W J Watt
1956	R H Orton	L G Travers, MBE	1976	W J Watt	M J W Sando
1957	R H Orton	L G Travers, MBE	1977	W J Watt	M J W Sando
1958	R H Orton	L G Travers, MBE	1978	M J W Sando	D Joseph
1959	L G Travers, MBE	J F McCulloch	1979	M J W Sando	D Joseph
1960	L G Travers, MBE	J F McCulloch	1980	D Joseph	W M Crosby
1961	J F McCulloch	L T Shea	1981	D Joseph	W M Crosby
1962	J F McCulloch	L T Shea	1982	W M Crosby	R B Holland
1963	J F McCulloch	L T Shea	1983	W M Crosby	R B Holland
1964	L T Shea	R B Speirs	1984	R B Holland	R W Smallwood
1965	L T Shea	Mary T Burnell	1985	R B Holland	R W Smallwood
1966	Mary T Burnell	R R Clark	1986	R W Smallwood	A B Baker
1967	R R Clark	N M Cass	1987	R W Smallwood	A B Baker
1968	N M Cass	K McCaul, MBE	1987 October	A B Baker	P D Livingstone
1969	N M Cass	K McCaul, MBE	1988	A B Baker	P D Livingstone
1970	K McCaul, MBE	T R O'Rourke-Brophy	1989	A B Baker	P D Livingstone
1971	K McCaul, MBE	T R O'Rourke-Brophy	1990	P D Livingstone	M J H Hodgson
1972	T R O'Rourke-Brophy	B E Dwyer	1991	P D Livingstone	M J H Hodgson

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

Elected	President	Vice President	Elected	President	Vice President
1992 February	P D Livingstone	M J Hodgson	1996	G D Phillips	R G Walsh
1992 June	M J Hodgson	M J Davies	1997	G D Phillips	R G Walsh
1993	M J Davies	N J Davis	1998	R G Walsh	T E Oh
1994	M J Davies	N J Davis	1999	R G Walsh	T E Oh
1995	N J Davis	G D Phillips	2000	T E Oh	R J Willis

*Upon this table
Now I lay
I hope to live another day
So beautiful lady
Behind your mask
Don't let me die
That's all I ask*

A poem written by a patient to his anaesthetist in Tasmania.



Dean's Message

Felicity Hawker

The formation of a Joint Faculty of Intensive Care Medicine of both the ANZCA and RACP has featured in my past two Dean's Messages, and it remains a priority for the Faculty. The first Meeting of the Working Party to develop criteria for Foundation Fellowship was held on 9 February – after the closing date for copy but well before publication of this issue of the *Bulletin*. Consequently, discussion of the recommendations of the Working Party will need to wait for a future edition.

There are, however, many other topics of interest.

The newly formed ANZCA Education Department will have many positive spin-offs for the Faculty. The Director, Dr Russell Jones, addressed Council recently outlining the many important projects he has identified already. Among these, a priority is development of material to support Supervisors of Training and to ensure their efforts are recognised appropriately. This will include workshops, educational packages, and resource material for tasks such as assessment of trainees and counselling unsatisfactory trainees. Dr Jones' background in assessment and evaluation of assessment processes will also be invaluable in review of the Faculty Examination, refinement of the Faculty In-Training Assessment process, and in development of web-based modules for continuing education. Dr Jones will be working with Dr Mary Done who has been appointed Assistant Director of Education in a half-time capacity. Dr Done is a practising anaesthetist with a Masters Degree in Clinical Education. Sometimes we lose track of the fact that although the Faculty has many functions, it is foremost a training body, and consequently the appointment of these educationalists will benefit us enormously.

I look forward to seeing many of you at the CSM in Hong Kong in May. Tom Buckley has put together an excellent program.

The Faculty of Intensive Care Foundation Visitor is Professor Laurent Brochard from Paris, who will speak on Optimal Management of ARDS in 2001 as well as several topics related to mechanical ventilation. The other overseas invited speakers are Professor Randall Chestnut from Portland, Oregon, who will discuss head and spinal cord injuries and Professor Mitchell Levy from Rhode Island, Providence, whose topic is tissue oxygenation in sepsis. They are supported by a number of excellent local speakers, who among more conventional topics will discuss some of the areas in which intensive care practice in Asia is different from that in Australia and New Zealand.

Next year the ASM will be held in Brisbane, back-to-back with the RACP Annual Scientific Meeting, and a combined RACP-ANZCA intensive care day is planned. What a great start for a new Joint Faculty it will be if the first ASM can be held jointly with both parent Colleges.

Other issues to be discussed and further explored at the next Board Meeting include intensive care in rural and remote areas of Australia and New Zealand, and the possibility of becoming involved in intensive care training in Singapore. I hope to report further on these areas in the next Dean's Message.



Dean's Message

Michael J Cousins, AM

Evidence for Chronic Pain as a Major Health Problem

Fellows should be aware that quite recently substantial new data have become available which clearly indicate that chronic pain is one of the major health care problems in Australia:

- A pivotal epidemiological study of 17,543 individuals reported that one in five people in NSW suffer chronic pain (see Blyth et al. Pain Feb.2001)
- The NHMRC report on acute pain in 1988 estimated that chronic pain costs Australia over \$10B per annum
- The Grellman Report in 1997 of the NSW Workers Compensation Commission found that chronic pain is a key cost driver in the exponential rise of costs causing a deficit of over \$2B in NSW at the present time.
- The Australian National Occupational Health and Safety Commission has estimated a loss of \$1M working weeks related to new compensable cases each year; poorly managed pain plays a major role in such cases (see Cohen et al, J.Occ.Health&Safety. August 2000).
- A surprisingly high percentage of patients with acute pain associated with surgery or injury progress to a chronic stage ranging from about 11% after inguinal herniorrhaphy to 47% following thoracic surgery. (see Perkins & Kehlet, Anesthesiology. 2000;93:1123-33)

Equally disturbing are ongoing reports of a high incidence of ongoing unrelieved pain and other suffering in patients with cancer. The most recent is a study in the New England Journal of Medicine reporting that 89% of children suffered substantially in their last month of life, predominantly from pain (see Wolfe et al, N.Engl J.Med. 2000;342:326-33)

New US Pain Assessment and Management Standards

In response to mounting evidence of inadequate management

of pain in the USA, the Joint Commission of Accreditation of HealthCare Organisations (JCAHO) published its Pain Assessment and Management Standards in August, 1999. The JCAHO standards require health care facilities to:

- Recognise the right of patients to receive appropriate assessment and management of pain
- Identify pain in patients during their initial assessment
- Document the efficacy of pain management treatment plans
- Educate patients and their families about pain management

The complete Pain Management Standards can be downloaded at www.jcaho.org/standard/pm_ac.Html#ri127

This is an extraordinary development since all hospitals and other health care facilities in the USA will now have to comply with the standards or risk losing their accreditation. One outcome of the publication of this standard and the commencement of review of hospitals, is that many facilities are now scrambling to develop policies and resources to enable them to comply. It would appear to be high time that moves were made in Australia and New Zealand to incorporate such standards into our requirements for accreditation of our hospitals and other health care facilities.

Pain as a Fifth Vital Sign

The JCAHO has sent a clear message that pain should now be regarded as the "fifth" vital sign which should be assessed together with the other four vital signs of temperature, pulse, respiration and blood pressure. The JCAHO recommends that pain be assessed during all patient encounters and at all times when the other four vital signs are assessed. A number of acute pain services in Australia and New Zealand have begun to document pain as a vital sign but this practice should

become a standard throughout Australian and New Zealand health care facilities.

Implications for Resources

One of the implications of the JCAHOs pain initiative is that health care facilities are required to have organised plans and to support activities and resources to ensure that the pain of all patients is recognised and addressed. Were such a program introduced in Australia and New Zealand, it would give a major impetus to providing training positions and funded positions for an appropriate range of health professionals in this relatively new field. I am old enough to have lived through the early days of development of intensive care as a specialty. It would seem extraordinary to us now not to have intensive care facilities of an appropriate level in all hospitals. However not so long ago intensive care was provided in a very *ad hoc* manner. In the January 2000 issue of the Medical Journal of Australia (MJA 2000;172:3-4) I referred to the relief of acute pain as a *basic human right*. This is certainly not stretching the situation too far for the large majority of patients who suffer currently with poorly managed pain. The Faculty will be working towards the introduction of similar standards in Australia to those of the JCAHO and to moving to a stage where

pain medicine is regarded as being a necessity in all the health care facilities.

Contributions of Fellows to Faculty Activities

Fellows will note under a separate item, that the Board of Faculty is seeking expressions of interest from Fellows in participating in various areas of the work of the Faculty.

What Should the Faculty be doing for its Fellows?

Fellows will be contacted in the coming months, to conduct a survey of what Fellows would like the Faculty to do to support them in the educational area. Please take the time to respond to this telephone survey since it will have a major impact on assistance to you in maintaining your continuing education.



Michael J Cousins AM
Dean

Highlights from the Board Meeting

HELD ON FEBRUARY 1, 2001

Admission to Fellowship by Training and Examination

The following trainee was admitted to Fellowship by Training and Examination:

RODRIGUES Lucia NSW FANZCA

Admission to Fellowship by Examination

The following candidate was admitted to Fellowship by Examination:

WEAVER Anthony Vic FANZCA, FFICANZCA

Admission to Fellowship by Election

The following were admitted to Fellowship by election:

PRESTON Sally NSW FRACP
ROFE Peter SA FRANZCP

Education

Please refer to separate item.

Examination

Dr Penny Briscoe, Chairman Court of Examiners, advised that the Examination Report following the 2000 examination is now complete and will be distributed to the Examiners and Supervisors of Training.

The 2001 examination is scheduled for October 18 and 19 at Sir Charles Gairdner Hospital, Perth.

Hospital Accreditation

Following a review of the Pain Management Centre at Nepean Hospital, NSW, one training position has been approved.

There will be a number of reviews of previously accredited units during this year and a schedule is to be drawn up by HAC. Enquiries have been received from several Multidisciplinary Pain Centres regarding the accreditation process.

Professional Documents

It was agreed that the following College documents be adopted by the Faculty:

PS4 (2000) Recommendations for the Post-Anaesthesia Recovery Room

PS7 (1998) The Pre-Anaesthesia Consultation

PS8 (1998) The Assistant for the Anaesthetist

PS10 (1999) The Handover of Responsibility During an Anaesthetic

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

PS18 (2000) Recommendations on Monitoring During Anaesthesia

PS31 (1997) Protocol for Checking the Anaesthetic Machine

P20 (1996) Responsibilities of the Anaesthetist in the Post-Operative Period

The Education Committee has been given the task of reviewing a list of other College documents with a view to modifying for Faculty purposes.

Recognition of Pain Medicine as a Specialty

The task force appointed to undertake this task met by teleconference in December 2000. A list of areas to be addressed has been identified and work will commence shortly.

Australasian Faculty of Occupational Medicine RACP Forum

It was noted that the report following this forum has not as yet been completed.

Development of White Papers

It was agreed to seek assistance from Fellows of the Faculty to assist with the development of white papers on key areas of clinical practice. Small taskforces were established last year, however, further manpower is required to assist with the co-ordination of the development of these papers. Please contact the Faculty Executive Officer if you are able to assist.

CSM May 5 – 9, 2001, Hong Kong

Mr Leigh Atkinson reported that plans for the meeting are progressing well. He advised that a restaurant has been booked for the Faculty dinner on Friday, May 4 and that a letter has been circulated to all Fellows regarding the dinner.

ASM May 11 – 15, 2001, Brisbane

Plans are continuing for this program.

A Summary of the Activities of the Education Committee

The Education Committee met at ANZCA headquarters on January 31, 2001.

The Objectives of Training and Reading List are now in a form suitable for distribution. These are part of the training material for Faculty trainees. It is believed that this material can also serve as a reference source for Fellows, particularly the Reading List. The Objectives of Training and Reading List and also a letter from the Chairman, Education Committee is enclosed with this edition of the Bulletin.

Dr Russell Jones, the College's recently appointed Educationist, met with members of the Committee and agreed to assist the Faculty in the area of education. Dr Jones will be of great assistance to the Education Committee, particularly with the next issues which the Education Committee will be addressing which are

- (i) the pre-examination short course; and
- (ii) what Fellows want from the Faculty and how Fellows can contribute to the Faculty.

With regard to item (ii), it was agreed that the best way to source this information is through a telephone survey. There will be an initial call to request a convenient time to conduct the survey and it is certainly hoped that all Fellows will participate.

Faculty of Pain Medicine

PROFESSIONAL DOCUMENTS

- PM2 (2000) Requirements for Multidisciplinary Pain Centres Offering Training in Pain Medicine
- PS38 (1999) Statement Relating to the Relief of Pain and Suffering and End of Life Decisions
- PS40 (2000) Guidelines for the Relationship Between Fellows and the Healthcare Industry
- PS41 (2000) Guidelines on Acute Pain Management

At the Board meeting held on 1 February 2001, the following College Professional Documents were adopted as Faculty Professional Documents with the noted amendment to the title for PS15 (2000):

- PS4 (2000) Recommendations for the Post-Anaesthesia Recovery Room
- PS7 (1998) The Pre-Anaesthesia Consultation
- PS8 (1998) The Assistant for the Anaesthetist
- PS10 (1999) The Handover of Responsibility During an Anaesthetic
- PS15 (2000) Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery with amendment to title to read "Recommendations for the Perioperative Care of Patients Selected for Day Care Procedures"
- PS18 (2000) Recommendations on Monitoring During Anaesthesia
- PS31 (1997) Protocol for Checking the Anaesthetic Machine
- P20 (1996) Responsibilities of the Anaesthetist in the Post-Operative Period



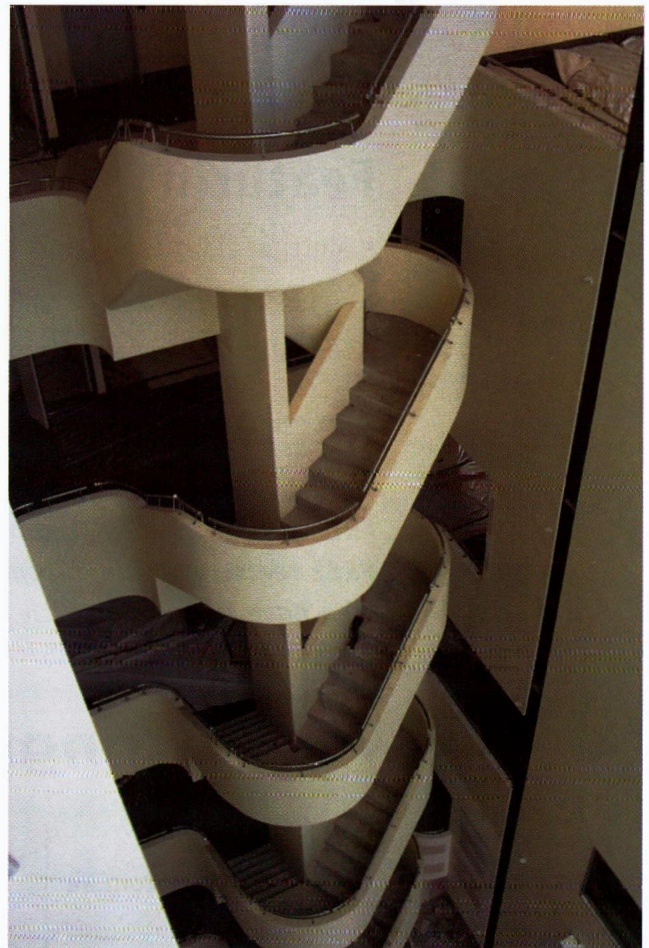
Extensions Near Completion

Work on the extensions to 'Ulimaroa' is nearing completion and it is expected that staff will move into the building in March.

Increased facilities will allow the College to continue servicing the growing needs of Fellows and the College Faculties.

The extensions also will permit other Colleges to conduct examinations and CME meetings there. Already, a number of key medical entities have expressed interest in securing the use of space in the building.

Expansion of the College library will follow the move into the six-level building and it is expected that the entire project will be completed by the end of April.



Faculty of Pain Medicine Board

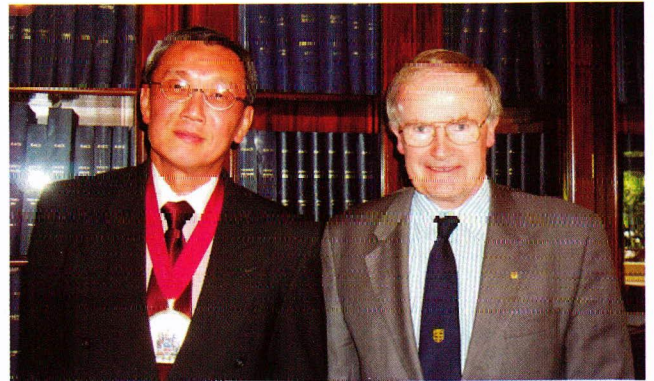


Front L to R: Mr Leigh Atkinson, Dr Roger Goucke (Vice Dean), Professor Michael Cousins AM (Dean), Dr David Jones, Ms Margaret Benjamin (Executive Officer)

Back L to R: Dr Pam Macintyre, Professor John Gibbs (ANZCA Representative), Drs Graham Rice, Bruce Kinloch, A/Professor Milton Cohen, Drs Terry Little, Penny Briscoe



Mrs Joan Sheales (Chief Executive Officer), Dr Kerry Breen (Past Chairman AMC), Prof Teik Oh (President), Dr Dick Willis (Vice President). Dr Breen addressed Council at its December meeting at the College Headquarters.



Chief Medical Officer Prof Richard Smallwood AO with ANZCA President Prof Teik Oh. Prof Smallwood addressed College Council at its recent meeting.

What is the Image of Anesthesiologists Among Lay People? And Can It Be Improved?

BY MICHAEL VLESSIDES

While several studies have found that the image of anesthesiology among the lay public is poor, the situation is not irreparable, according to an Australian anesthesiologist and communications specialist. Reporting at the 2000 World Congress of Anaesthesiologists, he cited the recent successes of the Australian and New Zealand College of Anaesthetists as testimony to how a directed communications program can overcome the traditional image problems of the specialty.

"The first question, really, is what is our image?" asked Mike Martyn, MD, a private-practice anaesthesiologist at Calvary Hospital in Hobart, Australia and Communications Officer for the Australian and New Zealand College of Anaesthetists. "And when you do a review of the literature, the reality is that we have no image at all."

Indeed, a 1995 study by Guy Orlay et al (ANZCA ASM 1995) showed that 18% of patients were unaware that anesthesiologists were medically qualified doctors. Moreover, 44% of those individuals had an unrealistic expectation of anesthetic mortality rate. Finally, while 76% remembered their surgeon's name within five years of the procedure, less than 10% were able to recall the name of their anesthesiologist.

"The problem is that if we don't do something about it, we'll be relegated to the task of technicians who are stuck in the operating theatre answering to everybody else," Dr Martyn commented.

Improving the specialty's image requires a multi-tiered approach, he commented, involving individuals, organizations, and the specialty as a whole. "The biggest level has to be the individual," he told *Anesthesiology News*. "If we can get all our anesthesiologists to train in communications, to get along fantastically with patients, and to think about anesthesia practice in broader terms, we could change this around in two or three years."

Having recognized the image problems of the specialty back in 1994, the Australian and New Zealand College of Anaesthetists hired a communications consultant to help improve public perception. More important, however, was training individual anesthesiologists to be more communication savvy. "It's very interesting that anesthesiologists who before would not have gone outside the operating theatre are now very keen to talk to media and promote what they're doing," he stated.

In an effort to improve communication skills among anesthesiologists, the Australian and New Zealand College of Anaesthetists has included these skills as a defined competency area required for fellowship. As such, an entire section of their training requirements focuses on communication skills, and includes such areas as patient and peer communication, stress management, crisis management, conflict resolution, and media relations.

"One of the things that is not done well is teaching young anesthesiologists how to do a preanesthetic consultation," he added. "The focus is very much on the science side, and it's very doctor oriented. But if you run a simulation through role-playing, you understand straight away that the patients turn off. It's little wonder that nobody remembers our names or what we do."

Organizations also need to become involved in helping improve the image of anesthesiology, Dr Martyn went on. This not only maintains the strength of the organization itself, but also gives anesthesiologists a powerful lobbying voice. The Australian and New Zealand College of Anaesthetists has taken multiple steps in this regard, beginning with the creation of a formal communications program.

The program called for a host of changes, including proactive media relationships, increased media and government contact, the creation of an Internet web site, and communication skills training for fellows. One of the very successful awareness programs it instituted was a series of National Anaesthesia Days. These events have each focused on a specific, understandable topic (such as "Pain Relief – A Basic Human Right"), and have been accompanied by media kits including posters, leaflets, stickers, and press releases.

Other events have also been held in conjunction with National Anaesthesia Days. These include inviting doctors, school-groups, and other community groups to visit, active displays in hospitals or local shopping centers, and static and visual displays in hospital and government lobbies. Media campaigns have targeted national magazines, radio programs, and television programs. The College has also instituted a number of so-called 'image-improving projects', including an antenatal education video, anesthesiology career booklets, media coverage of meetings, a virtual congress, and a college bulletin. "But the other area is the strategic area of the specialty as a

whole," Dr Martyn commented. "Where should we be headed as physicians? In Australia we've managed to get fairly well advanced in terms of intensive care, pain medicine, and perioperative medicine. In the US, however, it appears to me that anesthesiologists are very much at the stage where most of them are still stuck in the operating theatre most of the time. They have limited access to patients before or after.

"In Australia and New Zealand we've gone, I think, a fair way past that. For example, we have a Faculty of Intensive Care in our college. We also have a Faculty of Pain Medicine that involves five other colleges. We've done a lot of work on perioperative medicine, and most of the perioperative clinics in Australia have leadership from anesthesiologists."

As Lee A Fleisher, MD, pointed out, however, American anesthesiologists have not only attempted to improve their media-friendliness, they now have an excellent opportunity to tout their safety record to the public. "The ASA has attempted, to some degree, the improvement in communication," said the Associate Professor of Anesthesiology at The Johns Hopkins Hospital. "I'm just not sure how good a job we've done so far.

"However, if you look at the recent Institute of Medicine report, we look very good in the area of safety. In fact, we are held up as the model of all specialties with regard to how much work we've done to improve the safety of medical care. And I think as a specialty we really need to focus on that."

As Dr Martyn commented, the result of such increased awareness can be a tremendous improvement in the specialty's image. "Something like this is incredibly difficult to assess objectively," he reported. "Subjectively, there's been a massive change. We really haven't recently had any major, negative stories about anesthesia. There's also been quite a change in terms of the way the patients view us. But the other change that I really must stress is the cultural one of the way anesthetists are viewing themselves and what they say about themselves."

Based on a presentation at the **2000 World Congress of Anaesthesiologists** (number P7.1.04) and interview with **Mike Martyn, FANZCA**, and **Lee A. Fleisher, MD**.

Reprinted with permission from *Anesthesiology News*, November 2000

RUPERT HORNABROOK PRIZE



Dr Ruth Matters presents the Hornabrook Prize Certificate to Dr Brian Anderson

The Rupert Hornabrook Prize is awarded by the Day Care SIG for original research in the field of Day Care Anaesthesia. The inaugural award was presented to Dr Brian Anderson of the Starship Children's Hospital, Auckland as the presenting author of a paper entitled 'The dose effect relationship for morphine and vomiting after day-stay tonsillectomy in children'. Co authors were C Ralph, A Stewart, C Barker and N Holford. Rupert Hornabrook was a pioneer of anaesthesia in Australia, devoting the bulk of his practice in the years following the Boer War to promoting the specialty. He was honorary consultant in anaesthesia to the Melbourne General Hospital for many years and published extensively on issues of safety in anaesthesia. He was an early advocate of improved cardiovascular monitoring and was influential in popularising ethyl chloride-ether as an alternative to chloroform. His award in his name recognises his contribution to Australasian anaesthesia.

To be eligible for the Rupert Hornabrook Prize, researchers must present an original paper on a day care theme at a major scientific meeting of ANZCA, ASA or NZSA. Papers are judged by the Day Care SIG executive on the basis of scientific content, relevance and standard of presentation. Applications for the award can be made to Helen Morris, C/- ANZCA.

Letter to the Editor

Dear Mrs Sheales

I personally agree that if one is to have a follow-up system it should be sophisticated (Michael Gorton, *Bulletin* Vol 9, No 4, p.25)

In *Tai v Hatzistravou* the plaintiff's counsel appeared to be arguing for a cheap, unsophisticated system 'It would be very cheap would it not to have some sort of diary of people you've booked in for surgery...'

Had the defendant after replying 'No' added, 'It would take an expensive, sophisticated system', would that have been a defence?

Does the Trade Practices Act enter into this – that is, was the quality of care given consistent with the price paid, for clearly the plaintiff's counsel indicated the fee paid was only consistent with a cheap system.

Yours,
Ray Cook

The Medico-Legal Society Prize 2000

THE DOCTOR, THE THIRD PARTY, & THE EXAMINEE: IS THERE A DUTY TO INFORM?

Victor Harcourt

30 January, 2000

This paper is a short version of a paper appearing in (2000) 8(3) *Torts Law Journal*.

Victor Harcourt B Comm, LL.B

Partner, Russell Kennedy Solicitors

"This action is certainly one of a particularly unusual character. It is an action of damages by a patient against a medical man. In my somewhat long experience I cannot remember having seen a similar case before."

Farquhar v Murray (1901) 3F 859, 862

Introduction

A doctor owes a duty of care to her or his patients which has been described as a 'single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment'.¹ The doctor must exercise reasonable care and skill in respect of 'the examination, diagnosis and treatment of the patient and the provision of information'.² The doctor's duty imposed by the law of torts is similar to the contractual duty undertaken by a doctor, 'in the absence of a special contract between the doctor and a patient'.³

The contractual duty, rarely expressed in the form of a written agreement, has been described in various jurisdictions⁴ as one being: 'to advise and treat the patient with reasonable skill and care';⁵ 'to act at all times in the best interests of the patient';⁶ and 'to act with utmost good faith and loyalty'.⁷

The benefit of the protection of the law of torts or contract in the formulations outlined above depends upon a person falling within the definition of 'patient'. In the usual case whether a person may correctly be classified as a patient may seem to be 'blindingly obvious'.⁸ If the doctor has undertaken to provide medical treatment, whether at the request of the patient or another and whether payment is made by the patient or another or indeed not made, then generally the relationship of doctor and patient has been created.⁹

What is not so obvious is whether there exists a doctor and patient relationship in those circumstances where a doctor is engaged by a third party to provide a report of some description to the third party concerning a person who is not otherwise a patient of the doctor (whom I shall term 'the examinee'). For example, a doctor may be engaged to provide a medical report by a life insurance company for the purposes of assessing a proposal, or by a prospective employer for the purposes of considering a job application, or by an employer for the

purposes of continuing employment or advancement. In each of these cases the primary purpose of the medical report is not for the provision of medical treatment to the examinee, and the doctor has not been engaged by, nor has he or she undertaken to, provide medical treatment to the examinee.¹⁰ The AMA's Position Statement concerning independent medical examinations explains it in this way:

'Medical practitioners are requested to assess persons on behalf of third parties such as insurance companies and employers. In these circumstances, a traditional doctor/patient therapeutic relationship **does not** arise. The role of the medical practitioner in these assessments is to provide an impartial medical opinion. It is not to treat the person. The result of the assessment is a report to the third party, not to the person or the person's treating medical practitioner.'¹¹

For the doctor, however, this tripartite arrangement can pose a number of difficult questions about the nature of the legal relationship with the examinee. For example, if the doctor discovers a medical condition which has some significance for the examinee's health during the course of the examination, should the doctor inform the examinee or that person's treating doctor of the medical condition? I will refer to this as the 'duty to inform'. If the doctor does not owe a duty of care to the examinee but does inform that person or the treating doctor, has the doctor attracted a greater liability than he or she may otherwise have had? This may be so if the doctor gives a warning which inadequately conveys the nature of the risk, and the examinee does not take any appropriate steps in response as a consequence.

If the answer is that a doctor does owe a duty to the examinee to inform, is the doctor liable if he or she does not discover a significant medical condition that was readily apparent upon examination if the doctor had conducted the examination in accordance with the contract with the insurance company? And what is the legal position of the doctor who does not discover a medical condition of a material nature that was not readily apparent upon examination but discovered symptoms that should have sparked an enquiry that may have revealed the medical condition, but either fails to inform or does so inadequately?

The uncertainty of the doctor's position, highlighted by the debate, may be complicated by an expectation held by the community that the doctor should and would advise of any medical condition which has some significance for the examinee's health. A recent European study¹² investigated the attitudes of doctors and lay people to unsolicited medical intervention in three different situations, and found that lay people are more likely to find it appropriate than doctors.¹³

The AMA Position Statement although suggests that the doctor should not offer an opinion concerning the examinee's medical management to the examinee, but any serious concerns should be conveyed to the treating doctor. It also states:¹⁴

'Incidental matters identified during the assessment may be notified to the person, but there may be some situations where it is preferable to notify the person's treating medical practitioner.'¹⁵

The dilemma for doctors is whether to assist the examinee, or to remain silent and complete the task in accordance with the contract with the third party. The interface between the medicine and the law in resolving this is entangled in the competing rights of the examinee and the responsibilities of doctors, the expectations of both groups and whether the law can provide a sound basis for an answer to this problem. It also involves the traditional and hotly debated policy of the courts not to impose upon individuals a duty 'to take positive action to protect others from harm for which he was not responsible'¹⁶ unless there is a special duty to act.¹⁷ It is a question which has perplexed academics and which some courts have resolved without 'exploring the issues thoroughly'.¹⁸

The questions posed above may be readily capable of answer if the correct analysis of the tripartite arrangement concludes that as between the doctor and the examinee there is a doctor and patient relationship, attracting the single comprehensive duty owed by a doctor. This is not how the law generally sees the arrangement, however, and there is a significant debate as to whether a duty of care is owed and if it is, what is the scope of the duty of care.

Recent English decisions¹⁹ that have looked at the obligations of a doctor to an examinee have demonstrated a clear judicial reluctance to impose on a doctor a duty of care to the examinee. To the contrary of this there is general support in academic texts for the view that, notwithstanding there is no traditional doctor/patient relationship, the doctor has a duty to inform the examinee of any significant medical conditions found on examination.²⁰

Kennedy and Grubb argue, in their book²¹, that the English Courts should find persuasive the American case of *Green v Walker*²² in which a doctor, engaged by a company to conduct a medical examination of an employee, was held liable for failure to inform the employee of significant findings. Jones²³

also argues strenuously in favour of a duty of care being owed and against the position adopted to the contrary by the House of Lords in *X. (minors) v Bedfordshire County Council*.²⁴ Fleming²⁵ however relies upon this decision to support the view that the doctor does not owe a duty to the examinee for the accuracy of the diagnosis, unless he or she assumed a personal responsibility to the examinee and induced his or her reliance.

In Australia the limited case law²⁶ indicates that the conditions exist for the courts to recognise that doctors owe a duty of care to examinees encompassing a duty to inform. In this paper I will demonstrate that it is arguable a doctor does owe a duty of care to the examinee, and that this comprises the following three features:

- (1) A duty to exercise reasonable care and skill in undertaking the examination so as not to cause injury;
- (2) A duty of confidentiality; and
- (3) A duty to inform the examinee of any medical conditions that may have some significance for that person's health.

I will consider firstly the English decisions that have looked at the obligations of a doctor to an examinee, before discussing *Thomsen v Davison*.²⁷ I will then argue that the decision in *Lowns v Woods*²⁸ sets the scene for the creative litigant to maintain a cause of action against a doctor for a breach of a duty to inform, and for a progressive court to uphold the claim.

The Case Law

The case of *X. (minors) v Bedfordshire County Council*²⁹ involved a claim made against a third party's doctor in the context of a statutory authority exercising its statutory duties, and in which policy grounds against the imposition of a duty were strenuously raised. For the purposes of this paper the relevant facts can be shortly stated as involving a claim by a child and her mother against a social worker and a psychiatrist retained or employed by the local council to investigate allegations of sexual abuse of the child. It was alleged that the investigation was carried out in a negligent manner causing both the child and the mother to suffer a psychiatric disorder. The statements of claim were struck out as disclosing no cause of action and, on appeal, the question before the House of Lords was whether the health professionals owed a duty of care to the child and the mother.

Like the majority in the Court of Appeal,³⁰ the House of Lords held that the psychiatrist did not owe a duty of care to the child of the nature alleged. Lord Browne-Wilkinson, who delivered the leading judgment, concurred with the view taken by the majority in the Court of Appeal³¹ that 'the child was no more the patient than an applicant for life insurance who is examined by the company doctor'³². He noted that except for the duty owed to the examinee not to cause harm during the examination, the doctor's duties were owed to the insurance

company.³³ Staughton and Peter Gibson LJ in the Court of Appeal were prepared to accept that the psychiatrist also owed a duty of confidentiality to the examinee.³⁴

Lord Browne-Wilkinson further held that in any event it would not be just and reasonable to impose a duty of care on the psychiatrist for the same reasons that the council did not owe a duty of care.³⁵ These public policy grounds included a recognition of the impact on the statutory scheme, the complexity of the inter-disciplinary approach to the matter, the delicacy of the task of child-protection and the likelihood of a more defensive and cautious approach to the task.³⁶

The logic followed in the majority judgements has been the subject of criticism by Jones³⁷ who notes that there was not necessarily any inconsistency in the doctor owing a duty of care to both the child and the council, and that as a matter of principle 'there is no objection to holding that A can owe a duty to B in respect of advice given to C in circumstances where the advice was never intended to be communicated to B...'.³⁸ He also argues that the situation the court was considering was:

'[C]loser to the case where a doctor examining an applicant for life insurance causes injury than one where, having diagnosed a potentially dangerous condition, he fails to inform the applicant, with the result that the applicant loses an opportunity to have expeditious treatment.'³⁹

This is not to say that Jones believes that a duty to inform is not owed, as he later states it is strongly arguable that the third party doctor owes a duty to inform the examinee if he or she discovers something seriously wrong.⁴⁰ It would appear that the subject matter of the claim, concerning the investigation of child abuse, and the statutory framework within which the local authority had to work heavily influenced the outcome. In this regard there is some force to the suggestions⁴¹ that the statutory context of the case is a strong basis for distinguishing it from the 'contractual and commercial context of an examination by an insurance company doctor of an applicant for life insurance'.⁴²

Consistently with this view, the court in *Baker v Kaye*,⁴³ found that an independent doctor conducting a pre-employment medical examination for a prospective employer considering a job application owed a duty to the examinee to take reasonable care in carrying out the assessment and preparing the report.⁴⁴ The court held:⁴⁵

- (1) Economic loss was a foreseeable consequence of a failure to take care;
- (2) There were three key features of the relationship which indicated sufficient proximity to give rise to a duty to take care:
 - (A) The doctor was aware of the consequences of his report for the examinee;

- (B) The examinee provided confidential information to the doctor, which was not to be disclosed to the company, and he was entitled to expect the doctor would use due care in the use of the information; and

- (C) The doctor regarded himself as under a duty to inform the examinee to seek medical advice if the assessment revealed any indication of a medical condition for which he required medical treatment or advice.

- (3) It was fair, just and reasonable to impose the duty, there being no conflict between the doctor's duty to the company and to the examinee.⁴⁶

This reasoning, which at least one commentator considers to be 'impeccable',⁴⁷ has however been disapproved by the Court of Appeal in *Kapfunde v Abbey National plc*,⁴⁸ a case which also dealt with an independent doctor, retained by the prospective employer, who had provided a pre-employment medical report.⁴⁹ The Court of Appeal held that the doctor did not owe a duty of care to the examinee other than not to injure the examinee during the course of the examination.⁵⁰ Lord Justice Kennedy noted at the outset three factors significant to distinguish this from other cases. They were, firstly, that there was no doctor/patient relationship; secondly, the employer did not owe a duty to the examinee to exercise skill and care in the processing of job applications; and thirdly, the claim was only for economic loss.⁵¹ The position of the doctor was equated to that of the psychiatrist in *X. (minors) V Bedfordshire County Council*⁵² and the example of the life insurance doctor.⁵³

The arguments advanced by the Court of Appeal do not adequately address the analysis of the doctor and examinee relationship the court undertook in *Baker v Kaye*, as there is no attempt to address the key features identified in support of a finding of proximity of the parties. Lord Justice Millett did not seek to explore the examinee's interests in the transaction, upholding the primacy of the contractual relations between the third party and the doctor to the exclusion of the examinee. The court in *Baker v Kaye* considered that there was not a conflict between the doctor's contractual duties to the third party and the duty of care to the examinee that would militate against the imposition of such a duty,⁵⁴ a view not shared by the Court of Appeal or the House of Lords in the previously discussed cases.

There have been few Australian cases concerning the legal position of the third party's doctor vis-a-vis the examinee. It has been held that doctors who provide their services for free should exercise reasonable care and skill in the treatment provided, and owe a duty not to injure the examinee during the course of the examination.⁵⁵ It has also been held that a doctor who conducts an examination for the purposes of the examinee's employer owes a duty of care to the examinee in the case of *Thomsen v Davison*.⁵⁶

In this case a jury found that the doctor, a part-time regimental medical officer, was negligent in failing to ascertain the test results of the examination of an army trooper and failing to recommend to the plaintiff that his state of health ought to be investigated. The medical examination was required in support of an application by the plaintiff for admission to an officer's cadet training unit. Dr Davison appears to have gone beyond simply agreeing to provide a report to the army for the purposes of considering Thomsen's advancement within his employment as the evidence established 'that it was understood by both parties that the doctor would follow up these tests.'⁵⁷

In considering motions for judgment Campbell J discussed the nature of the relationship between the parties and found it to be more analogous to that of a general medical practitioner with his patients, than that of an insurance company doctor and an examinee.⁵⁸ The point which differentiates this case from the more common example of the insurance doctor is that the doctor had undertaken a responsibility to watch over the health of the soldiers which was relied upon by them.⁵⁹ It also adds support to the view expressed by Fleming⁶⁰ that a doctor does not owe a duty to the examinee unless he or she assumed a personal responsibility to the examinee and induced his or her reliance. Brennan J, in the case of *Pyrenees Shire Council v Day*,⁶¹ cites *Thomsen v Davison* as an example of 'the kind of reliance that a particular plaintiff may place upon a particular defendant who has assumed a responsibility to exercise due care and skill in... his medical treatment.'⁶²

Balkin and Davis posit that the basis of liability seems to be that the doctor 'as the repository of specialised information or knowledge, is, effectively, the only source upon which the individual can draw and on whom the individual must therefore rely'.⁶³ This does not, upon a close reading of the judgment, explain fully the rationale for the finding. The proper basis of liability lies in the fact that the doctor had, by his conduct, assumed a responsibility, which the examinee relied upon, to inform the examinee in the event the test results indicated that his health was not sound.⁶⁴ Campbell J bases his judgement very much upon this footing, and without analysing the position in the absence of such reliance.

Jones⁶⁵ also relies upon the decision in *Thomsen v Davison* to support the wider proposition that the doctor who undertakes the examination to assess the examinee's state of health has a duty of care to the employer and to the examinee to do it competently and not to do or omit to do anything that may cause damage including a duty to inform himself and the examinee of any significant test results. This proposition does not give sufficient weight to the importance the court placed upon the role the doctor played in the unit, the doctor's acknowledged role in looking after the health of the soldiers and the issue of reliance specifically placed on the doctor not only to complete his report for the admission application but also to advise of any adverse test results. Whether the same

elements can be said to exist when an applicant for life insurance attends for a medical examination is doubtful, as is also the conclusion Campbell J would have reached had there not been evidence given of the assumption of responsibility.

It would therefore seem that *Thomsen v Davison* is at least authority for the view that a third party's doctor may not only owe a duty to the third party, but may attract a duty of care to the examinee by assuming responsibility to inform the examinee of any significant medical conditions found. A company doctor may be more likely to be placed in such a position than the life insurance doctor, but again it would seem that the company doctor would not automatically assume the responsibility simply by virtue of undertaking the role.

The judicial resistance to holding a doctor owes an examinee a duty to inform lies in the fundamental distinction that is made in the law of torts between 'active misconduct working positive injury to others and passive inaction, failing to take positive steps to benefit others or to protect them from some impending harm'.⁶⁶ Liability for active misconduct will be more readily found than for passive inaction. In the absence of a contract, fiduciary relationship or statutory obligation, liability for the consequences of a failure to act will be found when some special relationship exists between the person harmed and the person who fails to act.⁶⁷

If there can be found circumstances to suggest a special relationship which may give rise to a positive duty on the part of one person to act for the benefit of another whether it is fair and reasonable to impose a duty to act will be extraordinarily difficult to satisfy, particularly if the claim is for economic loss rather than personal injury.⁶⁸ Certainly *Thomsen v Davison* suggests a more positive approach would be taken by Australian courts to the imposition on a doctor of a duty to inform the examinee.

However the question still remains whether a court considering the question today could hold a doctor liable for a failure to inform the examinee of a significant medical condition. It is arguable that a court could find such a duty and I will demonstrate this by analogy using the case of *Lowns v Woods*.⁶⁹

The duty of care owed to a third party

The decision in *Lowns v Woods* is the first time that a court has found a doctor liable for the consequences of not attending to the rescue of a person who was not already the doctor's patient. The doctor in this case refused a request made at his surgery to attend upon the plaintiff who was having an epileptic seizure nearby.⁷⁰ The case represents an exception⁷¹ to the general principle that the common law will not impose upon a person a duty to rescue another, even if the rescue would be easy, unless the source of the danger was connected to the person in a position to effect the rescue.⁷²

The majority of the Court of Appeal⁷³ upheld the decision of the trial judge who found that although there was no doctor/patient relationship there was a relationship of proximity between the doctor and the plaintiff, supported by public policy considerations.⁷⁴ The elements of proximity were described by the trial judge in the following terms:

- (1) Physical proximity was found in the request made to the doctor to attend at a place nearby;
- (2) Causal proximity was found in the fact that the doctor recognised the medical condition as a major medical emergency, life threatening and requiring urgent attention; and
- (3) Circumstantial proximity existed in that the doctor knew what the appropriate treatment was and the consequences of not providing it, was competent to provide it and was at the time of the request at his place of work.⁷⁵

Both the trial judge⁷⁶ and Kirby P⁷⁷ also found important the terms of the Medical Practitioners Act 1938 (NSW) which defined professional misconduct to include where a doctor unreasonably refuses or fails to attend upon a person, (not merely a patient) in need of urgent medical attention.

Is it not arguable that a similar analysis, absent the specific statutory provision, could apply in respect of a doctor conducting an examination, at the behest of a third party, of an examinee who discovers a medical condition of some significance for the examinee, and of which there is some doubt whether the examinee is aware. Present are the same elements of proximity although admittedly not in the context of an emergency. A similar analysis was undertaken in *Baker v Kaye* albeit of a different factual scenario.

The doctor is attending upon the examinee in a professional setting presumably in the doctor's premises during which the doctor acquires knowledge of the medical condition by virtue of the consent of the examinee to the medical assessment, which may primarily be for purposes other than to provide treatment or advice. The knowledge is acquired after the examinee has imparted confidential information on the implied if not express basis that such information cannot be disclosed to any other person save perhaps the third party.

The doctor may well fully understand the implications of not attending to the matter and will therefore be cognisant of the likely outcome if the examinee is not informed. The standards of the medical profession may call for the disclosure of the information,⁷⁸ or indeed the doctor may consider him or herself under an ethical obligation to act in the best interests of the examinee by imparting the information. Certainly there can be no argument that the doctor would incur any significant expenditure in informing the examinee of the medical condition. The circumstances may also be suggestive of an added dimension to the relationship which, although not sufficient to form a doctor/patient relationship, may give rise to a duty

to inform. For example, a company doctor performing a routine medical examination for the purposes of the company assessing continuing or future employment. The context of the employment relationship and the doctor's role may suggest an assumption of responsibility and reliance by the employees upon the doctor informing them of any significant medical condition.

In embarking upon the above analysis I am mindful that the decision in *Lowns v Woods* has not received universal approval⁷⁹ and that Kirby J has suggested that proximity's reign in the High Court 'at least as a universal identifier of the existence of a duty of care at common law, has come to an end'.⁸⁰ It does represent an extension of the duties of the medical profession perhaps taking into account their unique position held in our society and reflecting the higher standards that may be expected of them.

Conclusion

A doctor may be engaged by a third party to conduct an examination and provide a medical report in respect of a person outside the traditional doctor/patient relationship in a number of different settings and for a variety of reasons. Whilst there is a debate concerning whether and to what extent the doctor may owe a duty of care to the examinee in respect of the contents of the report itself, and by implication the examination and assessment, there are at least two aspects of the relationship calling for the exercise of professional skill and care. That is, a doctor owes to the examinee a duty of confidentiality in relation to any confidential information disclosed by the patient or ascertained in the course of the examination, which is governed by the body of law that has grown in this area. Of course, the duty of confidentiality is subject to the implied or express consent to disclosure to the third party for the purposes for which the examination was undertaken. A doctor also owes a duty to the examinee not to cause injury during the course of the examination.

Beyond this there is considerable uncertainty as to whether a doctor owes to an examinee a duty to inform of the existence of any medical conditions found on examination which may have implications for the examinee's health. If the circumstances exist which may attract such a duty of care then the obligation is upon the doctor to exercise reasonable care and skill in the performance of the task. Such care and skill may include not only informing the examinee of a medical condition that was in fact found, but also diagnosing a medical condition that should have been apparent from a properly conducted examination and assessment. It would certainly require that the information conveyed to the examinee was accurate and appropriate in all the circumstances.

A duty is more likely to be found to exist in the Australian context in the event that the doctor, by his or her conduct, undertakes some responsibility to the examinee which the latter

can be said to have relied upon. For example, an undertaking to complete and advise the results of tests, or an overriding obligation to look after the health of the examinee which exists in the circumstances but outside the traditional doctor/patient relationship.

Even in the absence of an assumption of responsibility it is arguable a doctor owes a duty to inform the examinee simply by reason of his or her undertaking the examination. It is arguable because there is no case which has conclusively determined this issue in either England or Australia and the conditions exist for an expansion of the law to encompass a duty to inform. Until the dilemma for doctors is resolved the conservative approach is for doctors to remain silent as to any medical conditions discovered. The very real fear is that disclosure or an undertaking to disclose may be construed as an assumption of responsibility for which potential liability may lie. However, non-disclosure is not in the best interests of the examinee nor is the uncertainty conducive to the practise of good medicine.

- 1 *Sidaway v Bethlem Royal Hospital* (1985) AC 871, 893.
- 2 *Rogers v Whitaker* (1992) 175 CLR 479.
- 3 *Breen v Williams* (1996) 186 CLR 71, 78.
- 4 L Skene, *Law and Medical Practice Rights, Duties, Claims and Defences* (1998), 40.
- 5 *Breen v Williams* (1996) 186 CLR 71, 78, 91 and 104.
- 6 *Sidaway v Bethlem Royal Hospital* (1985), AC 871, 904.
- 7 *McInerney v MacDonald* (1992) 93 DLR (4th) 415, 423.
- 8 I Kennedy & A Grubb, *Medical Law: Text with Materials* (2nd ed, 1994), 64.
- 9 *Ibid.* See also M Jones, *Medical Negligence* (2nd ed, 1996), 34.
- 10 Australian Medical Association Position Statement, *Independent Medical Assessments on Behalf of Parties Other than the Patient*, 1.
- 11 *Ibid.*
- 12 M Zwitter, T Nilstan, L Knudsen, B Zakotnik, J Klocker, S Bremberg, G Frentz, U Klocker-Kaiser, J Pedersen, 'Professional and public attitudes towards unsolicited medical intervention' (1999) 318 *British Medical Journal* 251.
- 13 In the first situation of a doctor passing by a traffic accident, the attitudes of doctors and lay people were similar with 96% of doctors stating they would intervene and 98% of lay people believing doctors should help. However the differences in attitude are more apparent in the other two situations considered in the study. Whereas only 23% of doctors would tell a stranger on a bus that a black spot on a person's face was most likely a melanoma, 34% of lay people said the doctor should. And the gulf was greater in the case of a doctor who has ascertained that a young woman has a genetic predisposition to breast cancer from a test conducted on her donated blood without her permission. Only 39.5% of doctors would contact the young woman compared to 62.6% of lay people who believed the doctor should contact her.
- 14 Australian Medical Association Position Statement, *Independent Medical Assessments on Behalf of Parties other than the Patient*, 2. In discussion with the AMA's employee solicitor it was ascertained that the advice usually given to medical practitioners concerned about whether they should disclose to the examinee any significant medical condition found on examination is to the effect that the treating doctor should be informed.

- 15 A similar statement appears in the New South Wales Medical Board, *Guidelines for medico-legal consultations and examinations*, August 1997 which states: '7. In the majority of cases it is appropriate to notify the patient of an incidental problem which has been identified by the examining doctor. There may be some situations where it is preferable to notify the patients treating doctor.' The Medical Practitioners Board of Victoria has provided some guidance for medical practitioners in respect of matters the subject of complaints arising from medico-legal examinations in *A Guide for Medical Practitioners* (June 1995), but it does not touch upon the issue being considered in this paper. Likewise, the Medico-Legal Society of Queensland Policy Statement, *Medico-legal Reports*, published in 1994, does not give guidance on the duty of the doctor to an examinee to inform of any significant medical condition. The statement may be found in (1994) 24 *Queensland Law Society Journal* 399.
- 16 *Stovin v Wise* (1996) AC 923, 930.
- 17 *Sutherland Shire Council v Heyman* (1985) 157 CLR 424, 478.
- 18 A Grubb, 'Doctors engaged by third parties: Duty to take care' (1997) *Medical Law Review* 348.
- 19 *X. (minors) v Bedfordshire County Council* (1995) 2 AC 633; *Kapfunde v Abbey National plc* (1998) IRLR 583; cf *Baker v Kaye* (1997) IRLR 219.
- 20 See for example Haisbury's *The Laws of Australia* Vol XX, Ch 3, para. 74, page 56, citing *McCormack v Redpath Brown & Co Ltd*, *The Times* 1961 and *Dale v Munthali* (1977) 78 DLR (3d) 588; Vol 27.2, Ch 3, para 13 page 23; and B Bennett, *Law and Medicine* (1997) 44.
- 21 I Kennedy & A Grubb, *Medical Law: Text with Materials* (2nd ed, 1994), 73-75.
- 22 (1990) 910 F 2d 291 (5th Circ, CA).
- 23 M Jones, *Medical Negligence* (2nd ed, 1996), 39-46.
- 24 (1995) 2 AC 633. I will consider the arguments put later in this paper.
- 25 J Fleming, *The Law of Torts* (9th ed, 1998), 160.
- 26 *Thomsen v Davison* (1975) Qd R 93; *Lowms v Woods* (1996) Aust Torts Reports 81-376.
- 27 (1975) Qd R 93.
- 28 (1996) Aust Torts Reports 81-376.
- 29 (1995) 2 AC 633.
- 30 *M. (a minor) v Newham London BC*; *X. (Minors) v Bedfordshire County Council* (1995) 2 AC 633.
- 31 *Ibid* 673, 683.
- 32 *Ibid* 673.
- 33 *Ibid* 753. Lord Nolan concurred with Lord Browne-Wilkinson's judgment except in relation to the basis for not finding that the health professionals owed a duty of care to the child. In his opinion, the psychiatrist would owe a duty, the situation being different to that of the 'contractual and commercial context of an examination by an insurance company doctor of an applicant for life insurance' but was protected on the basis of the doctrine of witness immunity (at 772).
- 34 *Ibid* 673, 683.
- 35 *Ibid* 754.
- 36 *Ibid* 750.
- 37 M Jones, *Medical Negligence* (2nd ed, 1996) 39-42.
- 38 *Ibid* 39. Jones relies upon the decisions in *Spring v Guardian Assurance* (1995) 2 AC 296, and *White v Jones* (1993) 3 WLR 730 to support this proposition.
- 39 M Jones, *Medical Negligence* (2nd ed, 1996), 43.
- 40 *Ibid* 44. Jones cites as support for the proposition the case of *Thomsen v Davison* (1975) Qd R 93 which I will discuss later in this paper.
- 41 A Grubb, 'Doctors engaged by third parties: Duty to take care' (1997) *Medical Law Review* 348, 352.
- 42 (1995) 2 AC 633, 772.

- 43 (1997) IRLR 219. The action concerned a claim by the plaintiff for damages for economic loss caused by the alleged negligent misstatement of the doctor and was heard before a single judge sitting in the High Court.
- 44 Ibid 225. The court did not however find that the doctor had acted negligently as the court stated, at 227, that the evidence suggested 'that a substantial body of reasonable medical opinion would have arrived at the same conclusion when interpreting the results'. In this respect the court was applying the principle derived from *Bolam v Friern Hospital Management Committee* (1957) 1 WLR 582 that a doctor is not negligent if he or she acted in accordance with a practice accepted as proper by a responsible body of medical opinion. The 'Bolam principle' was rejected by the High Court of Australia in *Rogers v Whitaker* (1992) 175 CLR 479 which retained for the courts the proper function of determining the appropriate standard of care, although a body of medical opinion could, it said, be a useful guide.
- 45 Ibid. The court applied the approach defined by the House of Lords in *Caparo Industries plc v Dickman* (1990) 2 AC 605 in its analysis as to whether the doctor owed a duty of care to the examinee. In reaching this conclusion the court, at 224, rejected the analogy with the case of *Hedley Byrne & Co. Ltd v Heller and Partners Ltd* (1964) AC 465 which concerned a claim for economic loss caused by a negligent misstatement as it could not be said that Mr Baker had relied upon the medical report in taking or not taking any particular action. It also distinguished, at 225, the case of *Spring v Guardian Assurance plc* (1995) 2 AC 296 in which it was held that an employer owed a duty of care to an ex-employee in the giving of a job reference, on the basis that the duty could be said to arise out of the pre-existing employment contract, a situation that did not pertain in Mr Baker's case.
- 46 Ibid 226.
- 47 A Grubb, 'Doctors engaged by third parties: Duty to take care' (1997) *Medical Law Review* 348, 350.
- 48 (1998) IRLR 583, 587 & 589.
- 49 The plaintiff was temporarily employed by the company and had applied for a permanent position but was rejected because she suffered from sickle cell anaemia and was therefore likely to have a higher than average level of absence from work. The plaintiff also sued for damages for economic loss caused by the alleged negligent misstatement of the doctor. At first instance the claim was dismissed on the basis, inter alia, there was no sufficient proximity between the parties and it would not be fair, just or reasonable to impose such a duty, nor was there any breach of such a duty if it existed. The judgment at first instance was referred to in the decision in *Baker v Kaye* (1997) IRLR 219 at 223, which noted the similarity between the cases and made no further comment. The court did not attempt to reconcile the different approaches nor to address the arguments raised against the imposition of a duty of care.
- 50 The court rejected any similarity with *Spring v Guardian Assurance plc* (1995) 2 AC 296, as did, it will be recalled, the court in *Baker v Kaye* (1997) IRLR 219 & 225.
- 51 (1998) IRLR 583, 585-6.
- 52 (1995) 2 AC 633, 730.
- 53 (1998) IRLR 583, 587 & 589.
- 54 Ibid 226. This discussion was undertaken in the light of the decision in *X (minors) v Bedfordshire County Council* (1995) 2 AC 633.
- 55 In *Goode v Nash* (1979) 21 SASR 419, a medical practitioner gave his services gratuitously at a free public screening for the detection of glaucoma. It was held that the doctor had negligently caused damage to the plaintiff's eye during the examination, and was liable in damages for the injury.
- 56 (1975) Qd R 93.
- 57 Ibid 97.
- 58 Ibid 96.
- 59 Ibid 97. Campbell J was of the view that the doctor should have been aware of the confidence and trust the soldiers were likely to place in him
- 60 J Fleming, *The Law of Torts* (9th ed, 1998), 160.
- 61 (1998) 192 CLR 330.
- 62 Ibid 343.
- 63 Balkin and Davis, *Law of Torts* (2nd ed, 1996), 215.
- 64 (1975) Qd R 93, 96.
- 65 M Jones, *Medical Negligence* (2nd ed, 1996), 44-45.
- 66 J Fleming, *The Law of Torts* (9th ed, 1998), 163.
- 67 *Pyrenees Shire Council v Day* (1998) 192 CLR 330, 368: '... A special relationship may arise from the ownership, occupation or control of land or chattels, from the receipt of a benefit or from an undertaking, assumption of responsibility or invitation which might induce the person harmed to act or to refrain from acting.'
- 68 *Stovin v Wise* (1996) AC 923, 929-930. See also *Sutherland Shire Council v Heyman* (1985) 157 CLR 424, 502.
- 69 (1996) Aust Torts Reports 81-376.
- 70 It should be noted that the doctor's evidence was that he did not receive such a request but if he had he would have had an obligation to attend. See *Lowns v Woods* (1996) Aust Torts Reports 81-376, 63, 174.
- 71 Perhaps even an 'assault on the rule itself' per L Haberfield, 'Lowns v Woods and the Duty to Rescue' (1998) 6 *Tort Law Review* 56, 58.
- 72 J Fleming, *The Law of Torts* (9th ed 1998), 164.
- 73 Constituted by Kirby P and Cole JA, Mahoney JA dissenting.
- 74 *Woods v Lowns* (1995) 36 NSWLR 344, 358-360.
- 75 Ibid 359-360.
- 76 Ibid 358.
- 77 (1996) Aust Torts Reports 81-376, 63, 155.
- 78 See for example Australian Medical Association Position Statement, *Independent Medical Assessments on Behalf of Parties other than the Patient*, 1.
- 79 See L Haberfield, 'Lowns v Woods and the Duty to Rescue' (1998) 6 *Tort Law Review* 56; K Amirthalingam & T Faunce, 'Patching up "proximity": problems with the judicial creation of a new medical duty to rescue' (1997) 5 *Torts Law Journal* 27; D Mendelson 'Dr Lowns and the Obligation to Treat: Creative Law - Making in the New South Wales Court of Appeal' (1996) 4 *Tort Law Review* 242; K Day, 'Medical Negligence - the Duty to Attend Emergencies and the Standard of Care: Lowns & Anor v Woods & Anor' (1996) 18 *Sydney Law Review* 386; O Melnitchouk 'Extending liability for medical negligence' (1996) 4 *Torts Law Journal* 259.
- 80 *Pyrenees Shire Council v Day* (1998) 192 CLR 330, 414. This view has not been accepted in New South Wales. See *TC v State of New South Wales* (1999) NSWSC 31, (11 February 1999) para 109.

Australian and New Zealand College of Anaesthetists

ABN 82 055 042 852

RECOMMENDATIONS FOR STAFFING OF DEPARTMENTS OF ANAESTHESIA

1. INTRODUCTION

- 1.1 "Staffing" refers to the numbers of senior and junior medical staff, nursing staff and technical staff in the various areas of clinical activity, and also the numbers of departmental management and clerical staff.
- 1.2 Appropriate staffing is fundamental for the provision of high quality and safe clinical anaesthesia and to enable all staff to participate in personal education, teaching, quality assurance, research and other activities.
- 1.3 In training institutions, appropriate staffing is necessary to provide a satisfactory environment in which trainees can acquire the knowledge, experience and support necessary to fulfill the requirements for the award of Fellowship of the College.

2. PRACTICE OF SENIOR MEDICAL STAFF IN TRAINING HOSPITALS

- 2.1 Different industrial awards and enterprise agreements have given rise to widely varying weekly work patterns, often resulting in staff spending less time in the training hospital.
- 2.2 Differentiation of staff into either full-time or visiting medical specialists is not relevant in the context of their input to trainee education and welfare. The contribution of specialist anaesthesia staff to trainee education should be considered in terms of the number of hours or sessions per week that the specialist spends in the training institution.
- 2.3 A core of staff who spend all or most of their professional time in the institution is important in order to ensure continuity of training programs, cohesion and corporate memory.

3. DUTIES OF SPECIFIC STAFF

3.1 Medical Staff

The duties of specialist anaesthetists are outlined in College Professional Document TE6 *Guidelines on the Duties of an Anaesthetist*. In institutions accredited by ANZCA for training, the duties are the same but with a greater focus on all aspects of training.

Time free from clinical duties must be set aside for the other professional activities of the Department and its

members. Such activities include organisation and participation in teaching programs for anaesthesia trainees and other professional groups, administration, research, continuing medical education, quality assurance and audit, participation in maintenance of professional standards programs, and in programs directed at maintaining the health and welfare of professional colleagues. Refer to College Professional Documents TE9 *Guidelines on Quality Assurance* and PS16 *Guidelines on the Standards of Practice of a Specialist Anaesthetist*.

Clinical work should not exceed an average of 0.7 of specialists' workload in order to provide time for other professional duties. This discretionary time should be allocated to staff by the Department Director in such a way as to ensure that the Department's non-clinical goals are achieved and individuals' expertise is best utilised, while still guaranteeing that all staff have adequate allocated time for professional development.

Medical staff duties are as follows:

3.1.1 Director of Anaesthesia

The Director has a prime responsibility to ensure that the Department functions safely and efficiently. Administration and personnel management comprise a significant part of the workload. Approximately 40% of the Director's workload should be allocated to clinical activities. If the Director is a part-time appointee, appropriate time must still be available for managerial duties as well as other non-clinical activities. This will result in a clinical commitment of less than 40%.

3.1.2 Deputy Director of Anaesthesia

In large Departments, a Deputy Director should be appointed to assist the Director with administrative tasks. Approximately 40% of the combined workload of both the Director and Deputy Director should be allocated to clinical duties.

3.1.3 Supervisor of Training

Reference is made to College Professional Document TE5 *Policy for Supervisors of Training in Anaesthesia*. The Supervisor of Training has an important College role providing liaison between trainees and the Department administration, the Regional Education Officer and the College administration. In addition to providing College information on training programs and examinations, the Supervisor also coordinates the In-Training Assessment process for the trainees. Refer to College Professional Document TE14 *Guidelines for the In-Training Assessment of Trainees in Anaesthesia*. At least one half day per week should be allocated to accomplish the necessary tasks. A greater period of time may be required in larger Departments.

3.1.4 Assistant Supervisor of Training

In larger institutions, an Assistant may provide useful support for the Supervisor of Training in his/her demanding and time-consuming role. An allocation of one half day is appropriate.

3.1.5 Specialist Anaesthetist

In addition to clinical activities, all specialist anaesthesia staff have obligations to teaching, some administrative duties, maintenance of professional standards and other activities. The time made available for these activities must be assessed in the context of the other professional activities of all the Department members.

3.1.6 Trainee

The trainee is a specialist-in-training who requires clinical supervision as an essential component of the training process. A trainee can contribute to the clinical service to a limited degree with Level 4 supervision at an appropriate time after the first three months of training. Refer to College Professional Document TE3 *Policy on the Supervision of Clinical Experience for Trainees in Anaesthesia*. The extent of such service will be dictated by the experience of the trainee, the mix of surgical specialties, subspecialty training rotations and the roster pattern, and may therefore vary significantly between institutions. The available service component is estimated at 30% of the trainee's workload over Training Years 1-4 and 50% of the Provisional Fellow's workload during the Provisional Fellowship Year. This estimate presupposes an even spread of trainees through Training Years 1-4. Provisional Fellows in subspecialty training will have a lesser service commitment. Refer to College Professional Document TE13 *Guidelines for the Provisional*

Fellowship Year.

Trainees should be assigned educational and administrative responsibilities appropriate to their level of training. Time must be allocated for these duties.

The number of approved training positions in a Department is determined by the availability within the training rotation of subspecialty training in paediatric, obstetric, neurosurgical and cardiothoracic anaesthesia, pain medicine and intensive care medicine.

3.2 Non-Medical Staff

3.2.1 Assistant for the Anaesthetist

Reference is made to College Professional Document PS8 *Recommendations on the Assistant for the Anaesthetist*. The assistant for the anaesthetist may be a nurse or a technician. The mix of nurses and technicians will vary between hospitals. Staff numbers must be sufficient to provide a dedicated assistant available both in-hours and after-hours for every patient who is being anaesthetised.

3.2.2 Nurses

Nurses may fill the role of the assistant to the anaesthetist as in 3.2.1 and also provide the staff for the Recovery Room.

For staffing of the Recovery Room, the ratio of nurses to patients needs to be flexible so as to provide no less than one nurse to three patients, and one nurse to each patient who has not recovered protective respiratory reflexes or consciousness. Refer to College Professional Document PS4 *Recommendations for the Post-Anaesthesia Recovery Room*

3.2.3 Technical Staff

Technicians may also fill the role of the assistant for the anaesthetist and/or provide technical support for equipment maintenance and repair. The required number will vary with each particular hospital and be dependent on the relative involvement of other groups (eg Biomedical Engineering Dept) and external service contracts.

3.2.4 Secretarial Staff

Secretarial staff duties comprise support for individual anaesthetists, support for departmental administration and support for educational activities. The number of staff required will depend on the size and activity of the Department. Refer to College Professional Document TE7 *Recommendations on Secretarial and Support Services to Departments of Anaesthesia*.

4. CALCULATION OF STAFFING NUMBERS

The calculation of the number of specialist anaesthesia staff required to provide all the required anaesthesia-related services is complex. The following matters must be fully understood in order to make a meaningful calculation:

- Number of hours of clinical work provided per week by each staff member
- Full extent of the weekly clinical services to be staffed
- Need to provide in-house after-hours clinical cover, and further cover for staff who have been on call and worked during the previous night
- Leave of all types taken by clinical staff in weeks per year
- Changing work practices and enterprise agreements
- Australian Medical Association Safe Hours Project
- Other factors specific to the individual hospital

A suggested method of calculation follows. Note that after-hours and weekend work is not considered on either side of the staffing/workload equation but will affect the number of in-hours staff sessions available.

This calculation uses "sessions" as the unit of time rather than "hours", in order to simplify the process. As the definition of duration of "session" varies in different countries and regions, a more accurate calculation can be made in a similar way by using "hours".

4.1 Workload Sessions (In-hours clinical commitments to be staffed)

Total clinical workload sessions per week	= A
Total clinical workload sessions per year (52 x A)	= B
Total clinical workload sessions lost per year from predicted theatre closures (eg over Christmas/New Year)	= C
WORKLOAD SESSIONS PER YEAR (B - C)	= D

4.2 Staff Sessions (available sessions for in-hours clinical work)

4.2.1 Specialist Staff

Total of all clinical sessions contributed by all specialist staff per week	= E
Average weeks of leave of all types per specialist per year	= F
Clinical working weeks per year (52 - F)	= G
Total of all clinical sessions contributed by specialist staff per year (E x G)	= H

4.2.2 Non-Specialists

(Calculation as for Specialists)

Total of all clinical sessions contributed by non-specialists per year	= I
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4.2.3 Trainees

Service sessions contributed by TY 1-4 trainees per week	= J
Service sessions contributed by PFY trainees per week	= K
Average weeks of leave of all types per trainee per year	= L
Total of all clinical sessions contributed by trainees per year (J + K) x (52 - L)	= M
STAFF SESSIONS PER YEAR (H + I + M)	= N

4.3 Staffing / Workload Balance

$$\text{TOTAL STAFF SESSIONS PER YEAR LESS WORKLOAD SESSIONS PER YEAR (N - D)} = Z$$

When Z is positive, adequate staffing exists
When Z is negative, a staffing deficit exists

RELEVANT PROFESSIONAL DOCUMENTS

TE3	<i>Supervision of Clinical Experience for Trainees in Anaesthesia</i>
TE5	<i>Supervisors of Training in Anaesthesia</i>
TE6	<i>Guidelines on The Duties of an Anaesthetist</i>
TE7	<i>Recommendations on Secretarial and Support Services to Departments of Anaesthesia</i>
TE9	<i>Guidelines on Quality Assurance</i>
TE13	<i>Guidelines for the Provisional Fellowship Year</i>
TE14	<i>Guidelines for the In-Training Assessment of Trainees in Anaesthesia</i>
PS4	<i>Recommendations for the Post-Anaesthesia Recovery Room</i>
PS8	<i>Recommendations on the Assistant for the Anaesthetist</i>
PS16	<i>Guidelines on the Standards of Practice of a Specialist Anaesthetist</i>

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Australian and New Zealand College of Anaesthetists

ABN 82 055 042 852

STATEMENT ON FATIGUE AND THE ANAESTHETIST

INTRODUCTION

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

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

PRINCIPLES

1. Fatigue has been demonstrated to impair vigilance and accuracy of response^(1,2). Decreased performance of motor and cognitive functions in a fatigued anaesthetist may result in impaired judgement, late and inadequate responses to clinical changes, poor communication and inadequate record keeping^(3,4,5,6). The decrement in cognitive psychomotor performance after 17 hours of sustained wakefulness is equivalent to the performance impairment observed with a blood alcohol level of 0.05%, and after 24 hours to a blood alcohol level of 0.1%⁽¹⁾.
2. Fatigue may contribute to adverse events and critical incidents^(7,8). In other industries these have been shown to be commonest in a bimodal distribution between 0300 and 0600 and between 1300 and 1500, when circadian drowsiness is greatest⁽⁹⁾.
3. Adults require (on average) eight hours of sleep each night. Fatigue will occur with sleep debt; this sleep debt is cumulative and does not dissipate. Short sleep nights (4 - 6.5 hours) are associated with a cumulative impairment in the performance of psychomotor tasks requiring vigilance⁽¹⁰⁾. Sleep efficiency decreases with increasing age⁽¹¹⁾. Ageing reduces the capacity to recover from fatigue⁽¹¹⁾.
4. Many individuals cannot reset their body time clocks to allow for effective daytime sleep after night duties. Daytime sleep is typically shorter and of inferior quality compared with sleep at night⁽¹¹⁾.
5. Individuals are often unable to recognise fatigue and their reduced capacity to continue working safely^(11,12). "Microsleeps", a sign of extreme fatigue, may be equally unrecognised⁽²⁰⁾.
6. Use of caffeine and other stimulants is an attempt to combat rather than to prevent the problem and as such is not recommended. Sleep loss-induced deterioration in performance is only mitigated by naps and caffeine for the first 24 hours of continuous wakefulness⁽¹³⁾. Naps are followed by a period of "sleep inertia" (drowsiness after waking) associated with reduced performance⁽¹⁴⁾.
7. Health facility employers have a responsibility under occupational health and safety legislation to provide a safe working environment for their employees^(15,16,17).
8. Inappropriate work practices and rosters that contribute to fatigue may put employees at risk of accidents to themselves and their patients while at work, and while travelling to and from work⁽¹⁸⁾.
9. Fatigue is no defence in negligence litigation^(15,16).

RESPONSIBILITIES

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

4. Departments, hospitals and groups of anaesthetists should have a management plan to address the short-term consequences of anaesthetists being unavailable for clinical duties because of fatigue following "on-call" work.
5. Long-term work patterns should be based on the following principles:
 - 5.1 Adequate time must be available for leisure activities.
 - 5.2 Adequate breaks must be taken during a day of clinical work.
 - 5.3 Rosters for shift and weekend work must be available for a significant time ahead.
 - 5.4 Recreation leave should be taken regularly.

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Australian and New Zealand College of Anaesthetists

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RECOMMENDATIONS ON MINIMUM FACILITIES FOR SAFE ANAESTHESIA PRACTICE IN OPERATING SUITES

The provision of safe anaesthesia in hospitals requires appropriate staff, facilities and equipment. These are specified in this Document.

1. PRINCIPLES OF ANAESTHESIA CARE

- 1.1 Anaesthesia should be administered only by medical practitioners with appropriate training in anaesthesia or by trainees supervised according to College Professional Documents TE3 *Supervision of Clinical Experience for Trainees in Anaesthesia*, PS2 *Recommendations on Privileges in Anaesthesia* and PS1 *Recommendations on Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia*.
- 1.2 Every patient presenting for anaesthesia should have a pre-anaesthesia consultation by a medical practitioner who has appropriate training in anaesthesia. See College Professional Document PS7 *Recommendations on the Pre-Anaesthesia Consultation*.
- 1.3 Appropriate monitoring of physiological and other variables must occur during anaesthesia. See College Professional Document PS18 *Recommendations on Monitoring During Anaesthesia*.

2. STAFFING

- 2.1 In addition to the nursing staff required by those carrying out the operative procedure, there must be:
 - 2.1.1 An assistant for the anaesthetist. See College Professional Document PS8 *Recommendations on the Assistant for the Anaesthetist*.
 - 2.1.2 Adequate assistance in positioning the patient.
 - 2.1.3 Adequate technical assistance to ensure proper functioning and servicing of all equipment used.

3. OPERATING SUITES

3.1 Anaesthesia Equipment

- 3.1.1 Essential requirements are listed below. Where a range of equipment is recommended, the hospital is expected to provide the type most suitable for its needs.
- 3.1.2 Each hospital must designate:
 - 3.1.2.1 One (or more) specialists to advise on the choice and maintenance of anaesthesia equipment.
 - 3.1.2.2 One (or more) of its nursing or technical staff to be responsible for the organisation of cleaning, maintenance and servicing of anaesthesia equipment.

- 3.1.3 There must be an anaesthesia delivery system for each anaesthetising location which is capable of delivering oxygen and medical air (where this is clinically indicated) as well as other anaesthetic agents which are in common use. Essential equipment includes:
 - 3.1.3.1 Calibrated vaporisers or other systems designed for the accurate delivery of inhalational anaesthetic agents.
 - 3.1.3.2 A range of suitable breathing systems with appropriate measures to ensure the sterility of breathing gases supplied to each patient. See College Professional Document PS28 *Guidelines on Infection Control in Anaesthesia*.
 - 3.1.3.3 Breathing systems suitable for paediatric use when necessary.

- 3.1.4 Safety devices which must be present in every anaesthesia delivery system include:
 - 3.1.4.1 An indexed gas connection system.
 - 3.1.4.2 A reserve supply of oxygen.
 - 3.1.4.3 An oxygen supply failure warning device. See College Professional Document PS18 *Recommendations on Monitoring During Anaesthesia*. Where medical gas pipeline systems are in use, there must be supply failure alarms which function according to the current relevant national Standards.
 - 3.1.4.4 A high pressure relief valve.
 - 3.1.4.5 An oxygen concentration analyser with appropriate alarm limits. See College

Professional Document PS18
Recommendations on Monitoring During Anaesthesia.

- 3.1.4.6 An anti-hypoxic device for use whenever nitrous oxide is administered must be fitted to all anaesthesia delivery systems by January 2002.
- 3.1.4.7 An approved non-slip connection for the common gas outlet.
- 3.1.5 A separate means of inflating the lungs with oxygen must be provided in each anaesthetising location. This apparatus should comply with the current relevant national Standards. The size of the device and its attachments must be appropriate for patients being anaesthetised at that location. Its oxygen supply must be independent of the anaesthesia delivery system.
- 3.1.6 Suction apparatus must be available for the exclusive use of the anaesthetist at all times together with appropriate hand pieces and endotracheal suction catheters. This apparatus should comply with the current relevant national Standards. Provision must be made for an alternative suction system in the event of primary suction failure.
- 3.1.7 In every anaesthetising location there must be:
 - 3.1.7.1 Appropriate protection for the anaesthesia team against biological contaminants. This must include gowns, disposable gloves, masks and eye shields.
 - 3.1.7.2 A stethoscope.
 - 3.1.7.3 A sphygmomanometer.
 - 3.1.7.4 Monitoring equipment complying with College Professional Document PS18 *Recommendations on Monitoring During Anaesthesia.*
The particular requirements of magnetic resonance imaging facilities can be met with appropriate equipment. See College Professional Document T2 *Recommendations on Minimum Facilities for Safe Anaesthesia Practice Outside Operating Suites.*
 - 3.1.7.5 An appropriate range of face masks.
 - 3.1.7.6 An appropriate range of oropharyngeal, nasopharyngeal, laryngeal mask and other artificial airways.
 - 3.1.7.7 Two laryngoscopes with a range of suitable blades.
 - 3.1.7.8 An appropriate range of endotracheal tubes and connectors.
 - 3.1.7.9 A range of endotracheal tube introducers and bougies.
 - 3.1.7.10 Endotracheal cuff inflating syringe and clamps.
 - 3.1.7.11 Magill's forceps and throat packs.
 - 3.1.7.12 A suitable range of adhesive and other tapes.
 - 3.1.7.13 Scissors.
 - 3.1.7.14 Sterile endotracheal lubricant.
 - 3.1.7.15 Tourniquets for use during IV insertion.
 - 3.1.7.16 Intravenous infusion equipment with an appropriate range of cannulae and solutions.
 - 3.1.7.17 Means for the safe disposal of items contaminated with biological fluids, "sharps" and waste glass.
 - 3.1.7.18 Equipment for scavenging of anaesthetic gases and vapours with interface equipment which prevents over-pressurisation of the anaesthesia breathing circuit.
- 3.1.8 In every anaesthetising location there must be readily available:
 - 3.1.8.1 Equipment for managing difficult intubations in all locations where endotracheal intubation is electively performed.
 - 3.1.8.2 Equipment for automatic ventilation of the lungs incorporating alarms as specified in College Professional Document PS18 *Recommendations on Monitoring During Anaesthesia.*
 - 3.1.8.3 Equipment as required for the direct measurement of arterial and venous pressures when appropriate, having regard to the procedures being undertaken.
 - 3.1.8.4 Equipment for the rapid infusion of fluids.
 - 3.1.8.5 Interpleural drainage sets including appropriate underwater seal drainage equipment or one way valves.
 - 3.1.8.6 A cardiac defibrillator with capacity for synchronised cardioversion.
 - 3.1.8.7 Equipment as required to warm and/or humidify respiratory gases during anaesthesia. In paediatric operating theatres, this equipment must be available in each anaesthetising location. A decision as to the use of active or passive devices will require consideration of the procedures being undertaken.

- 3.1.8.8 Equipment to cool patients in the event of inappropriate increases in body temperature.
- 3.1.8.9 Equipment as required for sub-arachnoid, epidural or regional nerve blocks.
- 3.1.8.10 Equipment as required to minimise patient heat loss including insulating sheets, forced air warming devices, mattress warmers and intravenous fluid warmers. The availability of active warming devices will require consideration of the procedures being undertaken.
- 3.1.9 Other requirements for safe anaesthesia include:
 - 3.1.9.1 Appropriate lighting for the clinical observation of patients which complies with the current relevant national Standards.
 - 3.1.9.2 Emergency lighting and electric power complying with the current relevant national Standards.
 - 3.1.9.3 Telephone/Intercom to communicate with persons outside the anaesthetising location and including an "anaesthesia emergency" call system.
 - 3.1.9.4 Refrigeration facilities for the storage of fluids, drugs and biological products.
 - 3.1.9.5 The means to maintain room temperature in the anaesthetising location within the range of 18 - 28°C.
 - 3.1.9.6 Patient transfer trolleys/beds as specified in College Professional Document PS4 *Recommendations for the Post-Anaesthesia Recovery Room*.
 - 3.1.9.7 Devices such as rollers or patient slides to assist with the transfer of patients to and from the operating table.
 - 3.1.9.8 A minimum of three people to assist with transfer of the patient from the operating table to the trolley/bed, with the anaesthetist having prime responsibility for the patient's airway, head and neck.

3.2 Drugs

- 3.2.1 In addition to the drugs and agents commonly used in anaesthesia, drugs necessary for the management of conditions which may complicate or co-exist with anaesthesia must also be available. Such conditions include:

Anaphylaxis
 Cardiac arrhythmias
 Cardiac arrest
 Pulmonary oedema
 Hypotension
 Hypertension
 Bronchospasm
 Respiratory depression
 Hypoglycaemia
 Hyperglycaemia
 Adrenal dysfunction
 Raised intracranial pressure
 Uterine atony
 Coagulopathies

- 3.2.2 In making an appropriate selection of drugs and administration equipment for the management of these conditions, advice should be sought as in 3.1.2.1.
- 3.2.3 Appropriate mechanisms must exist for the regular replacement of all drugs and drug administration equipment after use or when their expiry date has been reached.
- 3.2.4 A supply of dantrolene for the initial treatment of malignant hyperpyrexia should be immediately accessible to all anaesthetising locations with further doses being readily available on request.
- 3.3 *Routines for Checking, Cleaning and Servicing Equipment*
 - 3.3.1 Regular sterilising, cleaning and housekeeping routines for the care of equipment should be established.
 - 3.3.2 Documented servicing of the anaesthesia delivery system and medical gas equipment by an appropriate organisation must be carried out at least twice a year. After any modification to the gas distribution system, gas analysis and flow measurement must be carried out and documented before use.
 - 3.3.3 A copy of the College Professional Document PS31 *Recommendations on Protocol for Checking the Anaesthetic Machine*, or a similar document should be available on each anaesthesia delivery system.
- 3.4 *Recovery Area*
 - 3.4.1 Recovery from anaesthesia must take place under appropriate supervision in a designated area which conforms with College Professional Document PS4 *Recommendations for the Post-Anaesthesia Recovery Room*.
 - 3.4.2 Contingency plans must exist for the safe emergency evacuation of patients from the operating suite and/or recovery areas under adequate medical supervision.

RELEVANT PROFESSIONAL DOCUMENTS

- TE3 *Policy on Supervision of Clinical Experience for Trainees in Anaesthesia*
- PS1 *Recommendations on Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia*
- PS2 *Recommendations on Privileges in Anaesthesia*
- PS4 *Recommendations for the Post-Anaesthesia Recovery Room*
- PS7 *Recommendations on the Pre-Anaesthesia Consultation*
- PS8 *Recommendations on the Assistant for the Anaesthetist*
- PS18 *Recommendations on Monitoring During Anaesthesia*
- PS28 *Guidelines on Infection Control in Anaesthesia*
- PS31 *Recommendations on Protocol for Checking the Anaesthetic Machine*
- T2 *Recommendations on Minimum Facilities for Safe Anaesthesia Practice Outside Operating Suites*

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Australian and New Zealand College of Anaesthetists

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RECOMMENDATIONS ON MINIMUM FACILITIES FOR SAFE ANAESTHESIA PRACTICE OUTSIDE OPERATING SUITES

The provision of safe anaesthesia requires appropriate staff, facilities and equipment. These are specified in this Document which amalgamates previously published documents T3, T5, T6 and PS33.

1. PRINCIPLES OF ANAESTHESIA CARE

- 1.1 Anaesthesia should be administered only by medical practitioners with appropriate training in anaesthesia or by trainees supervised according to College Professional Documents TE3 *Supervision of Clinical Experience for Trainees in Anaesthesia*, PS1 *Recommendations on Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia*, and PS2 *Recommendations on Privileges in Anaesthesia*.
- 1.2 Every patient presenting for anaesthesia should have a pre-anaesthesia consultation by a medical practitioner who has appropriate training in anaesthesia. See College Professional Document PS7 *Recommendations on the Pre-anaesthesia Consultation*.
- 1.3 Appropriate monitoring of physiological and other variables must occur during anaesthesia. See College Professional Document PS18 *Recommendations on Monitoring During Anaesthesia*.

2. STAFFING

- 2.1 In addition to the nursing staff required by those carrying out the procedure, there must be:
 - 2.1.1 An assistant for the anaesthetist. See College Professional Document PS8 *Recommendations on the Assistant for the Anaesthetist*.
 - 2.1.2 Adequate assistance in positioning the patient.
 - 2.1.3 Adequate technical assistance to ensure proper functioning and servicing of all equipment used.

3. AREAS IN WHICH ANAESTHESIA IS ADMINISTERED

3.1 Anaesthesia Equipment

- 3.1.1 Essential requirements are listed below. Where a range of equipment is recommended, the facility is expected to provide the type most suitable for its needs.
- 3.1.2 Each facility must designate:
 - 3.1.2.1 One (or more) specialist anaesthetists to advise on the choice and

maintenance of anaesthesia equipment.

- 3.1.2.2 One (or more) of its nursing or technical staff to be responsible for the organisation of cleaning, maintenance and servicing of anaesthesia equipment.
- 3.1.3 There must be an anaesthesia delivery system for each anaesthetising location which is capable of delivering oxygen and medical air (where this is clinically indicated) as well as other anaesthetic agents which are in common use. Essential equipment includes:
 - 3.1.3.1 Calibrated vaporisers or other systems designed for the accurate delivery of inhalational anaesthetic agents when required.
 - 3.1.3.2 A range of suitable breathing systems with appropriate measures to ensure the sterility of breathing gases supplied to each patient. See College Professional Document PS28 *Guidelines on Infection Control in Anaesthesia*.
 - 3.1.3.3 Breathing systems suitable for paediatric use when necessary.
- 3.1.4 Safety devices which must be present in every anaesthesia delivery system include:
 - 3.1.4.1 An indexed gas connection system.
 - 3.1.4.2 A reserve supply of oxygen.
 - 3.1.4.3 An oxygen supply failure warning device. See College Professional Document PS18 *Recommendations on Monitoring During Anaesthesia*. Where medical gas pipeline systems are in use, there must be supply failure alarms which function according to the current relevant national Standards.
 - 3.1.4.4 A breathing system high pressure relief valve.
 - 3.1.4.5 An oxygen concentration analyser with appropriate alarm limits. See College Professional Document PS18 *Recommendations on Monitoring During Anaesthesia*.

- 3.1.4.6 An anti-hypoxic device for use whenever nitrous oxide is administered must be fitted to all anaesthesia delivery systems by January 2002.
- 3.1.4.7 An approved non-slip connection for the common gas outlet.
- 3.1.5 A separate means of inflating the lungs with oxygen must be provided in each anaesthetising location. This apparatus should comply with the current relevant national Standards. The size of the device and its attachments must be appropriate for patients being anaesthetised at that location. Its oxygen supply must be independent of the anaesthesia delivery system.
- 3.1.6 Suction apparatus must be available for the exclusive use of the anaesthetist at all times together with appropriate hand pieces and endotracheal suction catheters. This apparatus should comply with the current relevant national Standards. Provision must be made for an alternative suction system in the event of primary suction failure.
- 3.1.7 In every anaesthetising location there must be:
 - 3.1.7.1 Appropriate protection for the anaesthesia team against biological contaminants. This must include gowns, disposable gloves, masks and eye shields.
 - 3.1.7.2 A stethoscope
 - 3.1.7.3 A sphygmomanometer
 - 3.1.7.4 Monitoring equipment complying with College Professional Document PS18 *Recommendations on Monitoring During Anaesthesia*. Where volatile agents are not available, agent monitoring is not required.
The particular requirements of magnetic resonance imaging facilities can be met with appropriate equipment designed for the environment.
 - 3.1.7.5 An appropriate range of face masks.
 - 3.1.7.6 An appropriate range of oropharyngeal, nasopharyngeal, laryngeal mask and other artificial airways.
 - 3.1.7.7 Two laryngoscopes with a range of suitable blades.
 - 3.1.7.8 An appropriate range of endotracheal tubes and connectors.
 - 3.1.7.9 A range of endotracheal tube introducers and bougies.
 - 3.1.7.10 Endotracheal cuff inflating syringe and clamps.
 - 3.1.7.11 Magill's forceps and throat packs.
 - 3.1.7.12 A suitable range of adhesive and other tapes.
 - 3.1.7.13 Scissors.
 - 3.1.7.14 Sterile endotracheal lubricant.
 - 3.1.7.15 Tourniquets for use during IV insertion.
 - 3.1.7.16 Intravenous infusion equipment with an appropriate range of cannulae and solutions.
 - 3.1.7.17 Means for the safe disposal of items contaminated with biological fluids, "sharps" and waste glass.
 - 3.1.7.18 Equipment for scavenging of anaesthetic gases and vapours where these are in use with interface equipment which prevents over-pressurisation of the anaesthesia breathing circuit.
- 3.1.8 In every anaesthetising location there must be readily available:
 - 3.1.8.1 Equipment for managing difficult intubations in all locations where endotracheal intubation is electively performed.
 - 3.1.8.2 Equipment for automatic ventilation of the lungs incorporating alarms as specified in College Professional Document PS18 *Recommendations on Monitoring During Anaesthesia*, when appropriate.
 - 3.1.8.3 Equipment for the rapid infusion of fluids.
 - 3.1.8.4 A cardiac defibrillator with capacity for synchronised cardioversion.
 - 3.1.8.5 Interpleural drainage sets including appropriate underwater seal drainage equipment or one way valves.
 - 3.1.8.6 When appropriate, equipment to warm and/or humidify respiratory gases during anaesthesia. A decision as to the use of active or passive devices will require consideration of the procedures being undertaken.
 - 3.1.8.7 Equipment to cool patients in the event of inappropriate increases in body temperature.
 - 3.1.8.8 Equipment required for sub-arachnoid, epidural or regional nerve blocks, when appropriate.
 - 3.1.8.9 When appropriate, having regard to the procedures being undertaken, equipment to minimise patient heat loss including insulating sheets, forced air warming devices, mattress warmers and intravenous fluid warmers.
- 3.1.9 Other requirements for safe anaesthesia include:
 - 3.1.9.1 Appropriate lighting for the clinical observation of patients which complies with the current relevant national Standards.

- 3.1.9.2 Emergency lighting and electric power complying with the current relevant national Standards.
- 3.1.9.3 Telephone/Intercom to communicate with persons outside the anaesthetising location and including an “anaesthesia emergency” call system.
- 3.1.9.4 Refrigeration facilities for the storage of fluids, drugs and biological products.
- 3.1.9.5 The means to maintain room temperature in the anaesthetising location within the range of 18 - 28°C.
- 3.1.9.6 Patient transfer trolleys/beds as specified in College Professional Document PS4 *Recommendations for the Post-Anaesthesia Recovery Room*.
- 3.1.9.7 Devices such as rollers or patient slides to assist with transfer of patients when appropriate.
- 3.1.9.8 A minimum of three people to assist with transfer of the patient when required, with the anaesthetist having prime responsibility for the patient’s airway, head and neck.

3.2 Drugs

- 3.2.1 In addition to the drugs and agents commonly used in anaesthesia, drugs necessary for the management of the following conditions, which may complicate or co-exist with anaesthesia must also be available. Such conditions include:

Anaphylaxis

Cardiac arrhythmias

Cardiac arrest

Pulmonary oedema

Hypotension

Hypertension

Bronchospasm

Respiratory depression

Hypoglycaemia

Hyperglycaemia

Adrenal dysfunction

Raised intracranial pressure

Uterine atony (Delivery suites only)

Coagulopathies (Delivery suites only)

- 3.2.2 In making an appropriate selection of drugs and administration equipment for the management of these conditions, advice should be sought as in 3.1.2.1.

- 3.2.3 Appropriate mechanisms must exist for the regular replacement of all drugs and drug administration equipment after use or when their expiry date has been reached.

- 3.2.4 An initial supply of dantrolene for the treatment of malignant hyperpyrexia should be immediately accessible to all anaesthetising locations with further doses being readily available on request.

3.3 Routines for Checking, Cleaning and Servicing Equipment

- 3.3.1 Regular sterilising, cleaning and housekeeping routines for the care of equipment should be established.

- 3.3.2 Documented servicing of the anaesthesia delivery system and medical gas equipment by an appropriate organisation must be carried out at least twice a year. After any modification to the gas distribution system, gas analysis and flow measurement must be carried out and documented before use.

- 3.3.3 A copy of the College Professional Document PS31 *Recommendations on Protocol for Checking the Anaesthesia Machine* or a similar document should be available on each anaesthesia delivery system.

3.4 Recovery Area

- 3.4.1 Recovery from anaesthesia should take place under appropriate supervision in a designated area which conforms with College Professional Document PS4 *Recommendations for the Post-Anaesthesia Recovery Room*.

- 3.4.2 Contingency plans should exist for the safe emergency evacuation of patients from the operating suite and/or recovery areas under adequate medical supervision.

- 4. This is a generic document which is intended to be interpreted in the context of the particular service for which anaesthesia is administered. Specific issues may include:

4.1 Delivery suites

- 4.1.1 Staffing – for the establishment and management of epidural blockade in labour, the presence of a midwife trained and competent in obstetric epidural management is required. See College Professional Document PS14 *Guidelines for the Conduct of Major Regional Analgesia in Obstetrics*.

- 4.1.2 Staffing – at the time of delivery there must be an appropriately trained and qualified practitioner solely available to resuscitate the neonate.

- 4.1.3 Analgesia equipment – any apparatus used for administration of inhalation analgesia must deliver at least 30% oxygen.

- 4.1.4 There must be suction apparatus for the exclusive use of the anaesthetist which is separate from that required for resuscitation of the neonate.

- 4.1.5 There must be separate oxygen outlets and suitable attachments for administering oxygen to the mother and to the neonate.
- 4.1.6 Neonatal resuscitation equipment must include a suitable range of items for:
 - 4.1.6.1 Administration of oxygen to the neonate.
 - 4.1.6.2 Clearing of the airway.
 - 4.1.6.3 Intubation and ventilation of the lungs.
 - 4.1.6.4 Administration of intravenous fluids and drugs.
 - 4.1.6.5 Maintenance of the neonate's temperature.
 - 4.1.6.6 An appropriate range of drugs must be available.

4.2 ECT Locations

Where provision of an anaesthesia delivery system is not essential, as in an ECT area, there must be:

- 4.2.1 A breathing system capable of delivering 100% oxygen for both spontaneous and controlled ventilation. An alternative breathing system should be immediately available. Where more than one patient is to be treated, this equipment must be duplicated or there must be an inline viral filter. See College Professional Document PS28 *Guidelines on Infection Control in Anaesthesia*.
- 4.2.2 Adequate reserves of oxygen must be available. If a reticulated or indexed gas connection system is in use, an oxygen failure warning device is necessary. An emergency cylinder supply of oxygen is necessary in the event of a central supply failure.

4.3 Dental surgeries

- 4.3.1 There must be a dental operating chair which will allow the patient to be placed rapidly in the horizontal or head-down position.

4.4 Organ Imaging Locations

- 4.4.1 Monitoring equipment complying with College Professional Document PS18 *Recommendations on Monitoring During Anaesthesia*. Although special problems are encountered in MRI facilities, appropriate equipment to meet the recommendations is available.
- 4.4.2 The specific problems associated with the location of the anaesthesia delivery system, monitoring equipment and other necessary equipment (eg drug trolley and suction apparatus) in an environment where space is often limited due to the presence of imaging equipment must be prospectively considered.

RELATED DOCUMENTS

- T1 *Recommendations on Minimum Facilities for Safe Anaesthesia Practice in Operating Suites*
- TE3 *Supervision of Clinical Experience for Trainees in Anaesthesia*
- PS1 *Recommendations on Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia*
- PS2 *Recommendations on Privileges in Anaesthesia*
- PS4 *Recommendations for the Post-Anaesthesia Recovery Room*
- PS7 *Recommendations on the Pre-Anaesthesia Consultation*
- PS8 *Recommendations on the Assistant for the Anaesthetist*
- PS9 *Guidelines on Sedation for Diagnostic and Surgical Procedures*
- PS14 *Guidelines for the Conduct of Major Regional Analgesia in Obstetrics*
- PS18 *Recommendations on Monitoring During Anaesthesia*
- PS28 *Guidelines on Infection Control in Anaesthesia*
- PS31 *Recommendations on Protocol for Checking the Anaesthetic Machine*

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

Australian and New Zealand College of Anaesthetists

ABN 82 055 042 852

GUIDELINES FOR ASSISTING TRAINEES WITH DIFFICULTIES

Hospitals accredited by the College for the training of anaesthetists should aim to provide environments in which the necessary learning and experience for the development of sound, independent specialist practice is readily achieved. See College Professional Document TE1 *Guidelines for Hospitals seeking College Approval of Posts for the First Four Years of Vocational Training in Anaesthesia*.

The process of selection of medical graduates into anaesthesia training and their re-selection during training should ensure that those chosen are considered to have the necessary attributes to satisfactorily complete the course. Nevertheless, personal and professional difficulties may arise during training. This document aims to help with the identification and resolution of these difficulties. It should be read in conjunction with College Professional Documents TE5 *Policy on Supervisors of Training in Anaesthesia* and TE14 *Guidelines for In-training Assessment of Trainees in Anaesthesia*.

1. IDENTIFYING TRAINEES WITH DIFFICULTIES

1.1 Identifying trainees with difficulties affecting performance, or those whose performance or progress is below an acceptable standard, is an essential role for everyone involved with the training program. In all situations, the welfare of patients as well as the trainee must be carefully considered.

1.2 Professional and personal development during training requires that trainees:

- 1.2.1 Contribute to the work of their training department.
- 1.2.2 Reach work-related performance standards (appropriate to their level of training). These standards will be established jointly by the trainee and the relevant Supervisor of Training as part of the In-training Assessment process (see College Professional Document TE14 *Guidelines for the In-training Assessment of Trainees in Anaesthesia*).

1.2.3 Progress towards necessary levels of responsibility and autonomy.

1.2.4 Meet other training requirements such as successful completion of examinations.

1.3 Trainees may have difficulties at any stage of training notwithstanding optimal selection and training processes. These may include:

1.3.1 Failure to pass College examinations.

1.3.2 Clinical performance below expectations, particularly after College examinations have been successfully completed.

1.3.3 Personal problems which interfere (temporarily or permanently) with training and adequate performance of duties.

1.3.4 Personality traits which impair effective professional communication or teamwork.

1.3.5 Substance abuse with opioids, alcohol or other drugs.

2. PROCESSES TO BE FOLLOWED

Staff members with concerns about any aspect of a trainee's performance must discuss their concerns promptly with the Supervisor of Training or the Head of Department. When it is considered that significant problems exist, the procedures below may be followed, with a further review of the trainee's performance after an agreed period. The major objective is to overcome difficulties in a supportive and collaborative manner.

2.1 Trainees must be advised promptly by the Supervisor of Training or the Head of Department about perceived shortcomings in their performance or progress with training. They should be asked how they view their own performance and progress. Explanations for perceived difficulties should be sought with a view to offering assistance or access to resources designed to assist the trainee. Trainees must know what is expected of them at each stage of their training. Trainees should consider having a support person present during any formal interview.

2.2 It is appropriate for the trainee to have a mentor to provide advice, feedback and support. The Supervisor of Training or the Head of Department should discuss mentorship and the choice of the mentor with the trainee. However, the choice of a mentor is for the trainee alone. A mentor should have no formal involvement with the trainee's appointment or reappointment.

3. ADVICE AND COUNSELLING

3.1 Formal or informal advice is an important component of trainee guidance. The Supervisor of Training and/or Head of Department must ensure that appropriate advice is available. Early and effective advice plays a part in trainees' professional development. It is possible that all trainees will need help on occasion. The trainee may seek advice from:

- 3.1.1 A Mentor, as in 2.2.
- 3.1.2 A senior member of the Department.
- 3.1.3 The Regional Education Officer.
- 3.1.4 The Advisor of Candidates for Anaesthesia Training (see College Professional Document TE17 *Advisors of Candidates for Anaesthesia Training*).
- 3.1.5 A member of the Welfare of Anaesthetists SIG.
- 3.1.6 A spouse, partner or family member.

3.2 In some situations, the trainee must be advised to seek professional counselling. The trainee should be assisted to find an appropriate person when he/she requests. Prompt medical or psychological intervention may be essential on occasion. Counsellors may include:

- 3.2.1 The trainee's General Practitioner.
- 3.2.2 An appropriate medical specialist.
- 3.2.3 A psychologist, psychiatrist or cleric.
- 3.2.4 A member of the Doctor's Health Advisory Service.
- 3.2.5 A member of an Alcohol and Drug Dependency agency.
- 3.2.6 A Medical Careers advisor.

4. REMEDIAL LEARNING

The Supervisor of Training and/or the Head of Department should organise special learning experiences if appropriate to assist with issues such as examination presentation, the acquisition of deficient clinical skills or interpersonal skills development. The trainee has a responsibility to assist with these processes.

5. DOCUMENTATION

The Supervisor of Training and/or the Head of Department must maintain adequate permanent records of discussions with the trainee. The records should include the date of the discussion, the matters raised and the views expressed

by the trainee. Any warnings regarding possible loss of accredited training or disciplinary action must be clearly stated. Such warnings must be understood and acknowledged in writing by the trainee. A failure to accept or acknowledge a warning would be grounds for initiating a disciplinary process as set out in paragraph 7.

6. MONITORING PROGRESS

The progress of the trainee following institution of any procedure referred to in this document must be monitored at prospectively determined times. Progress monitoring may supplement the formal In-Training Assessment process (see TE14 *Guidelines for the In-Training Assessment of Trainees in Anaesthesia*).

7. UNSATISFACTORY PROGRESS

If the trainee's performance does not improve despite counselling and remedial measures, the Supervisor of Training and Head of Department should discuss with her/him a number of options (below). Advice from the College may be sought through the Regional Education Officer or the Chief Executive Officer. The processes of procedural fairness must be observed so that the trainee is formally notified of steps being taken. The Supervisor of Training must advise the College of any action that alters the training status of the trainee. The trainee may appeal to the College against any decision that affects his/her training. The College will consider the appeal according to its established procedures.

Options for the trainee may include:

- 7.1 A further period of specified training with special assistance and review of progress.
- 7.2 A transfer to a non-training post with the possibility of reinstatement to a training position when specified conditions have been met (e.g. a pass in the primary examination).
- 7.3 Leave of absence to be followed by a period of specified training (see Regulation 15.6 dealing with interrupted training).
- 7.4 A career change, on a temporary or permanent basis.

Disciplinary action in respect of employment or medical registration is a matter for the employer or the relevant Medical Board if there is evidence of serious breaches of care. In some situations (e.g. evidence of opiate misuse) it may be appropriate (or required) for the Head of Department to report the matter to the Medical Board or Medical Council. Any disciplinary action (especially dismissal) requires due process to be followed. The matters noted in paragraph 5 are of particular relevance.

8. ADDITIONAL INFORMATION

Human Resources Departments should be consulted for

advice on employment matters. The Welfare of Anaesthetists SIG Action Plans may be found on the College Web Site (www.anzca.edu.au) and contain information about a number of the issues noted in this document.

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- P28 (1995) Policy on Infection Control in Anaesthesia *Bulletin Mar 95, pg 38*
- PS29 (1997) Anaesthesia Care of Children in Healthcare Facilities without Dedicated Paediatric Facilities *Bulletin Nov 97, pg 82*
- PS31 (1997) Protocol for Checking the Anaesthetic Machine *Bulletin Nov 97, pg 84*
- PS36 (1997) Sedation for Regional Anaesthesia for Ophthalmic Surgery *Bulletin Nov 97, pg 93*
- PS37 (1998) Regional Anaesthesia and Allied Health Practitioners *Bulletin Mar 98, pg 79*
- PS38 (1999) Statement Relating to the Relief of Pain and Suffering and End of Life Decisions *Bulletin June 99, pg 93*
- PS39 (2000) Intrahospital Transport of Critically Ill Patients *Bulletin July 2000, pg 84*
- PS40 (2000) Guidelines for the Relationship Between Fellows and the Healthcare Industry *Bulletin Mar 2000, pg 55*
- PS41 (2000) Guidelines on Acute Pain Management *Bulletin Nov 2000, pg 80*
- PS42 (2000) Recommendations for Staffing of Departments of Anaesthesia *Bulletin Mar 2001 pg 63*
- PS43 (2001) Statement on Fatigue and the Anaesthetist *Bulletin Mar 2001 pg 66*

FACULTY OF INTENSIVE CARE

ABN 82 055 042 852

POLICY DOCUMENTS

- IC-1 (1997) Minimum Standards for Intensive Care Units *Bulletin Aug 94, pg 44*
- IC-2 (2000) The Duties of an Intensive Care Specialist in Hospitals with Approved Training Posts *Bulletin Nov 2000, pg 53*
- IC-3 (1998) Guidelines for Intensive Care Units seeking Faculty Accreditation for Training in Intensive Care *Bulletin Nov 98, pg 70*
- IC-4 (2000) The Supervision of Vocational Trainees in Intensive Care *Bulletin Mar 2000, pg 57*
- IC-5 (1995) Duties of Regional Education Officers in Intensive Care *Bulletin Nov 95, pg 50*
- IC-6 (1995) Supervisors of Training in Intensive Care *Bulletin Nov 95, pg 46*
- IC-7 (2000) Secretarial Services to Intensive Care Units *Bulletin Mar 2000, pg 58*
- IC-8 (2000) Quality Assurance *Bulletin Nov 2000, pg 55*
- IC-9 (1997) Statement on Ethics and Patients' Rights and Responsibilities *Bulletin Nov 97, pg 68*
- IC-10 (1996) Minimum Standards for Transport of the Critically Ill *Bulletin Mar 96, pg 42*
- IC-11 (1996) In-Training Assessment of Trainees in Intensive Care *Bulletin Mar 96, pg 46*
- IC-12 (1996) Examination Candidates Suffering from Illness, Accident or Disability *Bulletin May 96, pg 66*
- IC-13 (2000) Minimum Standards for High Dependency Units Seeking Accreditation for Training in Intensive Care *Bulletin Mar 2000, pg 59*
- PS38 (1999) Statement Relating to the Relief of Pain and Suffering and End of Life Decisions *Bulletin June 99, pg 93*
- PS39 (2000) Intrahospital Transport of Critically Ill Patients *Bulletin July 2000, pg 84*
- PS40 (2000) Guidelines for the Relationship Between Fellows and the Healthcare Industry *Bulletin Mar 2000, pg 55*

PROFESSIONAL DOCUMENTS

E = Educational P = Professional T = Technical

EX = Examinations PS = Professional Standards TE = Training and Examinations

- E1 (1996) Guidelines for Hospitals seeking College Approval of Posts for the First Four Years of Vocational Training in Anaesthesia *Bulletin Nov 96, pg 64*
- TE3 (1999) Supervision of Clinical Experience for Trainees in Anaesthesia *Bulletin Nov 99, pg 67*
- TE4 (1997) Duties of Regional Education Officers in Anaesthesia *Bulletin Nov 97, pg 88*
- TE5 (1997) Supervisors of Training in Anaesthesia *Bulletin Nov 97, pg 89*
- TE6 (2000) Guidelines on the Duties of an Anaesthetist *Bulletin July 2000, pg 86*
- TE7 (1999) Secretarial and Support Services to Departments of Anaesthesia *Bulletin Nov 99, pg 69*
- TE9 (1999) Quality Assurance *Bulletin June 99, pg 94*
- TE11 (1999) Formal Project Guidelines *Bulletin Mar 99, pg 70*
- E13 (1996) Guidelines for the Provisional Fellowship Year *Bulletin Nov 96, pg 66*
- E14 (1994) Guidelines for the In-Training Assessment of Trainees in Anaesthesia *Bulletin Aug 94, pg 62*
- TE17 (1999) Advisors of Candidates for Anaesthesia Training *Bulletin Nov 99, pg 66*
- TE18 (2000) Guidelines for Assisting Trainees with Difficulties *Bulletin Mar 2001 pg 76*
- EX1 (1996) Examination Candidates Suffering from Illness, Accident or Disability *Bulletin Nov 96, pg 70*
- T1 (2000) Recommendations on Minimum Facilities for Safe Anaesthetic Practice in Operating Suites *Bulletin Mar 2001 pg 68*
- T2 (2000) Recommendations on Minimum Facilities for Safe Anaesthetic Practice outside Operating Suites *Bulletin Mar 2001 pg 72*
- P1 (1997) Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia *Bulletin May 97, pg 81*
- P2 (1996) Privileges in Anaesthesia *Bulletin Nov 96, pg 72*
- PS3 (1998) Major Regional Anaesthesia and Analgesia *Bulletin Nov 98, pg 85*
- PS4 (2000) Recommendations for the Post-Anaesthesia Recovery Room *Bulletin Nov 2000, pg 72*
- P6 (1996) Minimum Requirements for the Anaesthesia Record *Bulletin Mar 96, pg 48*
- PS7 (1998) The Pre-Anaesthesia Consultation *Bulletin Mar 98, pg 73*
- PS8 (1998) The Assistant for the Anaesthetist *Bulletin Mar 98, pg 75*
- P9 (1996) Sedation for Diagnostic and Surgical Procedures *Bulletin Nov 96, pg 73*
- PS10 (1999) Handover of Responsibility During an Anaesthetic *Bulletin Nov 99, pg 62*
- P11 (1991) Management of Cardiopulmonary Bypass *Bulletin May 91, pg 43*
- PS12 (1996) Statement on Smoking as Related to the Perioperative Period *Bulletin Nov 97, pg 78*
- PS14 (1998) Guidelines for the Conduct of Major Regional Analgesia in Obstetrics *Bulletin Nov 98, pg 81*
- PS15 (2000) Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery *Bulletin Nov 2000, pg 75*
- P16 (1994) The Standards of Practice of a Specialist Anaesthetist *Bulletin Nov 94, pg 63*
- PS17 (1997) Endoscopy of the Airways *Bulletin Nov 97, pg 80*
- PS18 (2000) Recommendations on Monitoring During Anaesthesia *Bulletin Nov 2000, pg 78*
- P19 (1995) Monitored Care by an Anaesthetist *Bulletin Nov 95, pg 60*
- P20 (1996) Responsibilities of the Anaesthetist in the Post-Operative Period *Bulletin Mar 96, pg 52*
- P21 (1996) Sedation for Dental Procedures *Bulletin Mar 97, pg 56*
- P22 (1996) Statement on Patients' Rights and Responsibilities *Bulletin Mar 96, pg 53*
- P24 (1997) Sedation for Endoscopy *Bulletin May 97, pg 78*
- PS26 (1999) Guidelines on Providing Information about the Services of an Anaesthetist *Bulletin Nov 99, pg 63*
- P27 (1994) Standards of Practice for Major Extracorporeal Perfusion *Bulletin Nov 94, pg 46*

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