Australian and New Zealand College of Anaesthetists

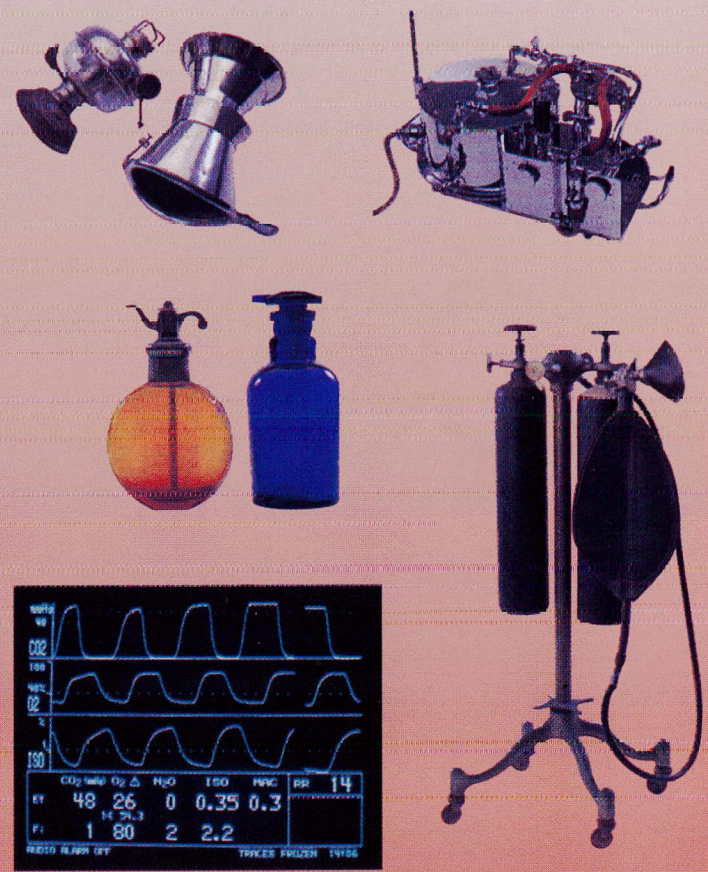
ABN 82 055 042 852

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'

Inside...



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Editorial

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President's Message

Teik E Oh, MD, PANZCA

Why a New FANZCA?

ANZCA is an independent professional body deriving its status and authority from the knowledge, contribution, and professionalism of its Fellows. It is an academic institution, with its own exacting standards, training program, examinations, and diverse educational activities to help anaesthetists, intensivists, and pain medicine physicians keep abreast of scientific and clinical knowledge. The FANZCA training program requires anaesthesia trainees to attain the experience and attributes that are necessary for a specialist anaesthetist to deliver safe, high quality care. ANZCA admits into Fellowship those who have completed the training program. That the anaesthesia-related mortality rates in Australia and New Zealand are among the world's lowest, attests to the high quality of its graduates. Why then, is the College embarking on a revision of its training program?

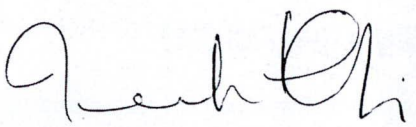
When ANZCA was founded, it took over the training program of the former Faculty of Anaesthetists, Royal Australasian College of Surgeons. The program itself originated from the founding of the Faculty, and was based on the training requirements at the time of the former Faculty of Anaesthetists, Royal College of Surgeons. Through the years changes were made to duration, clinical experience and examination elements, but without a major review of the whole. Anaesthesia has become increasingly more complex and training more structured, especially as regards anaesthesia subspecialties. So why not, 50 years down the track, look comprehensively at defined goals, framework, organization, content, and assessments in the training and education program? And in doing so, consider how we can evaluate the program to see that it achieves its goals, and how we should respond to community needs and expectations. Any revision should take into account methods of assessment to match and reinforce the program's goals (including attitudinal objectives), the needs of trainees, distance learning, and adult learning principles. Learning should be organized according to the stage of training, and a more seamless progression to Fellowship is desirable.

Council appointed a New FANZCA Working Party to do this and they are proposing concepts for a new program. A structure of Basic Training and Advanced Training is proposed. Rather than advancing in annual steps (current Training Year 1, 2, etc), trainees will be required to complete Modules. The overall aim of the Modules is for trainees to achieve the attributes of a Specialist in Anaesthesia as a Medical Expert, Communicator, Collaborator, Manager, Health Advocate, Scholar, Teacher, and Professional. A Module may be a subspecialty clinical rotation (eg Cardiothoracic Anaesthesia), an area of experience that can be completed in the course of normal clinical duties (eg Introduction to Anaesthesia and Pain Management), or aspects of professional practice (eg Professional Issues). Each Module encapsulates the aims in the acquisition of knowledge, skills, and attitudes that is required, and outlines what needs to be learned in basic sciences, clinical and technical skills, educational principles, communications skills, and other issues relating to clinical practice. Topics are clustered in Modules relevant to the stage of training. Modules need not be completed in sequence except for the first two by rookie trainees. The duration of a Module that is not a clinical rotation is dependent on tasks and is not time-specific. For Modules with subspecialty clinical rotations, the time to complete a Module will depend on the duration of the clinical rotation and a minimum period will be specified. Assessments and examinations are yet to be considered. The Primary and Final Examinations are likely to be retained, probably with modifications. A desirable aim is to use more regular in-training assessments and be less dependent on examinations as a discriminator.

There remain challenging problems, and big ones at that. As FANZCA is a qualification for a generic specialist anaesthetist, trainees must gain experience in all anaesthesia subspecialties. The drawback is that ANZCA does not provide the training experience, the hospitals do. Shortages of hospital junior posts in subspecialties will cause bottlenecks in trainees acquiring the required experience, a situation that ANZCA can do little about. This is the reason why ANZCA currently accredits only those posts that will provide such experience, a purpose repeatedly misunderstood or ignored by bureaucrats and the media. At present junior anaesthetists in unaccredited posts may work side-by-side with accredited trainees. This is wrong in principle and - although the numbers vary from region to region - should be addressed. Other items in the "hard basket" include workable methods of formative and summative assessment, support for teachers and supervisors, and provision of learning materials.

The success of any College venture depends on Fellows' contributions, none more so than in the FANZCA program. To teach *pro bono* on top of one's heavy work and family commitments requires support, appreciation, and recognition by the College. This ANZCA must respond to. Fellows are stakeholders in training and education. As subsequent proposals are developed by the Working Party, Fellows' comments will be welcomed through Regional and the New Zealand National Committees, this *Bulletin*, and the College website, beginning with a draft of all Modules when ready. The task will take many months; please be patient. Some Fellows will question the need for any review and accept in perpetuity what is current. Fair enough, but the quest for excellence is a commitment, one that must be ongoing. "*Any activity becomes creative when the doer cares about doing it right, or doing it better.*" (John Updike). "*Progress lies not in enhancing what is, but in advancing toward what will be.*" (Kahlil Gibran). Features of the new program when completed will be worthwhile. I urge all Fellows to support and contribute towards this FANZCA review, this commitment to excellence.

I extend to all Fellows, Trainees, staff and their families a joyous Christmas, good health and prosperity in the New Year.



TEIK OH

Deaths

Council noted with regret the death of the following Fellows:

Dr Ronald Wellesley Greville (ACT) – FFARACS 1956, FANZCA 1992
Dr Christopher Gordon Reid (WA) – FANZCA 1999
Dr Brian Francis Horan (NSW) – FFARACS 1978, FANZCA 1992
Dr George Anthony Osborne (SA) - FFARACS 1988, FANZCA 1992
Dr Stephen Nicholas Hocking (WA) - FANZCA 1996
Dr Stuart Mackay Bottrell (NSW) - FANZCA 2000

ANZCA Council Citations

Citation were awarded to the following:

- Dr L I G (Tub) Worthley (SA)
- Dr Bill Beresford (WA)
- Dr John Hankey (WA)
- Dr Max Sloss (WA)
- Dr Don Stewart (WA)

Honours and Appointments

Congratulations were extended to:

Dr Brian Pollard (NSW) – Commander of Merit, The Sovereign Military Hospitaller Order of St John of Jerusalem, of Rhodes and of Malta Australian Association.

Accreditation of Anzca

RICHARD J WILLIS
VICE PRESIDENT

This is the first of several articles to introduce Fellows to the new process of accreditation that all Specialist Medical Colleges will undergo over the next few years.

Background

The Australian Medical Council (AMC) was established in 1986. Its activities have included: Accreditation of University Medical Schools, Assessment of Overseas Trained Doctors (OTDs) including management of the AMC Examinations, Assessment of Overseas Trained Specialists (OTSs) in association with the Specialist Medical Colleges, Recognition of Medical Specialties, and recently the Accreditation of the Colleges processes and activities.

This new process of accreditation has been developed over the last two years. During 2001, two pilot assessment projects have been completed, yielding much useful information to refine the processes of assessment. The volunteers for these pilot assessments were the Royal Australian and New Zealand College of Radiologists and the Royal Australasian College of Surgeons.

Many Fellows of ANZCA have been involved in other institutional accreditation visits of various types, such as ACHS accreditation of hospitals and College and Faculty accreditation of training programs. The AMC accreditation caused some confusion during the pilot visits. It is important to note that this AMC accreditation process is totally new and will be different again.

When will it be ANZCA's turn?

Next! It has now been confirmed, that ANZCA will be the first College to undergo the full process. This of course excludes the two pilots. The nearest estimate of the actual date is towards the end of 2002.

What is involved?

The six aims of the accreditation process as outlined in the AMC Guidelines should:

1. Assess whether the education, training and professional development programs:
   - Are relevant to the objectives and outcomes determined by the training organisation,
   - Are appropriate in terms of modern educational methods and clinical practice,
   - Include appropriate assessment methods that test the trainee's knowledge, clinical skills, attitude and expertise for safe and competent practice of the specialty.
2. Encourage further improvements and developments in the program being accredited and so enhance its educational quality.
3. Provide an opportunity for the organisation being accredited to review and self-assess its program. The collegiate nature of accreditation should facilitate discussion and interaction with colleagues from other disciplines to benefit from their experience.
4. Assure the community that a doctor who has successfully completed an accredited education and training program is able to practise as a specialist in that area and is being assisted to maintain and enhance her/his knowledge, competence and performance.
5. Provide the basis for medical boards and the Health Insurance Commission to grant the legal requirements for practice in the relevant specialty.
6. Be focussed on the achievements of objectives, maintenance of academic standards, public safety expectations, and good outputs and outcomes rather than on detailed specification of curriculum content relevant to the specialty or discipline.

Where to from here?

This will be a lengthy and complex process that will involve a lot of work by both Fellows and College staff. The initial challenge will be the preparation and submission of the accreditation documentation. This will need to submitted about six months prior to the visit from the accreditation team.

All aspects of the Colleges activities will be scrutinised. Not only must we have robust processes in place for all activities but we must also be able to justify them and be able to indicate that they are yielding the results that are intended. Some of the areas of College activity to be assessed will include the following: selection and support of trainees; structure, content,

duration and supervision of training; assessment of trainees both in-training and by examination; subspecialty training; assessment of OTSs; MOPS; continuing medical education; retraining.

The assessment process will be conducted both at the College in Melbourne and in selected regions. Individual training hospitals will be chosen for 'site visits' and otherwise uninvolved Fellows and trainees may be interviewed. It is anticipated that New Zealand will be visited.

The process is intended to be constructive and this has been confirmed by reports of the pilot visits to the RANZCR and the RACS. It will not be a pass/fail process. There will no doubt be some criticism but there will also be compliments and it is very likely there will be opportunities to improve what I believe to be already very good systems.

I commend the accreditation process to you and look forward to your support. Further reports will appear in the Bulletin as more information becomes available.

Highlights of Council

FROM THE SEPTEMBER 2001 COUNCIL MEETING

WELCOME

The President welcomed Associate Professor Bruce Waxman representing the RACS and Dr Jim Bradley, Vice President of the ASA, representing the ASA President.

PRESENTATION OF GIFT TO THE COLLEGE

Dr David Chamley presented the President's Chair on behalf of the New Zealand Society of Anaesthetists to mark the establishment of the College and ANZCA House.

The shoulder of the Chair has a wooden carving depicting the Silver Fern (New Zealand) and Golden Wattle (Australia). A photo of this chair is published in this Bulletin

EDUCATION

Effective Teaching Techniques in Anaesthesia

Council agreed to fund a grant of up to $8000 for the proposed Effective Teaching Techniques in Anaesthesia for Supervisors of Training to be held at Cumberland Lorne Conference and Leisure Resort.

Drs Leona Wilson, Russell Jones and Mary Done will prepare a discussion paper for Council on a template of courses to be conducted by Regional and National Committees to support Fellows in teaching and Supervisors of Training in their activities.

Supervisors' of Training Support Kit

Council approved in principle a Supervisors' Support Kit for use by Supervisors as an information resource. This Manual will be in a loose leaf form for regular updating.

In-Training Assessment of Trainees in Anaesthesia

Council accepted, in principle, a revised form of formative assessment for trainees which will be promulgated following the October Executive, to be actioned from the beginning of the 2002 Hospital Year.

EMAC Course

Following completion of two pilot Effective Management of Anaesthesia Crises (EMAC) courses, Council resolved that both the EMST and EMAC courses be available to trainees as options for the compulsory course towards Fellowship of the ANZCA.

Courses Sub-Committee

In view of the disbandment of the Courses Working Party by December 2001, Council appointed a Courses Sub-Committee to review all courses which could be available to College Fellows and trainees.

Chairman and Councillor	W R Thompson
Chairman of CE&QA Committee	R N Westhorpe
Chairman of Education and Training Committee	L F Wilson
Fellows	B T Flanagan
	J M Weller
	L M Watterson

The Sub-Committee has been charged with developing appropriate Objectives and Terms of Reference.

College Tutors' Course

Council accepted the recommendation from the Education and Training Committee to support Dr Mary Done in developing the proposed Clinical Tutors' Course.

EXAMINATIONS

Panel of Examiners

Council has resolved that Fellows who are five years post successful Primary Examination and three years post Fellowship are eligible to be considered for appointment to the Panel of Examiners as Primary Examiners.

FINANCE

Fellows' Annual Subscription – 2003

- Due and payable on 1 January 2002, will remain at A$990 plus GST where applicable.
- Non Fellows' fee for MOPS A$500 plus GST where applicable.
- Overseas Trained Specialists Assessment fee A$1,300 plus GST.

Training Fees

- Register of Training fees for all trainees for 2002 will remain at A$950
- Annual training fee for 2002 be retained as follows:
  - Australia A$925
  - New Zealand NZ$925 plus GST
  - Hong Kong HK$925
  - Malaysia $925 (local currency converted into AUD)
  - Singapore to be capped amount in AUD equivalent to that paid by Australian trainees
- Examination entry fee A$1,900
- Occupational Training Visa assessment fee A$100

INTERNAL AFFAIRS

Assistant Assessor – New Zealand

Dr Malcolm Futter was reappointed the Assistant Assessor (NZ) and is responsible for the College's assessment of overseas trained specialists applying for vocational registration in New Zealand.

Name Change – "Ulimaroa Boardroom"

Following the establishment of the College in ANZCA House, Council reviewed the accommodation and activities to be conducted in Ulimaroa. The former Council Room will now be available for general and administrative meetings and identified as the Ulimaroa Board Room.

ANZCA Foundation

Following the announcement that Dr Peter Hollingworth, AC, OBE, Governor-General of Australia had accepted patronage of the ANZCA Foundation, Professor Michael Cousins has gained the agreement of several prominent business leaders to join the Foundation Board. Following the appointment of a Board Chairman fund raising will be pursued.

Mortality Committee

ANZCA has been responsible for the publication of the National Mortality Report for the trienniums (1993-1995 and 1994-1996). Council has now appointed Dr Patricia Mackay (VIC) and Dr Chris Borton (NSW) as joint Editors for the report covering the 1997-1999 triennium.

Asia Pacific

Following discussion on the provision of aid to Papua New Guinea, Council resolved:

1. That the College offer educational assistance to the University of Papua New Guinea for undergraduate and postgraduate programs in anaesthesia, intensive care and pain medicine.
2. That the College make available to the postgraduate training program in anaesthesia, intensive care and pain medicine at UPNG access to the College library resources, web-based educational material and CME material.
3. That the College support teaching visits to the Department of Anaesthesia and Intensive Care, UPNG, in conjunction with AusAID via MONAHP.
4. That the College support clinical placement in Australia and New Zealand for six to twelve months for selected registrars from PNG, in conjunction with AusAID, via MONAHP.
5. That the College support attendance of a PNG anaesthetist at its ASM periodically.

Area of Need Oversight

Council approved the document "Area of Need Oversight" - Guidelines for Advisors to assist Fellows providing oversight for overseas trained specialists occupying Area of Need positions.

Geoffrey Kaye Museum of Anaesthesia History

Council agreed to appoint a professional curator to the Geoffrey Kaye Museum of Anaesthesia History on a part time basis for three days per week.

PROFESSIONAL

NSW Health Department – Format of the National Medical Register

The President on behalf of ANZCA, has supported the principles of a portable national medical register, a portable specialists register, and annual re-certification of medical registrations.

Dental Sedation

A Working Party will be established with appropriate individuals from the dental profession to discuss mutual interests in dental sedation.

Australasian Society of Anaesthesia Technicians

In reviewing Professional Document PS8 – *Recommendations on the Assistant for the Anaesthetist*, there was general support for the concept of the College offering a certificate of completion of an appropriate course which meets the College's requirements for Anaesthesia Assistants.

Professional Documents

Council reviewed, approved and promulgated the following Professional Documents which are published in this Bulletin:

EX1 *Policy on Examination Candidates Suffering from Illness, Accident or Disability*
TE13 *Guidelines for the Provisional Fellowship Year*
PS6 *Recommendations on the Recording of an Episode of Anaesthesia Care (the Anaesthesia Record)*
PS12 *Statement on Smoking as Related to the Perioperative Period*
PS16 *Statement on the Standards of Practice of a Specialist Anaesthetist*
PS19 *Recommendations on Monitored Care by an Anaesthetist*
PS20 *Recommendations for Responsibilities of the Anaesthetist in the Post-Operative Period*

Professional Document PS22 – *Patient Rights and Responsibilities*

This Professional Document was withdrawn on the basis that the relevant issues are established under State legislation and common law rights of patients.

Professional Document PS26 – *Guidelines on Providing Information About the Services of an Anaesthetist*

Council agreed that when reviewing the above document, dental trauma will be specifically included in the list of risks about which patients should be informed.

CONTINUING EDUCATION AND QUALITY ASSURANCE

Maintenance Of Professional Standards Program

Following a meeting of the College MOPS Committee, the following changes to the College MOPS Program were approved:

- 1.1, 2.2: *Major meetings*; documentation required to be changed to "Meeting programs, registration receipt or attendance certificate".
- 1.2, 2.3: *Local meetings*; documentation required to be changed to "Attendance records or certificates, minutes (which should include a list of those present)".
- 6. *Simulator and Skills Laboratory Courses*: Additional code 613 "Simulator based courses offered as part of an approved conference, 5QA points and 5 CME points per hour".
- An additional code for Major Meetings that are combined QA and CME, awarding them 20 points per day or 3 points per hour in total, the breakdown of QA and CME to be determined by the MOPS Officer. Approval from the MOPS Office: Yes, in advance.
- Additional codes for sabbaticals, overseas aid trips (eg Interplast). Approval from the MOPS Office: Yes, in advance.
- Addition of code 253, Medico-Legal Work (eg appearing as an expert witness in a court case, sitting on a disciplinary body hearing a case, giving a formal opinion on the standard of care to a statutory body, eg Health and Disability Commissioner (NZ), 1 QA point per case. Approval from MOPS Office: No. Documentation required: Copy of letter of request, opinion.
- Addition of code 254, In Training Assessment of Trainees by Supervisors of Training. 10QA points per year. Approval from MOPS Office: No. Documentation required (examples): Copies of ITAs (with confidential material deleted).
- All returns received after the deadlines are still accepted, but Statements of Participation are endorsed with the words LATE RETURN, so that those returns not eligible for audit are identified.
- The points assignment for all conferences, CME + QA, is 3 points per hour. The alternative daily rate has been dropped.
- The codes for QA, CME, TTR have been changed so that they match - (major meetings, local meetings, committee work)
- Professional Practice Review: the points allocation has been changed. The participant will get 25 CME + 50 QA points, and this will allow them to meet the QA minimum for that and the next year. The reviewer will get 30 QA points, the same whether they review one or two participants.
- Other activities: (code 700). There will be two specific categories created; overseas aid trips (eg interplast) (2 CME, 2 QA, 5 TTR points per day), and sabbatical/approved study leave (25 CME points per three months). Both will need prior approval, as for the rest of code 700 activities.

Anaesthesia Simulators

Council resolved that an Education Grant be provided to evaluate the use of simulators in education and research in anaesthesia, intensive care and pain medicine.

Participation in MOPS Program – Fiji

The College agreed to offer the Maintenance of Professional Standards Program to anaesthetists practising in Fiji. This initiative will be funded by an AusAID grant for the Fiji School of Medicine.

2001 New Fellows Conference

Dr Tim McCulloch (NSW) presented the report of the New Fellows' Conference held in conjunction with 2001 CSM in Hong Kong which aimed to assess the place of alternative and complementary medicine with respect to the practice of anaesthesia, intensive care and pain medicine. A copy of this report is published in this *Bulletin*.

New Fellows Conference 2002

Council accepted the recommendation that the theme for the 2002 New Fellows' Conference to be held at O'Reilly's Rainforest Guesthouse, Canungra Queensland, be "The Challenge of Change".

ASM 2003

Dr Kate Leslie (Vic), has been appointed the Australasian Visitor to the 2003 ASM in Hobart.

ANAESTHESIA CONTINUING EDUCATION COORDINATING COMMITTEE

Acute Pain Audit

Council agreed that the Acute Pain Audit be included on the Acute Pain SIG website.

RESEARCH

Thirty applications totalling $1,130, 339 were received with the total funding available of $350, 925.

Details of the awards are published elsewhere in this *Bulletin*.

Law Report

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

"New Privacy Laws for Doctors"

Medical practitioners have always been subject to an array of professional, ethical and legal obligations.

With the amendments to the **Commonwealth Privacy Act** taking effect on 21 December 2001, they will be subject to more.

The new law will introduce a set of 10 National Privacy Principles, or "NPPs", which establish minimum standards for the handling of personal information. The NPPs will apply to all organisations that have an annual turnover of $3 million or more as well as any organisation or individual that provides a health service and, in the process, collects health information.

Health service is defined broadly in the new law and includes an activity performed in relation to an individual that is intended to treat, assess or diagnose the individual's illness or disability. Health information includes information or an opinion about the health or disability of an individual.

It is clear that these changes will apply to doctors.

Taking a back seat to the Commonwealth initiative is a new piece of Victorian legislation, the ***Health Records Act* 2001 (Vic).**

This State Act has to date been overshadowed by its Federal counterpart but will assume greater prominence in the lead-up to its introduction next year.

The Health Records Act is particularly relevant to medical practitioners as it establishes a separate regulatory regime for the handling of health information and applies with particular vigour to health service providers. It is similar to legislation in other States and Territories, notably in the Australian Capital Territory.

Any medical practitioner providing health services in Victoria will be regulated by two separate privacy regimes.

Both the Commonwealth and State privacy schemes take a similar approach to health information and accord it special treatment. Under the Commonwealth law it is placed in the category of "sensitive information".

The Victorian legislation introduces a set of 11 Health Privacy Principles, or "HPPs", that cover similar ground to the Commonwealth NPPs. However, the standards contained in the Victorian legislation are more stringent and have particular application to doctors.

The Victorian AMA supports the view that complying with the Victorian legislation, in time for the commencement of the Commonwealth law will generally satisfy both schemes. This seems a sensible approach.

It is therefore imperative that doctors take the time to become familiar with the HPPs, as they set down the rules which prescribe how health information (and other personal information) is to be collected and handled.

The HPPs can be summarised under the following headings:

Collection and use of health information

A medical practitioner can only collect health information where this is necessary for the performance of an activity or function.

A medical practitioner can only use or disclose the health information for the purpose for which it was collected unless the individual's consent has been obtained.

Data quality and security

A medical practitioner must take reasonable steps to ensure that the health information it holds is accurate, complete, up-to-date and relevant to its functions. It must also safeguard the information against misuse, loss, unauthorised access and modification.

A medical practitioner will generally be prohibited from destroying or deleting health information about an individual until at least 7 years have passed since the individual's last attendance.

Transparency

A medical practitioner must document clearly expressed policies on its management of health information and make this statement available upon request.

Access and correction

A medical practitioner is required to provide access to health information and to allow individuals to make corrections to the information where this is necessary to maintain the integrity of the record.

A medical practitioner must, upon request by an individual, make health information relating to the individual available to another health service provider.

Identifiers and anonymity

A medical practitioner may only assign an identifier to an individual if the assignment is reasonably necessary to enable the organisation to carry out any of its functions efficiently.

A medical practitioner must allow individuals the option of entering transactions anonymously wherever this is lawful and practicable.

Transborder data flows

A medical practitioner can only transfer health information outside Victoria if the recipient is subject to laws which are substantially similar to the HPPs.

Transfer or closure of the practice of a health service provider

Before the business of a medical practitioner is either transferred or closed down, the medical practitioner must give notice of the proposed transfer or closure to patients and former patients to allow those individuals to apply for their health information before the change takes effect.

WHAT THIS MEANS FOR YOU?

The introduction of the new regime will not prevent you from continuing to collect and use health information. However, you will need to introduce specific measures to ensure that information handling practices comprehensively address the requirements outlined in the HPPs.

This will involve examining your current information handling practices to identify areas in need of reform.

As a starting point you should consider the impact of the collection principle which provides that health information can only be collected for a 'primary purpose' or series of single "primary purposes" (ie, the health care of the patient). In those circumstances, it would not be incompatible with the spirit of the legislation to take down a full medical and family history of the patient. However, this needs to be communicated to the patient at the initial consultation so that the expectations of the patient are consistent with yours.

Both the Victorian and Commonwealth regimes place a high premium on the right of an individual to gain access to personal information held by a medical practitioner.

Accordingly, you will need to think carefully about the way in which you intend to give effect to this right and have in place a policy for dealing with access requests, and any applicable fees.

You will also need to review methods of storage and ensure that patient records are retained for the prescribed period.

Above all you will need to take a pro-active approach to the new privacy law and demonstrate to patients that you take the new regime seriously. You should introduce a privacy statement and place this prominently in places such as waiting rooms.

Make privacy compliance a priority and ensure that it becomes an important part of the professional service already offered to patients.

Steps that doctors and, particularly, hospitals and health bodies should consider are:-

- Undertake a comprehensive audit of current procedures dealing with the collection, storage and maintenance of personal information.
- When collecting personal information from now on, seek consent from individual concerned to use and disclose the information in the manner required.
- Consider seeking similar consent from individuals in respect of the personal information already held.
- Develop a privacy statement and appoint a privacy officer.
- Review contracts to ensure they do not breach the Act.
- Where transferring personal information to third parties, obtain written undertakings from them to ensure they comply with the Act.

[I am grateful for the work of **Catherine Symons**, Solicitor with **Russell Kennedy Solicitors** in the preparation of this Article.]

"Liability for Your Office Staff"

A recent decision of the New South Wales Supreme Court confirms the position that a doctor can be liable for the negligent act of their office staff. In this case, a receptionist, when advised of the symptoms of a patient (even though the patient was not present), failed to refer the issue to the doctor for action, or take other steps which may have suggested to the patient that other steps were appropriate.

Australian Courts have already determined that the responsibility of doctors in relation to the non-receipt or non-follow-up of medical reports and tests. A leading South Australian case confirmed that doctors must, in their practice, have systems in place to ensure that, when requesting tests or seeking reports, they have a system to ensure that the test results are received and communicated to the patient, or that the reports are received, analysed and appropriately acted upon. A missed report, a fax that goes missing, or a test result which is not communicated to a patient in a timely manner are all circumstances where a successful negligence action is likely. The Courts confirmed that doctors have a duty of care to ensure that they have appropriate systems in place to deal with these issues.

The case of *Alexander v. Heise* (NSW Supreme Court 2001) now confirms the liability of the doctor for the acts or omissions of their office staff - in this case, a general practitioner potentially being responsible for the actions of his receptionist.

Again, like in so many cases, the factual situation was disputed. In summary, a wife presented at a general practice seeking an appointment for her husband to visit the doctor following symptoms of a severe headache. There is some dispute as to whether the patient's wife conveyed a sense of urgency, and as to exactly what symptoms were communicated. However, the Court accepted that her husband had had an unusually severe headache, and, uncommonly, had asked his wife for a migraine tablet. In fact, the husband had been suffering from headaches during the previous month, although it is not clear that this was communicated to the receptionist.

The Court also accepted that the receptionist (working in her husband's surgery) gave the impression that she was an experienced medical receptionist, when there was evidence that this may not have been the case. The allegation was therefore made that the receptionist, through inexperience or failure to refer the symptoms to the doctor, failed to arrange for an appointment or checkup with the doctor in a timely way.

Ultimately, the husband with the headache did not meet the appointment and died from an aneurysm shortly thereafter. There was evidence that, had the headache been followed up and the aneurysm detected, a different result may have occurred.

The Court accepted that the patient and his wife had no medical knowledge that would have enabled them to appreciate the risk. Whereas, if the receptionist had consulted the doctor, and advised the doctor of the specific symptoms of a severe headache, the doctor would have appreciated the risk.

Expert evidence from other senior GPs, including a President from the Royal Australian College of General Practitioners, was that their receptionists were trained and expected to refer such symptoms to the doctor for consideration. Expert evidence was such that the doctors would, "*have expected in those circumstances that the receptionist tell you, so that the receptionist could then tell the (patient) they should be doing something about it, either coming to see you or seeing another medical practitioner.*" The Court accepted expert evidence that a general practitioner has a responsibility for determining whether patients require urgent medical attention.

Notwithstanding that neither the doctor, nor the receptionist, saw the actual patient (having merely had information relayed through his wife), a duty of care existed. The Court accepted that a general practitioner has the responsibility to ensure that patients seeking appointments are properly prioritised. A doctor should have guidelines in place so that, where a receptionist is unsure, if a patient's medical condition is of an urgent nature, the receptionist should consult the doctor as to whether the patient should be seen urgently, and, if so, the time period in which they need to be seen.

Interestingly, the Court also concluded that a medical receptionist separately owes a duty of care to the patient, to ensure that, if the patient presents with a possible urgent medical condition, the patient will be seen in a timely manner. If the doctor is unavailable, and a patient presents with an urgent medical condition, the receptionist should refer the patient elsewhere (such as the nearest hospital, A&E Section, or another medical practice).

The Court stated, "*It is my view that the general practitioner had a duty of care to properly instruct the receptionist on the proper management of patients who presented with complaints which may warrant urgent attention.*"

Notwithstanding this duty, the Court confirmed that, in this particular case, neither the doctor, nor the receptionist, actually breached their duty. The Court concluded that the receptionist acted reasonably and prudently in allocating an appointment within the timeframe set. Whilst aware of the nature of the symptoms, the Court noted that the concerns expressed by the patient's wife "*in an amiable manner*", and sought a check up in the context of a full medical examination, where there was no patient to assess on the spot. The Court accepted that the receptionist, acting reasonably and prudently, would not have appreciated that the patient could have a life-threatening condition on the information provided. The risk of the patient suffering the aneurysm was not "foreseeable" and, accordingly,

neither the doctor, nor his receptionist, breached the duty of care that they owed to the patient.

The Court accepted that the doctor had instructed the receptionist on how to appropriately perform duties at the surgery. The Court accepted that the receptionist had been appropriately trained and, in fact, had attended an external training course, which covered such issues as bookings, handling of complaints, and determining the priority of patients. These issues were reinforced with regular meetings with staff to discuss such issues and problems.

The implication for doctors is, therefore:

1 A doctor's practice as a whole, including its staff, must be aware of the issue of prioritisation of patients.

2 A doctor has a responsibility to ensure that his/her office staff are appropriate trained in such issues as prioritisation of patients.

3 In appropriate cases, office staff must refer symptoms or issues to the doctor for a decision, or arrange for immediate or timely review through an alternative medical practice or hospital clinic.

4 Doctors should be aware of the difficulty of patients who "present by proxy", either through a member of the family presenting on their behalf, or by telephone conversations, where the real patient is not immediately available for assessment.

The NSW case is subject to appeal.

MOPS Program Update

In this article, we would like to bring you up to date with the latest developments in the MOPS Program, and answer some of the more common questions that have been received by the MOPS Office.

The Program has been reviewed

The MOPS Manual has been updated and is available on the ANZCA website.

To verify the accuracy of returns and the relevance of activities claimed in individual Programs, random reviews of up to 5% of participants have been undertaken for the last two years, As a result of that audit, we would like Hospital Departments to keep lists of attendances at local CME and QA meetings.

The following changes have been made to the Program

- The 50 point CME requirement can now be made up using a combination of CME and TTR activities.
- Attendances at meetings will only be counted in hours, and the alternative option of counting days will be eliminated, which should simplify the process for participants. This was introduced because many meetings are now a combination of CME and QA sessions, but it will also have the advantage of stopping meetings being counted twice, as has been detected in the audits. Thus, a meeting will be credited for a certain number of CME hours and QA hours.
- Late returns will be accepted, but will be stamped as such to indicate that they were not eligible for selection for auditing.

The following codes have been added:

- Code 613, Simulator and Skills Laboratory Courses, simulator based courses offered as part of an approved conference: 5 CME points and 5 QA points per hour.
- Code 253, Medico-Legal work, eg appearing as an expert witness in a court case, sitting on a disciplinary body hearing a case, 1 QA point per case.
- Code 254, In Training Assessment of Trainees by Supervisors of Training, 10 QA points per year.
- Code 339, Publications, Reviews of Manuscripts and Grants – addition: letters published in a refereed Journal 2 TTR Points
- Code 701, Sabbaticals / Approved study leave, 25 CME points per 3 months
- Code 702, Official Overseas Aid Trips, 2 CME, 2 QA and 5 TTR points per day.

The Program is going online from the beginning of 2002

We decided to change to an online format rather than produce a new electronic diary, as changes can be made easily to the online version, whereas the electronic diaries, once produced, are almost impossible to change or trouble shoot.

- From January 2002 the current electronic diaries will be obsolete as we are making some modifications to the program.
- The problems currently existing with submitting returns, creating backup files, transferring data between computers and using one computer for multiple participants will be eliminated. Computer crashes will not affect the data.

Paper diary users will be able to fill in the return online.

However, the option of using a paper diary will be retained.

- The paper diary will be updated in line with the online diary.
- New diaries will be forwarded to participants when they submit their 2001 Return

There are still codes which need prior approval by the MOPS office

131 Approval required if not an ANZCA, Faculty, ASA, NZSA or ANZICS activity
151 Approval required if not an officially registered EMST, ATLS or APLS course.
321 Approval required for non-College/Faculty examinations
322 Approval required for preparing questions other than for HELP self-assessment modules
336 Approval required for category rating from MOPS Office
411 Approval required in advance from MOPS Office
412 Approval required in advance from MOPS Office
511 Approval required in advance from MOPS Office
512 Approval required in advance from MOPS Office
611 Approval required if not an approved course
612 Approval required if not an approved course
613 Approval required if not an approved conference
700 Approval required, preferably in advance
701 Approval required in advance from MOPS Office
702 Approval required in advance from MOPS Office

MOPS participation will remain voluntary for Fellows

MOPS participation is not a requirement for Fellows of ANZCA.

- However, for those in clinical practice, as part of maintaining the high standards of practice of a specialist anaesthetist, PS 16, "Statement on the Standards of Practice of a Specialist Anaesthetist" states:

  Specialist anaesthetists recognise that:

  - Continuing professional development is essential. This should be evaluated by participation in the ANZCA Maintenance of Professional Standards Program.

- The Medical Council of New Zealand and New South Wales Medical Board require participation in MOPS (or equivalent) for recertification / registration as a medical practitioner.

- In New Zealand, all vocationally registered specialists must be in a recertification program recognised by the Medical Council of New Zealand, and by July 2004 must have complied with the requirements of that program. ANZCA's MOPS Program has been recognised for anaesthetists in New Zealand.
- The New South Wales Medical Board "considers it essential that all practitioners participate in continuing professional education, relevant to their areas of practice, and at a level at least equivalent to that prescribed by the appropriate College". Certification of participation in ANZCA's MOPS Program is accepted as proof of participation.
- The other Australian states do not require participation in MOPS (or equivalent) for registration purposes , but may do so in the future.
- Overseas Fellows of ANZCA practising in the United Kingdom, Ireland, USA, Canada and South Africa can undertake the MOPS of that country.

Many participants have asked about QA points, and how to obtain them.

How do meetings qualify for QA points?

Quality Assurance (QA) can be defined as *"an organized process that assesses and evaluates health services to improve practice or quality of care"*. It provides participants with the opportunity to study, analyze, and audit selected aspects of their clinical performance with the aim to improve their practice. All QA processes should be relevant to the participant's clinical practice.

QA Meetings are meetings, workshops, or seminars conducted by an official professional organisation to specifically foster QA. QA eligible meetings are those whose prime focus is the development, implementation, evaluation and consequent improvement of quality assurance activities related to patient care. Meetings in which data from clinical care, collected in a formal and systematic manner, are evaluated against accepted standards are also eligible.

Some examples are meetings, sessions, workshops, or seminars on critical incidents monitoring, clinical indicators, clinical audits, and maintenance of professional standards; APSF major meetings.

Reports from major audits, such as the NSW Special Committee Investigating Deaths Under Anaesthesia, or the AIMS database, are included in QA meetings, as they are the reporting back part of those audits.

Meetings at which new standards, protocols, guidelines for practice are developed, are also regarded as QA, as these are directed at improving the quality of patient care. An example would be a recent meeting by Standards New Zealand and the University of Auckland launching the new AS/NZS 4360: 1999 Standard for Risk Management in Health Care, using the need for, and possible development and implementation of a protocol for safe administration of intravenous drugs as an example. (This resulted from the concerns generated by high profile cases of patient harm caused by errors in drug administration).

Sessions at CME meetings have, on occasion, been considered QA eligible, such as reports from Medical Insurance Societies of recent claims, and strategies for avoidance of future medico-legal problems. Other sessions have been considered on a one off basis, as conference organisers experiment with new formats for sessions. To qualify, there needs to be some element of:

- assessment of clinical care of patients, or related decision making,
- judgement against accepted standards,
- recommendations for changes in practice..

Conferences / sessions approved for MOPS points will be identified on the MOPS website.

What is a clinical audit project?

- Clinical Audit Projects review clinical care, identify areas for improvement, recommend changes, and finally evaluate the effect of those recommended changes on improving clinical care. They are the audits that are undertaken as part of an institution's routine Quality Assurance Program, and do not have to be research projects.
- To qualify for points as an active participant in a Clinical Audit Project, that person must have their work audited, receive the results of that audit either in person at a meeting or in writing, and alter their practice if necessary as a result of the audit. Thus, those participants working in institutions with an active Quality Assurance and Audit Program should have no trouble in meeting the QA minimum points requirement.
- For those participants who do not have an organised Quality Assurance Program at their workplace, but would like to institute an audit program, we are investigating setting up an "audit exchange" project, in which those with audits that have performed well could offer them to those wanting a good audit. Please let us know if you would consider such a service useful, or if you would be willing to contribute your best audits.

Professional Practice Review earns QA points

This is a one-day review of a participant's practice, on-site at the practice, by a peer nominated by the Regional / National Committee and endorsed by the QA/MOPS Officer. This is a formal process, and has not been used yet in its full form. A kit is available from the MOPS Office.

It should not be confused with other types of peer review, such as taking part in hospital credentialling committees (QA Committee work), or having your peers in your own institution review your work (Local QA Meeting, Clinical Audit Project).

Hospital Attachments earn QA points

This is a period of attachment at a hospital accredited for FANZCA training, where a participant can observe and engage in hands-on clinical practice. The number of QA and CME points earned depend upon the duration of the attachment. These attachments have been used by a number of participants.

However, as well as obtaining MOPS Office approval in advance, participants in the one-week HA need to submit a copy of the preceptor's report to the MOPS office for approval to be complete.

Why does ordinary clinical work not earn MOPS points, and why has the MOPS Program not specified a minimum quantum of clinical work?

This is best answered using CPD PS 16 "Statement on the Standards of Practice of a Specialist Anaesthetist". In this, it is stated that, "to maintain the high standards of practice in anaesthesia that are expected of a specialist anaesthetist,... anaesthetists recognise that:

- *1.3.1. Regular work in anaesthesia of appropriate volume and complexity is necessary to maintain clinical skills*
- *1.3.2. Continuing professional development is essential. This should be evaluated by participation in the ANZCA Maintenance of Professional Standards Program"*

And the MOPS Manual states that:

- The objective of the MOPS Program is to *"foster continuing scholarship in order to maintain a high standard of clinical practice. Thus the principle role is educational and the program validates continuous medical education, quality assurance and other self-improvement educational activities".*

The activities validated by the MOPS Program are those which allow the maintenance and enhancement of the knowledge, skills and attitudes necessary for clinical practice, future career development (CME), and those in which the clinical care given is assessed and evaluated in order to improve care (QA). As stated above, it is considered necessary that anaesthetists undertake BOTH regular work in anaesthesia AND continuing professional development (CPD); partaking only work in anaesthesia OR CPD is not enough.

The issue of the minimum quantum of clinical work required is more difficult. The above statement (CPD PS 16, 1.3.1) has resulted from an appreciation of the variety in clinical practice of specialist anaesthetists, and the lack of any sound evidential base for a level of minimum quantum that can be applied to all specialist anaesthetists.

A related question has been "why does work in a Public Hospital with registrars not qualify for MOPS points". Part of this is already answered above, in that MOPS points are awarded for those activities that are undertaken as well as clinical work. However, implicit in this question is the idea that the registrars are there to teach the specialist, not the specialists teach the registrars. While the presence of a trainee can stimulate further learning by the specialist, supervision of ANZCA trainees by specialists is intended to be the specialist teaching the trainee.

Conclusion

We hope that this answers many of your questions. However, if you have further questions, please let us know.

LEONA WILSON
QA / MOPS OFFICER

RETURNS FOR 2001 ARE DUE BY THE END OF FEBRUARY 2002

All queries and comments should be made via Juliette at the MOPS Office at cme@anzca.edu.au

Examinations Prize Winners

Primary Examination – Renton Prize

The Prize for the period ending 30th June 2001 was awarded to Dr Andrew Hugh Jackson (NSW).

At the September examination Dr Michael Clifford (Vic) was awarded the Prize.

Final Examination – Cecil Gray Prize

The Prize for the period ending 30th June 2001 was awarded to Dr Brian Cowie (Vic). Dr Cowie was awarded the Renton Prize for his Primary Examination.

Admission to Fellowship by Election Under Regulation 6.3.1 (b)

The following were invited to accept Fellowship by Election:

- Dr Keith I Barclay (NZ)
- Dr John C Hyndman (NZ)
- Dr Charles Theron (NZ)

PRIMARY ORAL EXAMINATION
September 2001

Front: Drs Julia Fleming, Neil Warwick, Neville Gibbs (Chairman), Harry Prevedoros, Gill Bishop

Back: Dr Renald Portelli, A/Prof Paul Myles, Prof Tony Gin, Prof Guy Ludbrook, Drs Terry Loughnan, Malcolm Futter, David Cottee

Retiring Examiner Dr Malcolm Futter with Dr Neville Gibbs, Chairman, Primary Examination Committee

Retiring Examiners Drs Andy Pybus, Sandra Taylor and Wally Thompson with Dr David Scott, Chairman, Final Examination Committee

FINAL ORAL EXAMINATION – September 2001

Front: *Drs Michael Jones, Megan Gray, Moira Westmore, Brian Trainer, David Scott (Chairman), Sandra Taylor, Roman Kluger, Penny Briscoe, Dick Willis (Vice President), John Russell*

Middle: *Andrew Puddy, Michelle Mulligan, Michael Paech, Maggie Bailey, Doug Rigg, Tony Weeks, Geoff Mullins, Michelle Joseph, Kersi Taraporewalla, Leona Wilson, Greg Purcell*

Back: *Michal Kluger, Craig Morgan, Peter Dawson, Andy Pybus, Ed Loughman, Wally Thompson, Vaughan Laurenson, Michael Bujor, David Jones, Cameron Buchanan, Pat Farrell*

Primary Examination

JULY/SEPTEMBER 2001

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

The viva examination was held at College Headquarters, Melbourne.

SUCCESSFUL CANDIDATES

S K Aaronson	WA	S S Ho	HK	J F Pedley	VIC
M J Adams	NZ	L C Holford	NZ	H Pham	NSW
L S Aiono-Le-Tagaloa	NZ	N Hughes	QLD	R A Rathborne	VIC
A Ali Beck	NSW	A M St.C Inglis	NZ	J Ray	QLD
W K Alkhazrajy	SA	N D Ireland	NZ	J L Reynolds	NSW
J L Anderson	VIC	E D Irwin	TAS	A D Ringuet	QLD
J Ang	VIC	C A Johnson	ACT	A Samuel	VIC
J D B Black	SA	Z Katic	NZ	J Savage	VIC
L P Bromilow	NSW	K J R King	NSW	I S Sherratt	NSW
A K Brothers	NSW	Kwok, Yung	HK	D E Simmons	SA
G S Bunsee	QLD	H H L Lam	NSW	S Singham	NZ
H M D Cardwell	NZ	L H Le	NSW	L H Smail	NSW
S R Charlesworth	VIC	L C Lee	WA	C Y So	HK
B Chia	VIC	S Liew	NSW	V Spika	NZ
W Y M Choi	NSW	M L Lim	VIC	B H Srun	VIC
Chong Yew Chuan, D	HK	S K Lim	ACT	K M Stanton	NSW
C M Clegg	SA	S L Lim	VIC	M J Stead	QLD
M P Clifford	VIC	Lim, Boon Kian	HK	T M Stone	QLD
A E Curo	VIC	P G Lorraway	QLD	F L Strahan	VIC
P R Dalley	NZ	K N K Y Low	HK	K S Tan	HK
S J Davies	ACT	T N Ma	NSW	B M P Tang	NSW
A J Dawson	NZ	C J Mair	NZ	K S Tanggaveloo	MALAY
S K Day	TAS	B K Mander	UK	Tay, Kwang Hui	SING
T P Ding	VIC	L S Marsh	NZ	M L Teoh	SING
A D Dubyk	NSW	J W Maussen	QLD	Teoh Hui Ling, W	SING
R I Duncan	QLD	F McGain	VIC	A M Walker	NSW
C H Fiddes	VIC	B R McGuirk	VIC	I H Walkley	SA
K R Fitzsimmons	QLD	S L McInnes	NSW	A F Wallis	TAS
I C Forsyth	VIC	A A Messmer	ACT	V P Wijeyewickrema	NZ
L A Freestone	TAS	A Miedecke	TAS	J A Williams	QLD
J A French	NSW	B C Millard	SA	A C Wong	NZ
N F R Ghadiali	SING	C J Mitchell	VIC	D M Y Wong	VIC
J P Gibson	NSW	J L Momsen	NSW	G K M Wong	NSW
S Gopinath	NSW	R S Newland	NSW	D F Wood	QLD
J M Graham	WA	J R Ngan	QLD	K L Woon	SING
R Gupta	NSW	J R Nielsen	NSW	A P Wright	NSW
K Hall	QLD	R J O'Connor	NSW	M J Yarrow	NSW
A C Harmon	QLD	M E O'Regan	QLD	H Y C Yong	NZ
S M Hilmi	WA	L T O'Shea	QLD	H Y Yousif	NZ

RENTON PRIZE

The Renton Prize for the period ending 31st December 2001 was awarded to Dr. Michael Peter Clifford of Victoria.

Final Fellowship Examination

AUGUST/SEPTEMBER 2001

The written section was held in all capital cities in Australia, Auckland, Dunedin, Hamilton, Hong Kong, Singapore and Wellington

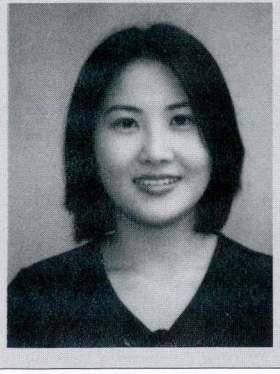
The Viva Examination in anaesthesia and medicine was held at The Prince of Wales and Sydney Children's Hospitals in Sydney.

SUCCESSFUL CANDIDATES

N J Acworth	QLD	C M Hunt	NSW	C B O'Sullivan	NSW
R J Ayer	NSW	N V Ignatenko	NSW	G G Pattullo	NSW
A J Bergin	QLD	Kwok Fung Kwai	HK	D J Probert	QLD
J D Boessenkool	NZ	K C Lee	NZ	A Rasmussen	SA
J L Brown	SA	H A Leggett	NSW	P B Ronchi	VIC
J E Chaffer	ACT	Li Ching Fan Carina	HK	A J Ryan	SA
L J Chapman	NZ	S J Lightfoot	NSW	C W Scarff	VIC
C P Chau	HK	D T H Lim	HK	J M Shirley	QLD
J O L Cheung	SA	E H Lim	WA	R H Solly	VIC
P K Y Chung	NSW	Liu Kowk Kuen	HK	T J Studholme	NZ
P D Cooper	TAS	K K Lundqvist	NSW	S Sturland	NZ
K L Cunningham	NZ	J Marxsen	VIC	Suen Sai Tsz	HK
P J Dunkin	NSW	A P McDougall	QLD	S J Tame	NSW
M L Edwards	NZ	M S McManus	QLD	K L Taylor	NSW
R S Emmett	SA	R S Moss	NSW	F N Thomas	NZ
D J Fahlbusch	SA	N F Mostert	NZ	M D Tran	NSW
C G Flynn	QLD	A K Nagy	VIC	A M Tymms	VIC
S C Fong	QLD	S P W Neff	NZ	V L Walsh	NSW
D C Gardiner	QLD	D W Nemeth	SA	D C Williams	SA
J R Gregson	NSW	Ng Ka-Lai	NT	A O K Wong	HK
C M Hew	SA	S A Nicolson	NZ	K Wong	NSW
Hui Ki Ling	HK	T J Nixon	NSW	S S Wyatt	WA

CECIL GRAY PRIZE

The Court of Examiners recommended that the Cecil Gray Prize for the half year ended 31st December 2001 be awarded to Mark Lewis Edwards of New Zealand.



Undergraduate Prize in Anaesthesia

GILBERT TROUP PRIZE

The recipient of the 2000 Prize for the University of Western Australia was Dr Mei Hui Eleanor Koay.

Admission to Fellowship

BY EXAMINATION

Barclay	Keith Irvine Ford	NZ	Hanavan	Clare Frances	WA	Poon	Anthony Bruce Yew Wai	VIC
Bennett	Felicity May	NSW	Haughton	Andrew John	VIC			
Brake	Timothy James	HK	Henderson	Gary Paul	NSW	Price	Darcy John	NZ
Burgess	Neil David	NSW	Hill	David Reginald	NSW	Seppelt	Ian Mark	NSW
Castanelli	Damian John	VIC	Hunt-Smith	Julian John	VIC	Shearer	Virginia Maria	QLD
Chan Ka Lai	Anita	HK	Hyndman	John Chirnside	NZ	Strykowski	Rodney John	NSW
Chow	Tony Kun Fai	VIC	Illingsworth	Anna Lynda	NZ	Theron	Charles	NZ
Cooper	Paul David	TAS	Ismail	Mohamed Hilmy	NZ	Webster	Bronwyn Heather	VIC
Cox	Leonard Edward	QLD	Khoo En Szee		SA	Weidmann	Peter John Crispin	UK
Crilly	Helen Margaret	QLD	Lam Wang-Leuk	Desmond	HK	Yu	Sui-cheung	HK
Found	Philip William	UK	Lee	Mei Lei	QLD			
Gerber	Daniela	QLD	Lowe	David Arthur	NSW	**Overseas Trained Specialists**		
Gibson	Stephen Bruce	NSW	Lowe	Belinda Yvette Rogers	NZ	Cripwell	Ian Terence	QLD
Gillies	Robyn Louise	VIC	McFadyen	Colin Brett	NSW	Harvey	Peter Richard	QLD
Graham	Bruce Huxtable	NSW	Miles	Ian MacKay	Can			
Hadlow	Timothy Barrymore	WA	Morphett	Simon John	TAS			
Halliday	Emma Louise	NSW	Murphy	Edward John	SA			

2002 Research Grants

The following Research Grants for 2002, recommended by the Research Committee, were awarded by Council at the September 2001 meeting:

Dr Michael Bennett
(NSW)
$15,000
Development and validation of hyperbaric chamber attendant decompression schedules.

Professor Duncan Blake
(VIC)
$10,000
Intrathecal omega-conotoxins and dexmedetomidine in the treatment of neuropathic pain.

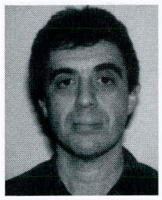
$10,000
Pre-emptive multi-modal analgesia for thoracic and upper abdominal surgery.

Dr Chris Bolton
(VIC)
$14,320
An investigation of the effect of shared post-operative care in children.

Dr Marianne Chapman
(SA)
$15,000
Motor patterns and gastric emptying in the critically ill.

Dr **Andrew Davidson**
(VIC)
$5,000
Perioperative blood glutathione and paracetamol levels in children.

Dr Mary Done
(VIC)
$40,000
Implementation of a Clinical Tutors Course.



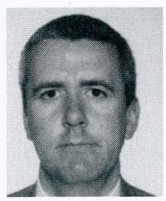
Dr Mark Fajgman
(VIC)
$10,000
Utero-placental hypoperfusion during laparoscopy: can it be prevented?

Dr Frank Liskaser (VIC)
$5,000
The acid-base effects of two different cardiopulmonary bypass primes.

Dr Thomas Morgan
(QLD)
$25,000
Determining the optimal ion difference in crystalloid resuscitation fluid.

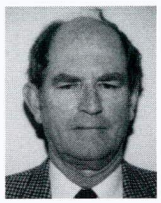
Associate Professor Paul Myles
(VIC)
$44,981
Influence of gender and sex hormone differences in recovery from anaesthesia.

Dr J A Myburgh
(NSW)
$10,000
The Australasian Traumatic Brain Injury Study (ATBIS).



Dr Michael O'Leary
(NSW)
$10,000
Nutrition and protein metabolism in sepsis: quantity, delivery route and catabolism modulation.

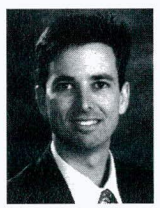
Dr Michael Paech
WA)
$10,000
The effect of ketamine and magnesium on postoperative morphine use after remifentanil.



Clinical Associate Professor Rigg
(WA)
$15,000
Preoperative risk factors, adverse outcomes and effects of epidural and spinal anaesthesia.

Dr David Story
(VIC)
$6,000
Post-operative creatinine changes in patients with pre-existing renal impairment after isoflurane or sevoflurane: a randomised clinical trial.

Dr Suellen Walker
(UK)
$54,981
Inhibitory modulation of spinal pain pathways by alpha$_2$-adrenergic agonists: effect of developmental age.



Dr Paul Wrigley
(NSW)
$59,981
Mechanisms of cannabinoid and opioid action in neuropathic pain states.

"Effective Management of Anaesthetic Crises"

A NEW COURSE FOR ANZCA TRAINEES

"The Effective Management of Anaesthetic crises" (EMAC) is a new course that will be available for ANZCA trainees from the beginning of 2002. The Courses Working Party developed the course over the last 2 years. This College working party is chaired by Dr Walter Thompson, and has received the support of members of the College Council, the Education Unit and the Director of Professional Affairs, Dr Gary Phillips.

EMAC was developed in response to the perceived need for trainees to gain skills in crisis prevention and management, and the current lack of any specific measures to ensure trainees are competent in this area. The required knowledge, skills and behaviours are difficult to acquire in the traditional training program as crises occur rarely, crises cannot be scheduled at a time appropriate to the learner, and for reasons of patient safety, a more experienced clinician will frequently take over management from the trainee. The EMAC course has been designed to address these deficiencies.

The EMAC course is available to ANZCA trainees who have passed the Primary Examination. Successful completion of this course *or* the EMST course will be a requirement for FANZCA.

MOPS program points can be awarded for attendance at the course. A limited number of places will be available from time to time for specialists to attend the course.

Course objectives

The goals of the course are to prepare trainees to manage critical events they may encounter during their clinical work. The key elements of the course are the acquisition of core knowledge and essential technical skills, improving decision-making and development of behaviours effective in the management of emergencies.

The structure of the course

The course consists of five discreet modules run consecutively over 2.5 days. All modules encourage a high degree of participation and are very relevant to clinical problems. Each module includes a variety of instructional techniques and specific pre-reading. A theme of improved decision-making, leadership and teamwork runs throughout the course.

Overview of modules

The five modules of the EMAC course are Airway Management, Human Performance, Cardiovascular Emergencies, Anaesthetic Emergencies and Trauma Management. A brief overview of each of the modules follows.

Airway Module: author Dr Leonie Watterson

The major objective of this module is to ensure participants can effectively manage the patient with the difficult airway. At the end of this module the participants should be able to:

- Assess the likelihood of airway problems preoperatively.
- Outline a plan for the management of expected and unexpected airway problems.
- Understand the rationale and principles of a systematic approach to the difficult airway.
- Demonstrate the appropriate use a variety of approaches to failed intubation and/or failed oxygenation, including:
  - Optimising mask ventilation and intubating conditions.
  - Aids to oral intubation, including Fast-Trach and light wand.
  - Techniques of transtracheal oxygenation.
  - Emergency surgical airway.

The airway module consists of skills stations, videos, presentations, case discussions and clinical simulations aimed to ensure competency with the necessary skills and drills, and improved decision making in airway management.

Cardiovascular module: Author Sandy Garden

Upon completion of this module it is expected that the participant will understand how to recognise and provide the perioperative management of the following life-threatening cardiovascular emergencies:

- Myocardial ischaemia and the acute coronary syndromes
- Cardiac arrest and post-arrest care.
- Peri-arrest conditions and cardiac dysrhythmias.
- Emergency vascular access.

Problem-based learning discussions, skills stations based on arrhythmia recognition and use of defibrillator, computer based simulations and full-scale clinical simulations are used to present the material in this module.

Human Factors Module: Author Brendan Flanagan

The principle objective of this module is to understand how the performance of anaesthetists, as individuals and as part of health care teams, can impact on patient care.

Following completion of this module, course participants should:

- Understand the general principles of crisis prevention and management.
- Understand the psychology of human error.
- Recognise performance-shaping factors including production pressure.

- Understand a systems approach to investigating adverse events and implementing solutions.

This module includes presentations, group exercises, discussions and a clinical simulation, aimed at developing understanding of the issues involved and practising specific skills in teamwork and communication.

Anaesthetic Emergencies Module: Author Jennifer Weller

The objectives of the session on anaesthetic emergencies are to:

- Practice for uncommon and life-threatening clinical events.
- Develop skills in working in a team.
- Develop an immediate response to a crisis.
- Develop strategies to improve decision-making.

By experiencing a structured series of anaesthetic critical events on the High Fidelity Simulator, trainees will be able to rehearse an immediate response to a crisis, and develop a systematic approach to the diagnosis and management of unanticipated problems including hypoxia and difficulty with ventilation. Participants will have the opportunity to practice behaviours important in crisis management. These include leadership, communication and task allocation. Reflection and learning from this experience is aided by watching the videotaped scenario.

The module consists of a series of clinical simulations, debriefs and tutorials, with an opportunity for all participants to experience managing important anaesthetic crisis in the simulator.

Trauma Module: Author Richard Morris

The resuscitation and management of the trauma patient in the perioperative period can be considered in three phases: initial resuscitation, definitive management of injuries and ongoing care and recovery. Anaesthetists have the greatest involvement in the second phase. However, they must be familiar with the priorities of the Emergency Department resuscitation and ongoing care in the ICU ward.

The objectives of this module are to:

- Understand the process of early evaluation and resuscitation of the trauma patient (primary and secondary survey).
- Effectively review the trauma patient on handover from the resuscitation team.
- Evaluate evolving injuries during anaesthesia care.
- Coordinate management priorities and effective team behaviours.
- Manage specific problems including:
  - Cervical spine injuries
  - Intracranial trauma
  - Concealed bleeding
  - Large volume resuscitation
  - Cardiothoracic injuries

The teaching methods include presentations, skills stations, case discussions, X-ray tutorial, and a simulated trauma case.

Assessment

At the end of the course, a certificate will be awarded to participants who have successfully completed the program.

Successful completion will be based on the following criteria.

1. Active participation throughout the course in skills stations, simulations and discussions.
2. Demonstration of competence in technical skills taught during the course.
3. Demonstration of essential core knowledge to manage life-threatening emergencies including ACLS protocols and failed intubation drill.
4. Demonstration of understanding of effective behaviours in management of emergencies in anaesthesia.

Inability of a participant to meet these criteria would lead to the withholding of the certificate until such time as the participant, following further training in one or more areas, could demonstrate satisfactory completion of the course.

Evaluation of the course

Two pilot EMAC courses have been run this year. Dr Russell Jones, the Director of Education, in conjunction with Dr Gary Phillips and College Council observers, Drs Ian Rechtman and Wally Thompson, evaluated both courses. Participants, instructors and observers completed questionnaires at the end of each module and also at the end of the course. A focussed discussion was led by Dr Jones after the final session to elicit the strengths of the course and areas for improvement. In addition, written feedback was sought from instructors and observers after the course. Based on this information, Dr Jones produced a detailed report for the College. The following is an edited summary of his report:

> "Participants all reported learning as being 'relevant to their practice' and indicated they would change their practice as a result of the course, and recommend the course to both trainees and specialists. This is a clear indication of the perceived value of the course to both trainees and Fellows and speaks to the value of the course for the College. Participants were highly satisfied with the course structure, content and perceived value of the course for professional practice.
>
> Courses such as EMAC provide a rich and varied educational experience for course participants at all levels of experience."

Course manual: Editor Brian Robinson

All participants received a copy of the course manual prior to attending the course. The manual chapters were written by the module authors and contain the core material in that module, references and suggested reading.

Implementation of the course

The courses will be offered to trainees from the beginning of 2002, initially at existing Simulation Centres. Each centre wishing to offer the course will require accreditation from the College, to ensure that the facilities, instructors and resources are adequate to meet the instructional objectives of the course. The Simulation Centres are developing an Instructors' manual detailing the module objectives, methods of instruction and the resources required. New instructors will be required to attend an EMAC course as a participant, attend an Instructor Training Course and participate as a trainee instructor prior to becoming an EMAC instructor. The first instructor-training course will be held in Wellington in the near future.

Further information about the course can be obtained from Jennifer Weller or Brian Robinson at Wellington Hospital, Department of Anaesthesia, Private Bag 7902, Wellington South, New Zealand.

JENNIFER WELLER

Carbon Monoxide Production by Soda Lime Degradation of Volatile Anaesthetic Agents

It has recently been noted that in particular and unusual circumstances, potentially toxic levels of carbon monoxide may be produced by degradation of volatile anaesthetic agents in soda lime or barium hydroxide absorbers.

Those agents that contain a CHF, - group, when in contact with a dry alkali base, produce varying amounts of carbon monoxide. The agents which are affected are, in descending order of magnitude, **desflurane, enflurane and isoflurane**. Halothane and sevoflurane are essentially unaffected.

In order for the reaction to occur, the absorbent chemical must be dry. The absorbents are normally supplied with a water content of 12% to 15%. Such a degree of dessication is only likely to occur if the circuit and absorbent is subject to a continuous flow of dry gas for prolonged periods. This accounts for the fact that the only reports of clinically evident carbon monoxide toxicity have occurred in the first case of the day after the gas flows from the anaesthesia delivery system had not been turned of at the end of the previous session.

In view of the potential hazard, it is recommended that soda lime or barium hydroxide absorbent be replaced if the gas flows in the anaesthesia delivery system have not been turned off after the previous anaesthesia session. In addition, it is advised that anaesthetists should ensure that all gas flows are turned off at the end of a session.

Further reading:

ECRI Hazard Report. *Carbon monoxide exposures during inhalation anaesthesia:The interaction between halogenated anesthetic agents and carbon dioxide absorbents.* Health Devices, Nov. 2000, 29 (11), 435-438

Karasch ED, Editorial: *Putting the brakes on anesthetic breakdown.* Anesthesiology, 1999, 91:1192-1194

Baxter PJ, Garton K, Kharash ED, *Mechanistic aspects of carbon monoxide formation from volatile anesthetics.* Anesthesiology, 1998, 89:929-941

Fang ZX et al, *Carbon monoxide production from degradation of desflurane, enflurane, isoflurane, halothane, and sevoflurane by soda lime and Baralyme.* Anesth Analg, 1995, 80:1187-93

Berry PD, Sessler DI, Larson MD, *Severe carbon monoxide poisoning during desflurane anesthesia (case report).* Anesthesiology, 1999, 90:613-616

Woehlck HJ et al, *Physical factors affecting the production of carbon monoxide from anesthetic breakdown.* Anesthesiology, 2001, 94:453-456

Woehlck HJ et al, *Mathematical modeling of carbon monoxide exposures from anesthetic breakdown: Effect of subject size, hematocrit, fraction of inspired oxygen, and quantity of carbon monoxide.* Anesthesiology, 2001, 94:457-460

ROD WESTHORPE

PHARMACEUTICAL TECHNICAL AND SAFETY OFFICER

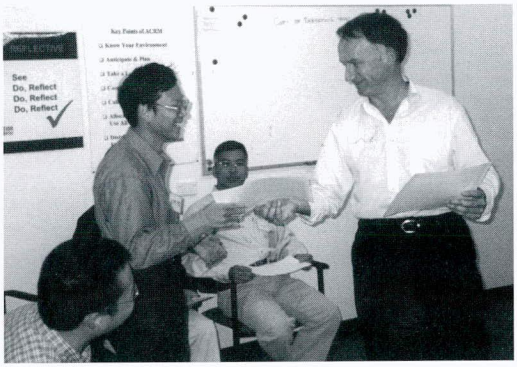
Professional Documents Under Review

In line with College policy, the following Professional Documents are due for review in 2002:

TE4 *Duties of Regional Education Officers in Anaesthesia*
TE5 *Policy for Supervisors of Training in Anaesthesia*
P1 *Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia*
PS17 *Endoscopy of the Airways*
P24 *Sedation for Endoscopy*
PS29 *Anaesthesia Care of Children in Healthcare Facilities without Dedicated Paediatric Facilities*
PS31 *Protocol for Checking the Anaesthetic Machine*
PS36 *Sedation for Regional Anaesthesia for Ophthalmic Surgery*

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

Monash Simulation Centre First



Dr K M Ho receiving ACRM Instructors' Certificate from Dr Brendan Flanagan

The three-day Anaesthesia Crisis Resource Management (ACRM) instructors' course created at Stanford University, California, by Professor David Gaba, is now being conducted in Melbourne.

The course is being run at the Southern Health Simulation and Skills Training Centre at Monash Medical Centre.

Professor Gaba gave "tacit approval" for Monash to run the course, according to the Centre's Medical Director, Dr Brendan Flanagan, who worked with Professor Gaba in California in the mid 1990s.

After his return to Australia in 1996 Dr Flanagan has been involved in the conduct of ACRM instructors' courses in California and London.

Currently, Monash is the only centre outside the US to have gained Stanford's recognition to conduct the instructors' course on a regular basis.

Leading anaesthetists from Hong Kong attended the first ACRM instructors' course at Monash.

The instructors' course is designed to enable anaesthetists involved in the establishment of new simulator centres to learn how to run the day-long course in ACRM for anaesthetic trainees and consultants.

The highly regarded ACRM course flowed from Dr Gaba's research into critical incident management and human performance in anaesthesia. This research led him to believe that there was a gap in systematic training in anaesthesia crisis management.

In the late 1980s, he invented a simulator specifically designed to fill the gap he had identified in anaesthesia training programs.

"Gaba's group also produced guidelines for crisis resource management in the operating room,." Dr Flanagan says.

"Through these and the training sessions, including videotapes of aviation and anaesthesia mishaps and hands-on simulator training, the course aims to integrate these concepts into the anaesthetists' everyday thought processes.

"The rationale for the course is that the behaviours that will ensure optimal management of the entire "situation" of the crisis are generic to every situation, no matter what the medical nature of the event.

"In general terms, the Gaba ACRM course spends at least 60% of the discussion time on behavioural issues and not more than 40% of the time on medical/technical issues," Dr Flanagan said.

The anaesthetists from Hong Kong who attended the first course at Monash were Professor T W Lee, President of the Hong Kong College of Anaesthesiologists, and Doctors K F Ng, K M Ho and Y F Chow.

Professor Lee welcomed the opportunity to take the ACRM instructors' course in Australia.

"There are several simulators in the Territory but this is the first time we have had access to "high end" training.

"Our visit reflects the close relationship between the two colleges, with many Hong Kong anaesthetists training in Australia and ANZCA assisting with the external examination for Fellowship.

"Beyond the value of the ACRM training for Hong Kong anaesthetists, we have been developing relationships with our counterparts in Beijing.

"This dialogue may well lead to collaboration in training, not only with China, but other countries in the region," Professor Lee said.

Dr Flanagan said approval to run the ACRM instructors' course in Australia was a reflection of the high standards of simulation training and research in this country.

Australian and New Zealand College of Anaesthetists

ABN 82 055 042 852

Foundation Fellowship of the Joint Faculty of Intensive Care Medicine

The Royal Australasian College of Physicians

ACN 000 039 047

The Joint Faculty of Intensive Care Medicine of the Australian and New Zealand College of Anaesthetists and the Royal Australasian College of Physicians will be formed early in 2002. It is expected that Foundation Fellows will be elected to Fellowship in February and that the first meeting of the inaugural elected Board will take place in June.

The criteria for Foundation Fellowship were determined by a working party consisting of members nominated by RACP and FICANZCA. The criteria are as follows:

1. FFICANZCA or FRACP (with two years training in intensive care accredited by SAC-IC SAC(P)/ CPPT or JSAC-IC).

2. Persons who commenced specialist training before 1989 or specific training in Intensive Care before 1995 and who have the qualifications FANZCA or FRACP when the applicant has:

   (a) spent two years in a training capacity in intensive care units (ICUs) approved by FICANZCA or the RACP (SAC-IC or SAC(P) / CPPT) for core training purposes, OR

   (b) practised as a specialist in ICUs approved by FICANZCA or the RACP (SAC-IC, or SAC(P) / CPPT) for core training purposes, full time for 5 years or more, or the sessional equivalent at 5/10ths or more over a longer period (example, full time for 5 years, 5/10ths for 10 years), OR

   (c) trained in intensive care outside of Australasia, provided that the training was equivalent in duration, structure and content, assessments and supervision to that required by the Australasian intensive care training bodies.

Persons who consider they meet the above criteria are invited to apply for Foundation Fellowship of the Joint Faculty of Intensive Care Medicine. Applications forms are available from:

The Executive Officer
Joint Faculty of Intensive Care Medicine
C/- ANZCA,
"Ulimaroa"
630 St Kilda Road
MELBOURNE VIC 3004

Ph: +61 3 9530 2861
Fax: +61 3 9530 2862
Email: ficanzca@anzca.edu.au

Applications close on 31st January 2002

The Victorian Doctors' Health Program

The *Victorian Doctors' Health Program* was officially opened on 30th August 2001 by the Minister for Health, the Honorable John Thwaites. The program has been established to provide a service to meet the health needs of doctors and medical students, with an emphasis on those disorders that would, if ignored, impact on their ability to practice their profession. It offers confidentiality and compassion, and aims to provide the very best management of these health problems, including alcohol, other drug (AOD) and mental health problems. It is a fully independent legal entity with its own five-member board of management. Our program has been largely based on models that have been established in North America, some of which have been operating for more than two decades. These programs have been extremely successful in caring for doctors for whom, otherwise, future prospects both professionally and personally would have been bleak or desperate.

As anaesthetists we are more conscious of these risks than most other groups in the medical profession. Sadly, most of us who have been around for a long time have known colleagues whose lives have been lost or careers ruined by problems with drugs or psychiatric disorders. In the USA anaesthetists, who make up about 3% of doctors, accounted for 14% of admissions of doctors to a large AOD clinic. Approximately 1 to 2% of all anaesthetists have had or will develop these problems – that is, most big Departments of Anaesthesia will have had experience with affected colleagues. Anecdotal evidence suggests Australian figures would be similar. The awareness of the high prevalence of these problems has led to a constructive response by our profession. The College of Anaesthetists with the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists have formed a Special Interest "Welfare of Anaesthetists Group"; there has been instruction for registrars on AOD and other welfare issues - indeed questions on anaesthetist impairment have already been asked in the Final Fellowship examinations.

Our program focuses on the early identification of and intervention in these cases. We aim to continue to raise the awareness of early signs, and encourage the self-referral (or "assisted" self-referral) of anaesthetists at an early stage. This increases the likelihood of a successful outcome before the onset of major problems – the disruption to careers, the involvement of the authorities, indeed, the loss of one's life. Intervention and case management are completely confidential; the aim at all times is the restoration of good health and the resumption of a productive career and an enjoyable life.

The *Victorian Doctors' Health Program* enjoys widespread support from across the Victorian medical community, including that of the Victorian Branch of the Australian and New Zealand College of Anaesthetists. There are, of course, no national implications at this stage, although it is reasonable to assume that the other states and territories will be watching its progress with interest.

Anaesthesia is a wonderful medical career. It can however be associated with tragic consequences for some of us. The best way to prevent these tragedies is to encourage early presentation of a colleague who appears to be in trouble, or to present early if it is yourself.

If you think you may have a problem, or know of a colleague who may be at risk, please phone us. Your enquiry will be treated confidentially – and you may choose to be anonymous. **Our telephone number is (03) 9495 6011.**

Naham (Jack) Warhaft, FANZCA
Medical Director,
Victorian Doctors Health Program

Education Report

RUSSELL W. JONES, Director Of Education, ANZCA

With regard to education I am often asked "should we consider any changes and, if so, why?" The impetus to make any change to our current educational system stems from (1) a desire to build on present and past success, (2) the need to keep pace with evolving clinical practice, (3) an awareness of the reorganisation of health care delivery, and (4) an acceleration in research which, in turn, hastens the speed at which technological and procedural changes are being incorporated into medical practice.

In recent months I have encountered a desire among some instructors to cast aside entirely the use of problem-based learning strategies in favour of case-based learning strategies. Others have sought to completely cast aside lecturing in favour of alternative educational techniques. Yet, the fact remains that both problem-based learning and lecturing are educational techniques with many advantages (such as, in the case of the lecture, an ability to quickly present an enormous amount of information to a large audience). Rather than discard problem-based learning or the lecture as an educational technique it is more appropriate to consider all possible educational techniques and then to select the educational technique that is optimum to fulfil a specific educational aim with a particular audience. On many occasions an educational technique such as problem-based learning or a lecture will be the best method, many times they will not.

Modifying our educational techniques is often meritorious though it may be counterproductive to make wholesale changes merely because we are able to make changes. Such a strategy invariably leads to throwing the baby out with the bath water. Before undertaking any educational change it is essential to ensure that the proposed change will improve education. Unless we are convinced that a proposed change will improve education we should approach change with caution. By world standards our College produces a large number of high calibre specialists each year. In addition, the quality of service provided by these anaesthetists is high. A report on Anaesthesia Related Mortality In Australia (edited by N.J. Davis) reveals that of 8,500,000 procedures only 135 deaths could be partly or wholly attributed to anaesthesia. This represents 1 death for 65,000 procedures or 0.00016 percent. By any standard this is a very good record.

When choosing the best educational technique for a specific purpose we must choose the most appropriate technique from amongst the available alternatives. These alternatives include small group learning, workshops, tutorials, one-on-one clinical instruction, simulation, see-one do-one teach-one, clinical skills stations, problem-based learning, case-based learning, lectures, discussion groups, audio/visual aids, demonstration and reading. Rather than seek to eliminate one or more techniques from our instructional repertoire, we should endeavour to learn the strengths/weakness, advantages/disadvantages, and optimal use of each of these techniques and apply them correctly in those situations ideally suited for them.

REFERENCE

Davis N J. *Anaesthesia related mortality in Australia, 1994-1996,* ANZCA, Melbourne, 1999.

"Which Doctors?" – Complementary and Alternative Medicines

RECOMMENDATIONS FROM THE NEW FELLOWS CONFERENCE

I would like to draw to your attention the recommendations made to Council by the recent New Fellows' Conference. At this conference, ably organised by Phoebe Mainland, New Fellows from Australia, New Zealand and Asia discussed the significance of complementary and alternative medicines (CAM) for anaesthetists, intensivists and pain medicine specialists.

The consideration of CAM is timely; recent evidence shows that many of our patients take these therapies, often without telling us, with at times unpredictable consequences for their care by us. CAM are "in the news", in New Zealand, a Ministerial Advisory Committee is being appointed to advise the Minister of Health on CAM.

At the Conference, the themes covered included what is known of the range, efficacy and adverse effects of CAM, and interactions with therapeutic drugs, especially anaesthetic drugs; that is, increasing the knowledge of CAM within the profession. Another theme was considerations of the reasons for the popularity of CAM with many patients; that is, is there room of improvement in conventional medical treatment? A third theme was balancing the principle of patient autonomy against the duty of care owed by medical practitioners to their patients. A final theme was the classification of therapies into evidence based and otherwise, acknowledging that orthodox medicine includes many unproven therapies.

Out of consideration of these themes, and wide ranging discussions, the recommendations to Council were developed. The recommendations indicate the action that the New Fellows considered should be taken to improve patient care in anaesthesia, intensive care and pain medicine with respect to CAM.

Tim McCulloch, the New Fellows representative, will join the Education and Training Committee for the next year, to follow up action taken as a consequence of the recommendations.

LEONA WILSON
COUNCILLOR-IN-RESIDENCE

Report –

TIM MCCULLOCH MBBS BSC(MED.) FANZCA

The Newer Fellows' Conference (NFC) this year was held in the salubrious surrounds of the Beas River Country Club – a facility of the Hong Kong Jockey Club. The aim of the conference was to "assess the place of complementary and alternative medicine (CAM) with respect to the practice of anaesthesia, intensive care medicine and pain medicine". Many of the delegates were initially unsure that there would be much to say on this topic but, while preparing for the meeting, it became apparent that many issues relating to CAM are of relevance to our profession. This report attempts to summarise some of the lively debates at the conference.

Definition

CAM has been defined as "a broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period."[1] Using this definition, a particular medical practice can be considered orthodox by one culture at one point in time while being considered alternative in a different culture or a different era.

CAM can be based on spiritual practices, herbal medications, physical therapies, or therapeutic devices. Some forms of CAM, such as chiropractic, acupuncture and traditional Chinese medicine, are based on a long tradition and a sophisticated body of theory and knowledge.

Popularity

A 1996 survey of Australian adults found half of respondents had taken a non-medically prescribed complementary medicine in the past year.[2] The authors estimated that Australian expenditure on alternative medicines is about twice the patient contributions to orthodox pharmaceuticals. Last year, an American survey found 22% of patients presenting to a preoperative clinic were taking herbal remedies.[1]

The popularity of CAM may be increased by such factors as dissatisfaction with orthodox medicine, a perception that CAM is more "natural" and therefore safer, and a focus of CAM on maintaining well-being rather than just treating disease. Patients may turn to CAM if they feel alienated by orthodox medicine or if orthodox medicine is seen to have limited effectiveness. Patients with chronic or terminal conditions may be particularly likely to seek help from CAM.

Efficacy

Given the wide range of practices encompassed by CAM, it is clearly not possible to make any general statements regarding

their efficacy. The fact that people are voting with their feet indicates that these therapies are successful in that patients perceive a benefit.

There was much discussion regarding the lack of scientific evidence for most of CAM. On the other hand, much of our orthodox practice is also unsupported by outcome-based evidence. It has been noted that it is unreasonable to demand higher standards of proof from complementary medicine than from orthodox medicine.[3] In the absence of outcome-based evidence, orthodox therapies are often favoured because they make sense within the theoretical framework of medical science. Similarly, CAM practices are often logical within their particular paradigm.

Most CAM therapies have not been subject to adequate placebo-controlled trials. One constraint is that the resources available for research into orthodox drugs are not available for the study of CAM because alternative therapies are typically not patentable.

Adverse Effects

Contrary to the image of alternative therapies as "natural", and therefore benign, they can have adverse effects. Physical therapies such as manipulation can cause trauma. Patients using CAM for serious illnesses may not receive proven orthodox therapies.

In recent years, there has been much interest in adverse effects of herbal medicines. Adverse effects can occur due to:

- exaggerated therapeutic effect (eg due to overdose)
- side effects
- adulterants/contaminants
  - heavy metals (eg mercury, lead, arsenic)
  - substituted herbs
  - orthodox drugs
- interaction with orthodox drugs[4]
- pharmacodynamic
  - pharmacokinetic
  - hypersensitivity reactions

Some herbal remedies have been used for centuries without apparent harm and this is evidence for their safety. However, adverse events can still occur when herbs are used in ways outside their traditional use, or in combination with modern pharmaceuticals.

As an example of adverse reactions to herbs, the Australian Therapeutic Goods Administration (TGA) recently released a warning regarding drug interactions with St John's Wort, a popular herbal remedy for depression. St John's Wort stimulates some hepatic enzymes, causing reduced activity of several important drugs including digoxin, cyclosporin, oral contraceptives and warfarin. There is a risk of serotonin syndrome if St John's Wort is taken with anti-depressants that share its serotonergic mode of action.

The active ingredients of herbal preparations are often unknown, or their activity may rely on interaction between multiple compounds. This makes development of appropriate assays and standards difficult. In some countries, herbal products are often deliberately adulterated with orthodox drugs; eg corticosteroids, indomethacin, thiazide diuretics, caffiene and paracetamol.

The TGA has also released a Practitioner Alert regarding *aristolochia* herbs. These species of herbs contain renal toxins that have caused several cases of end stage renal failure in Europe when *aristolochia* was inadvertently substituted for another herb in a weight-loss preparation. Substitution of herbs is usually due to confusion, either due to similar appearances or similar names. Also, herbs may be deliberately substituted with a cheaper or more easily obtained plant.

Reporting of Adverse Reactions

Adverse reactions are under-reported for orthodox medications but this problem is even greater for alternative treatments. The Australian Drug Reactions Advisory Committee (ADRAC) actively encourages reporting of adverse reactions to alternative therapies. Interpretation of adverse reactions is complicated by uncertainty regarding the contents of alternative medications. Whenever possible, a sample of the product, and any information regarding its source, should be retained.

Regulation of Complementary and Alternative Medicines

The supply of alternative medications is largely unregulated in much of the world. Australia has one of the more stringent regimes for regulation of their production and labelling. The Register of Therapeutic Goods includes alternative medications in two categories:

1. Listed Goods
   - safety and quality are the main criteria for listing
   - no proof of efficacy required
   - restricted claims: cannot claim to 'treat' or 'cure' disease
   - manufacturer must be licensed by the TGA
   - over 4,500 herbal products are approved for listing
2. Registered Goods
   - requires evidence of efficacy to be submitted to the Complimentary Medicines Evaluation Committee
   - allows claims of efficacy
   - very few herbal products are registered

The licensing of manufacturers ensures greater reliability regarding the safety of herbal products in Australia compared to other countries such as the USA.

The **Medical Council of New Zealand** has developed a policy regarding the use of unconventional therapies by registered medical practitioners. They note that orthodox medicine also includes many unproven therapies and that practitioners are entitled to incorporate alternative treatments into their practice. To protect public safety, the Health and Disability Commissioner Act stipulates several requirements for the use

of unproven therapies that are outside the orthodox practice of medicine: doctors should maintain the usual standards of diagnosis and investigations, doctors should have reasonable expectation that the treatment is safe and that the patient will not be harmed by withholding orthodox treatment, patients should be informed if an unconventional therapy is unproven or experimental, the doctor should not make unsupported claims, and the doctor should not receive excessive compensation.

Implications for the Practice of Anaesthesia, Intensive Care Medicine and Pain Medicine

Anaesthesia

The area of most concern to anaesthetists is the possibility of perioperative complications related to use of alternative medications.[5]

- ***CNS***: Some herbal products act on the central nervous system and could, in theory, alter the sensitivity to general anaesthetic agents.
- ***Haemostasis***: Many herbal products have been found to inhibit platelet function *in vitro* and there are a several reports of herbal products being associated with spontaneous bleeding including subdural haematomas. At the time of the NFC, we were not aware of any reports of herbal products being associated with perioperative bleeding complications but there has subsequently been a case-report of bleeding after laparoscopic cholecystectomy in a patient taking *gingko biloba*.[6]
- ***Cardiovascular***: The *ma huang* plant is used in herbal remedies, including products for weight loss and respiratory symptoms. Extracts of *ma huang* contain ephedrine and other sympathomimetic compounds. Acute use can cause tachycardia, hypertension arrhythmias, myocardial ischaemia and stroke. Chronic use can cause tachyphylaxis and depletion of endogenous catecholamines. Life-threatening interactions can occur between *ma huang* and monoamine oxidase inhibitors.

Despite the millions of patients worldwide regularly using CAM, there is almost no direct evidence that herbal remedies are dangerous in the perioperative period. However, given the theoretical risks, it may be reasonable to recommend patients cease taking such therapies preoperatively. The American Association of Anesthesiologists has suggested that patients cease all complementary and alternative medications 2 to 3 weeks prior to elective surgery (www.asahq.org/NEWSLETTERS/2000/02_00/herbal0200.html).

Intensive Care

The issue of most concern in the Intensive Care Unit (ICU) is the use of CAM by hospital inpatients. The New South Wales Therapeutic Assessment Group has prepared an information bulletin entitled "Complementary Medicines in Public Hospitals". They note that there is a tension between the right of autonomy for a patient who wishes to use CAM and the obligation of medical practitioners to avoid patient harm.

The critically ill intensive care patient presents additional dilemmas. Patients in ICU are usually not competent to make their own decisions but family members may request administration of an alternative therapy. Some low risk therapies, for example aromatherapy, may not present any difficulty. However, many intensivists will be unwilling to allow systemic administration of alternative medicines. On the other hand, the possible risks of such therapies may need to be balanced against the additional stress to the patient and relatives that could follow from refusal to allow the therapy. At the NFC it was felt that, on the majority of occasions when these issues arise, frank and open discussion with the family and/or patient should enable a satisfactory solution for all concerned.

Pain Medicine

Pain medicine is one branch of orthodox medical practice that does adopt a holistic approach. It is often necessary to acknowledge that pain will not be cured and the focus then turns to a life-style and whole-person approach to living with the pain. The use of CAM may help the patient adopt a positive approach.

Conclusions

1. The conference concluded that there is a need for greater awareness within the profession regarding the widespread use of CAM and the potential for some alternative therapies to affect the cardiovascular, neurological and haemostatic systems, and to interact with orthodox drugs.
2. It would potentially be useful to include questions about the use of CAMs in the routine preanaesthetic assessment. Without direct questioning, most patients using CAMs do not volunteer this information. A non-judgemental approach to questioning is most likely to result in a complete medication history.
3. It may be advisable for patients to cease taking CAMs prior to elective surgery.
4. Suspected adverse reactions to CAMs should be reported in the same manner as reactions to orthodox drugs. If a herbal product is associated with a reaction, a sample should be obtained for analysis.
5. There is a need for clinicians to have access to information regarding the potential clinical effects of CAMs, for example by reference manuals or electronic databases.
6. The principle of patient autonomy applies to people who wish to use CAMs during their hospital admission. However, there is a competing principle of duty of care if the treating doctor believes there to be a foreseeable risk of the CAM causing harm. These ethical issues are particularly problematic in critically ill patients who are unable to express their will and are unable to self-administer their medications. We concluded that decisions

regarding the use of CAMs in hospital should be made on a case-by-case basis. Discussions with the patient and family, and any advice given, should be included in the clinical record.

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Acknowledgments

Thanks to Dr Phoebe Mainland, Convenor, and Dr Claudia Cheng, Deputy Convenor for organising a very successful conference. Dr Leona Wilson, Councilor-in-Residence, and A/Professor Jack Havill, Intensive Care Board Member-in-residence, were invaluable guides and voices of reason. We would also like to thank the people whom the convenors organised to share their expertise in CAM: in particular, Anthony Perillo, D.C. (chiropractor) and Dr Xu Mi (researcher into traditional Chinese medicine).

Dr George Anthony Osborne

South Australia – FFARACS 1988, FANZCA 1992

George Anthony Osborne was the third and youngest child of a gold miner. He was distinguished as a scientist before he began to study medicine at the age of 33, becoming an anesthetist – a medical specialty in which he was to play a developing role at the Royal Adelaide Hospital.

When the family moved from Kalgoorlie to Perth, George went to school at Christian Brothers' College and as well as being an excellent student he was a fine sportsman. He was a quiet boy and it was only from his school friends (or their mothers) that his parents learned that their son had been appointed captain of the school's senior football and cricket teams.

Initially, George was discouraged from a career in medicine after high school. He studied at the University of Western Australia earning a BSc in 1963 and a PhD in physical chemistry in 1968.

He married his first wife, Ilus, in 1965 and the had three children – Christopher now a corporate lawyer working in Thailand, Donald a trainee in orthopaedic surgery and Phillippa a software engineering student.

George Osborne worked as a research scientist for eight years at the University of Southern California at Los Angeles, the National Research Centre in Ottawa, Canada, and the Australian National University in Canberra. Asked by a colleague why he changed careers, George said it was because he thought medicine was one job where he could always be guaranteed employment. But colleagues suspect it was more than that. They say George could no longer ignore an earlier calling in him to more directly serve people in the very human profession of medicine.

George complete his medical degree in 1980 and worked at Royal Adelaide Hospital, Adelaide Children's Hospital and Queen Victoria Maternity Hospital where he also complete a diploma in obstetrics. During an anaesthetic rotation as part of the Family Medicine Program, George's aptitude for the specialty was quickly recognized and hw was asked to join the College training program. Upon attaining his FFARACS in 1988, such was his standing, George was immediately offered a consultant post at the RAH which he occupied until his death.

George married his second wife, Paula, in 1983 and they had two children, Naomi, 14 and Zoe, 6.

George had a brilliant, analytical mind, a true enthusiasm for his work and a cautious, but warm and measured approach to his patients' welfare. With his steely gaze and quite demeanour, George must have put many nervous surgical patients at ease.

With the growth of day surgery in the 1980s and 1990s, George became a major contributor in the development of anaesthesia for these procedures. His firm grounding in scientific method, combined with originality of clinical thought, led to the publication of landmark studies in this new area.

George was a feverent but quiet republican, and reading, travel (especially Ireland), wine, golf, cooking and the Adelaide Crows occupied his leisure time. George was one of those fierce and loyal supporters who managed to travel to the MCG to be present for both of the Crows 1997 and 1998 AFL premiership triumphs. But always his greatest love was his family, of whom he was intensely proud.

George was a very interesting and generous man, with a firm belief in social justice and free thought. Some thought him a relic from the 1960s, with his Albert Einstein hairstyle, his blue jeans and his familiar kombi van which will be sadly missed from the Royal Adelaide Hospital car park.

As the end of a long illness, he spent six weeks in the Mary Potter Hospice before his death, proclaiming: "This is a good hospital!"

Robert Singleton

Dr. Brian Francis Horan

New South Wales – FFARACS 1978, FANZCA 1992

My close friend, mentor and colleague Brian Horan quietly passed away in the early hours of the morning on August 11th, 2001. Brian died at home after a long illness, throughout which he had been cared for by his wonderful wife and daughters, boosted by a constant stream of friends and family.

There will, I'm sure, be other written praises to this great man, who by his sincerity, generosity and faith has inspired so many. Brian was talented, intelligent and dedicated. His calm, detached advice was sought after by many. His passing has left us uncertain and grasping for what is no longer with us.

Brian grew up in North Sydney where his father Joseph worked as a general practitioner. He was educated at St Aloysius College, where he excelled both academically (Dux of the school with a maximum pass in the Leaving Certificate 1963), and on the sporting field.

In 1964 Brian joined the Jesuit Novitiate outside of Melbourne where he spent the next eighteen months. Prior to commencing Medicine at Sydney University in 1966 his appetite for research was fine-tuned by six months as a laboratory assistant at the Garvan Institute.

I first met Brian at this stage, as we both unsuccessfully had tried to fit the subject Latin into our Medicine 1 schedules. We had to settle for Applied Maths and so began a long friendship in which I was the fortunate recipient of Brian's wisdom, humour and faith.

Brian sailed through the undergraduate years with expected aplomb graduating with Honours in 1972. He spent two years at St Vincent's Hospital before travelling to England where he studied for his English Fellowship in Anaesthesia at Oxford. This early training set the pattern for a life of publication and research. His curriculum vitae lists one book, nineteen scientific papers, twelve editorials, six letters to the editor and forty three formal lectures or presentations. Brian returned to Australia in 1977 gaining his Australasian Fellowship and appointment as a staff specialist at St Vincents Hospital, a position he still held when illness forced his resignation in 2000. From 1985 to 1996 Brian was Director of the Department of Anaesthesia.

Brian was a gifted anaesthetist, able to combine a deep seated caring, compassion for his patients with a natural easy going persona. His popularity and the regard in which he was held was never more emphasised when all elective surgery at St Vincent's Hospital was suspended on the morning of August 15th to enable surgeons, anaesthetists and nursing staff to attend his funeral.

Brian's special talent was teaching. His portfolio extended from undergraduates at the University of New South Wales, to anaesthetic trainees in Australia and overseas, to senior anaesthetists in many countries. His overseas appointments included:
1989 and 1990 – external examiner, primary examinations, University of Malaysia;
1995 – Visiting Professor, Chinese University, Hong Kong;
1996 – Visiting Professor, State University of New York, New York, USA

In 1992 Brian visited Vietnam as a member of the Australian Foundation for the Peoples of the South Pacific (AFSP). This visit facilitated upgrading of anaesthetic equipment and training throughout Vietnam. Vietnamese doctors now have access to anaesthetic and intensive care placements in Australia.

Brian contributed much to anaesthetic advancement and training throughout Australia. From 1981 to 1988 he was the editor of Anaesthesia and Intensive Care, the journal of the Australian Society of Anaesthetists. This led to College roles as Federal Councillor 1993-1995, Member of NSW Regional Committee 1992-2000 and examiner 1981-1993. He served on other important committees; NSW Special Ministerial Committee Investigating Deaths under Anaesthesia (1990-2000) and the NSW Department of Health Working Party on Infection Control in Anaesthesia (1994).

But Brian thought of all these duties as routine. His great love was his family, his wife Jackie and his daughters Kate, Bridgit and Lucy. Throw in his passion for languages, a good wine and the odd game of tennis or golf and you have the ingredients of a truly exceptional man.

He endured his prolonged illness with characteristic fortitude and faith. The physical and mental support received from his family as they joined the struggle, was unmatched. My friend was humble, inspirational, always caring and will be remembered fondly by us all.

Frank Moloney

Dr. Ronald Wellesley Greville

Australian Capital Territory – FFARACS 1956, FANZCA 1992

Dr Ray Cook obtained the following obituary for Dr Greville, prepared by Dr John Donovan from information supplied by Sir William Refshauge, Mr Kevin O'Brien, and Mr Tony Greville.

Dr Ron Greville, who died on 9 June 2001 in Canberra aged 88, was born in Sydney in 1912 and educated at Cleveland Street High School, which he left early to work in a local pharmacy – experience that he carried with him all his life. He returned to study at the North Sydney Boys High School and the University of Sydney, where he graduated in Veterinary Science in 1936. Following a year as the House Surgeon at the Veterinary School, Ron moved to Townsville as a veterinary officer with the Queensland Department of Agriculture animal health laboratory. Later in 1937 he commenced work as the veterinary surgeon at the Lort-Smith Animal Welfare League Hospital in Melbourne. It was here that Ron met Nan Mellor; they married in January 1939.

In 1940 he enlisted, serving as Officer Commanding 2/5 Field Hygiene Section in Malaya until he was captured in 1942. He was a prisoner of war on the Burma – Siam Railway for 3½ years.

After the war Ron studied Medicine at the University of Melbourne. He graduated in 1950 and did his residency year at the Royal Melbourne Hospital. In 1951 he commenced worked as a GP, with an interest in anaesthesia, in the Moonee Ponds/Essendon area of Melbourne. He started worked as a Specialist Anaesthetist in 1954, gaining his Diploma in Anaesthetics in 1955, Membership of the College in 1956, and Fellowship in 1957. During this time he also served as an anaesthetist in the RAAF Medical Reserve.

From 1958 to 1960 Ron was medical consultant to the Commonwealth Serum Laboratories in Melbourne. Then he moved into medical administration. He was Medical Superintendent of the Geelong and District Hospital from 1960 to 1961, when he returned to the Commonwealth Serum Laboratories as Director, a post he held until 1965. His own notes record "It was during this period that a steering committee of which I was a member was formed in Melbourne to consider setting up a college or association of medical administration. I was a member of the foundation council of the Australian College of Medical Administrators."

Ron's appointment as Director coincided with the formation of the Commonwealth Serum Laboratories Commission. The transition period was difficult, and that the Laboratories enhanced their reputation during this period of change was largely due to his efforts. His service to the laboratories was recognised during their 60th anniversary celebrations in 1978, when the Animal Vaccine Laboratory was named in his honour.

From 1966 to 1967 he served as First Assistant Director-General, Laboratory Services and Quarantine Division, in the Commonwealth Department of Health. He brought to that post invaluable experience as a veterinary surgeon, as a medical scientist, and as an administrator. It is a tribute to his vision that during this appointment much was done to consolidate quarantine procedures.

In 1968 Ron was appointed Secretary of the National Health and Medical Research Council. In four years in this post he helped to consolidate and increase the Commonwealth's support for medical research. In particular he played a significant role in funding of research institutes such as the Walter and Eliza Hall Institute in Melbourne.
In 1972 he was appointed Senior Medical Officer at Australia House in London. For five years he had responsibility for medical matters associated with Australia's immigration policy in the UK. Ron returned to Australia in 1977 and retired from the Commonwealth Department of Health. From then until 1982 he was the Medical Director of the Australian Kidney Foundation, again giving outstanding service. He also served on the Social Security Appeals Tribunal in Canberra from 1981 to 1983.

Ron's life was characterised by a strong determination to improve himself and his understanding of the world. He had a fascination with recent discoveries in medical science and he continued to read in this area. His approach to understanding was both analytical and objective, a characteristic observed by many who worked with him. However, a major thread through Ron's life, both professional and private was his sense of social justice and his need to contribute by way of public service, much of which was through the health system. He was also an active member of Legacy over many years. Through his example he imbued in his family both tolerance of others and a love of words.

Nan Greville died in Canberra on 25 April 2001. They are survived by their four children, to whom we extend our sympathy.

Dr. Christopher Gordon Reid

Western Australia – FANZCA 1999

The Anaesthetic community of Western Australia has been deeply saddened by the tragic death of Dr Christopher Gordon Reid.

Christopher was born and educated in Auckland, New Zealand, where he was an excellent student, and a first class sportsman. During his medical student days he spent a year playing professional cricket in Middlesex in England, and he traveled widely through Europe, Asia and Africa before coming to Perth in 1990 as an intern at Royal Perth Hospital. He joined the Western Australian rotational teaching program in Anaesthesia in 1993, passed his Primary Examination in 1994, and completed his Examinations in 1997. He went on to become a capable and caring paediatric anaesthetist at Princess Margaret Hospital for Children.

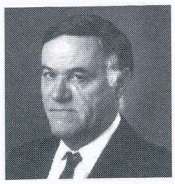
Chris was dedicated and enthusiastic about his chosen field quickly developing an interest in the management of pain in children. He was awarded the Boots Young Investigator Prize for research he performed in this field. He was one of only a small number of paediatric pain specialists in the country having successfully passed his Faculty of Pain Medicine exams last year. He was developing with enthusiasm a Pain Service for children with chronic pain conditions at PMH which was immensely appreciated by his patients, their parents and his colleagues. He was keen to promote the use of epidural infusions for pain relief in neonates and was organising a multi centre study to assess its effectiveness.

Chris Reid's dedication and enthusiasm will be missed by all at PMH. He will be sadly missed by all who knew him. We extend our sincere sympathy to his family and close friends.

Ric Bergesio

Dr James Loughman

A Tribute: to Dr Jim Loughman, FFARACS and Dr John Mainland, FANZCA



Dr John Mainland

THEIR PROMOTION OF RESIDUAL CURRENT DEVICES IN THE INTERESTS OF ELECTRICAL SAFETY IN AUSTRALIA OF THE 1970'S

John Williamson, DA(Melb.), FANZCA

Jim Loughman died in 1992,[1] John Mainland in 1999,[2] each from carcinoma. This brief account of some events involving these notable Australian anaesthetists is told with the approval and the kind assistance of their respective families, as well as of one or two of their colleagues. It is an indication the courage, initiative (and humour!) of these two innovators. It also illustrates just how far ahead of their time they and in particular one of their biomedical engineering colleagues were in the 1970's, in the matter of electrical safety in this country.

The events herein recounted have been known only to a few colleagues and to the families of the two men. With the passage of time such events run the risk of being forgotten, so I am moved to place them on record. While the accuracy of what follows is the result of my best efforts from consulting the few remaining persons who were directly involved, further details could now only be verified by Jim and John themselves. The comments of any reader in possession of more accurate information would be warmly welcomed.

The College of Surgeons and Faculty of Anaesthetists Seminars

In the early 1970's the Royal Australasian College of Surgeons with the then associated Faculty of Anaesthetists, convened two significant Seminars in Melbourne, one in 1971 on *Safety in the Operating Theatre* [3] and another in 1973 on *Occupational Injuries*.[4] John Mainland took a prominent role in the 1971 Seminar submission, addressing "Theatre Design" (Chairperson, Dr Ross Holland).[5] Jim Loughman contributed his valuable advice from behind the scenes to myself, concerning, among other matters, the value of a "Residual Current Device" ("RCD") (known at that time as an "Earth Leakage Core Balance" device or "ELCB"), for inclusion in the submission "Electrical Equipment – Fires and Explosions" (Chairperson, Dr Tess Brophy).[6]

However it was during the *Occupational Injuries* Seminar submission on "Electrocution"[7] that Jim, with the support of his two co-authors, John Mainland and myself, advanced compelling arguments for the adoption in Australian homes and industry of the still unfamiliar (then) ELCB device. This relatively simple device, he said, correctly installed and functioning, would make external accidental electrocution (i.e electrocution through intact human skin) from 240 Volts (V), 50 Hertz (Hz) alternating current (AC) mains supplies, much less common in Australia.. The data presented in our submission clearly indicated the serious and on-going frequency of accidental fatal domestic and occupational electrocutions in Australia at that time.[7]

A brief history of Residual Current Devices (RCD's)

Earth leakage detectors had been trialed previous to the 1970's, but were never accepted due to the high incidence of "false alarms" (i.e their low specificity). These detectors measured current leakage directly in the earth (ground) wire of installations, and were subject to numerous problems. A later invention measured earth leakage *indirectly*, by the process of algebraic addition of the directionally opposite active and neutral currents.

Under ideal circumstances (i.e. no leakage), all active current entering an appliance will exit it via the neutral wire. In the case of an appliance with leakage, the active and neutral currents will not be quantitatively the same due to some of the active current leaking via the earth wire. The later invention utilised this phenomenon by detecting the difference between active and neutral currents, the difference being the earth leakage.

These later devices were known as "Core Balance" devices owing to the technology employed (using a balanced toroidal transformer as the detecting device). Such an arrangement could reduce nuisance tripping to negligible levels and also facilitated tripping threshold adjustment. An important aspect of the tripping mechanism in core balance devices is its response time within thousandths of a second - less time than it takes for a current to reach the human heart from the peripheral contact (e.g. hand) on the victim's body. These basic design features are still to be found in today's devices.

The original terminology ("Core Balance", "Earth Leakage", "Circuit Breaker") underwent a number of iterations over time. The present technical term used to describe these devices is "Residual Current Device" or "RCD". However the same device is more popularly known, and promoted, as a "Safety Switch". In the account that follows, I shall retain the historical term "ELCB" in the interest of contemporary authenticity.

Public reaction to the suggested introduction of the "ELCB's" in 1973

Perhaps not surprisingly, Jim, John and their supporters (a handful of biomedical engineers and medical colleagues) immediately met with the resistance of mainstream electrical engineers, upon grounds which never became clear to any of us (*"The good doctors should stick to medicine"*!). Jim and his biomedical engineering colleague and biomedical co-worker in this field, Alex Watson, had earlier published a seminal paper concerning electrical safety in Australian hospitals,[8] and not long prior to the *Occupational Injuries* Seminar, Jim had appeared in Sydney newspapers extolling the virtues and desirability of ELCB's. So the mainstream engineers were well primed to react by the time the Seminar details were made public.

John's and Jim 's different approaches

John in Melbourne, continued quietly but firmly to counter objections to ELCB's with data, fact and reason, at the same

time explaining their limitations. Jim, supported by Alex, did the same for a while in Sydney (Figure 3), as the two anaesthetists, John and Jim, collaborated by phone. Eventually the ebullient Jim could take the various "illogical objections" no longer. In close consultation with Alex Watson, he arranged to conduct a potentially dangerous, live (sic!) demonstration on Sydney television, of the effectiveness of the ELCB in preventing electrocution – with himself as the potential 'victim'! John in Melbourne was concerned and counselled Jim not to do this, but if he was determined, to take every possible precaution. This of course Jim agreed to do, having the services of an electrical engineer from the company marketing the ELCB's of that time. But more importantly, also off-camera and in close consultation was his expert colleague Alex Watson from his Hospital's Department of Biomedical Engineering. (This collaboration is not to be confused with Jim's and Alex's other "close collaboration" in a well known [at least amongst medical persons] Sydney jazz group of that time!)

Jim Loughman's television demonstration of ELCB effectiveness This pre-recorded demonstration in Sydney was destined for a *Current Affairs* television programme! During its filming – and while John waited anxiously in Melbourne - a series of events ensued, some of which were related personally by Jim to myself some months later. However the most accurate and important "details" come from Alex Watson himself, as an active participant!

It was well established at that time that the risk of human ventricular fibrillation from 240 V, 50 Hz AC external electrocution occurred with currents as low as 100 milliamps (mA). Alex having settled on a safe trip current for the ELCB of 20mA for the demonstration, the correct function of the device was carefully checked prior to filming. With Alex (as well as the manufacturer's engineer) in close attendance off camera, Jim was first interviewed; Jim then voluntarily touched the "live wire", while the TV camera and sound track whirled.

The ELCB tripped and Jim reacted but leapt inadvertently backwards out of camera range! Nothing for it but to repeat the demonstration, said the camera crew! So Jim lined up again! This time, the crew pleaded, don't jump back! Jim and Alex did it again, Jim stayed resolutely in camera view, but this time, again at the critical moment exclaimed involuntarily, but most audibly, "*Shit*!"!

Incredibly a third demonstration was finally, safely and satisfactorily conducted (again sic!). How's that for guts, I hear you say? Now read on.

Neither Jim, John nor Alex had come down with the last shower, especially where electrical safety and its relative unpredictability were concerned! They also knew well as practising professionals, "All demon-strations are doomed to failure"! Let Alex tell the story: "*What nobody knows is that Jim never received that shock! We were not that confident ourselves at that time, although the figures (for ELCB effectiveness) were there. ...I rigged the demonstration so that as Jim got the 'shock' and feigned reaction, I secretly triggered the device which dutifully went off at the same time. The rest is history.*"

So Jim and Alex exhibited that good sense and wisdom that comes with expertise and experience. John, 'in the know' in Melbourne, contacted Jim afterwards and was reassured that 'all went well'! Subsequently, the impact of that 'demonstration', together with the continued persuasions of Jim, John and Alex, flowed on more than effectively around the country - although it took another few years for electricians and legislation to catch up. Nowadays, ELCB's, better known as "Safety Switches", are installed in the majority of Australian homes and factories, and are an accepted, and in many places a legislated safety measure. Few people now know the seminal role played in this advance by Jim, Alex and John.

Many colleagues will recall that John Mainland went on to co-author a pioneering text with Professor Hugh Dudley,[9] and to occupy an influential role in Medical Safety Standards (and a contribution to NASA space technology[2]). Jim and Alex Watson, in a subsequent and brilliant Australian study with a surgical colleague, settled the raging international debate that prevailed at that time (the "epidemic that never happened"!) concerning safe thresholds for the human heart from *internal* electrocution (i.e. microamperes [mA] of current reaching the myocardium inadvertently via invasive lines).[10]

Jim Loughman soon after became one of the distinguished international pioneers in the clinical development and application of cardiac pacemaker technology. We miss them both and thank them for sharing their lives and talents with us all. Alex continues his innovative teaching and research contributions (especially as a Visiting Consultant in Papua New Guinea), as the long-serving Director of Biomedical Engineering at his major Australian hospital.

Acknowledgments

I am particularly grateful to Jim's wife, Mrs Pam Loughman, for her non-stop support and interest in this project. I also thank her daughter Elizabeth, and Dr Ed Loughman of Sydney. Keith Daniel of Sydney was helpful and Dr Noel Cass was encouraging. My gratitude goes especially also to John's wife, Mrs Jill Mainland, and his anaesthetist daughter, Dr Phoebe Mainland, FANZCA, and to both the Loughman and the Mainland families for providing the photographs and for permission to report this story.

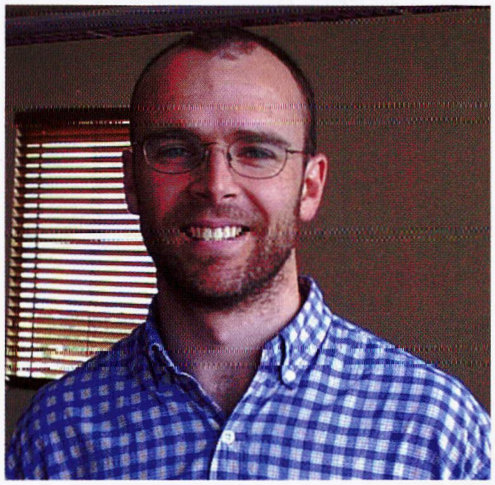
Extensive efforts were made in National and State Libraries and through newspaper offices, to locate the origin of the photograph in Figure 3, without success. The author apologises for not being able to provide a credit for its source, and would respectfully invite any reader with that information to contact him.

However it is to Alex Watson must go my very special thanks. Alex not only contributed powerfully to this account as an eye witness and reviewed the manuscript (declining to be a co-author), but he himself played a pivotal role in the described events. I thank him also for allowing them to be published. Australia is also in his debt for his pioneering and distinguished contributions to medical and domestic electrical safety and understanding in this country and beyond. I know John and Jim would have want that said.

For references refer to page 74

Who Wants To Be A Millionaire?

GREGG BEST
ANAESTHETIC REGISTRAR, LAUNCESTON GENERAL HOSPITAL



Dr Gregg Best

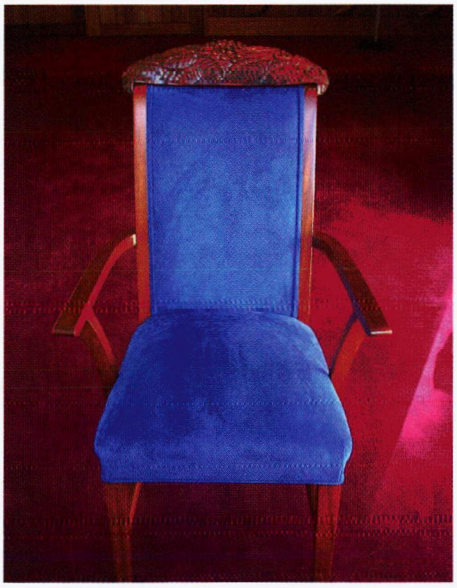
Who wants to be a millionaire? I'm sure the short answer is – everybody, my wife Carla included. So after months of watching me watch the television show, she registered our phone number on their database. Carla only made five or six calls so its easy to imagine our shock and jubilation at receiving a phone call from the show.

Initially the aspect I was most worried about was the dreaded wave. Four very long seconds of looking very silly on national TV. The "Fastest Finger First" part I found the most stressful. Thank goodness candidates don't have to answer that quickly in exams. I managed to scrape in just at the end of the show. Talk about palpitations. Sitting in the hot seat answering questions asked by Eddie is mostly about luck. If you are lucky, they ask questions to which you know the answers. In that respect I feel I was pretty lucky when I returned the following week.

One of the most pleasing aspects I found about the show appearance (aside from winning $125,000) was the way it affected the people around me. The excitement and enthusiasm shown by friends, family and work-mates was almost palpable. It also seemed to capture the attention of the greater Launceston community. With only a small handful of Tasmanians having appeared on the show, people seemed impressed that a guy from Launceston could make it onto "Who Wants To Be A Millionaire".

After a couple of exciting weeks, life has pretty much returned to normal. Back to work and back into study for the primary. In that respect I feel the show has helped me in a small way. If there is a question in the exam about Haydn, now I should get it right.

Amagnificent plate designed and created by distinguished glass artist Lisa Bush.



Chair presented to Dr David Chamley on behalf of the New Zealand Society of Anaesthetists. The shoulder of the Chair has a wooden carving depicting the Silver Fern (New Zealand) and Golden Wattle (Australia).

Dr Tub Worthley (right) and Mrs Janine Worthley with Mrs Lala Oh, Professor Teik Oh (President) and Dr Felicity Hawker (Dean, Faculty of Intensive Care) following presentation of a College Citation to Dr Worthley.

Professor Oh receiving a presentation of a glass plate (see page 44) from Dr Ian and Mrs Mary Rechtman.

COUNCIL 2001

Back L to R: *Dr Diane Khursandi, Professor John Gibbs, Drs Walter Thompson, Tony Weeks, Leona Wilson and Mrs Joan Sheales, CEO.*
Front L to R: *Drs Michael Martyn, Steuart Henderson, Felicity Hawker (Dean, Faculty of Intensive Care), Professor Teik Oh (Predident), Dr Richard Willis, Professor Michael Cousins (Dean, Faculty of Pain Medicine).*

ANZCA Workforce Questionnaire 2000

SUMMARY

Introduction

In December 1999, a workforce questionnaire was sent out with annual subscription notices to all Fellows of the Australian and New Zealand College of Anaesthetists. The response rate was 60.5 %. (The response rate to the 1994 ANZCA Workforce Survey was 63%).

The data has so far been analysed in four geographical regions; Australia, New Zealand, Eastern Asia (Hong Kong, Singapore and Malaysia) and other countries. A detailed report of results from Australian Fellows has already been published in the Bulletin.

Further reports will be compiled on male and female Fellows, regional and rural Fellows, as well as Intensivists and Pain Medicine practitioners.

The following report includes all respondents to the Workforce 2000 survey in active practice.

Gender

The ratio of male to female respondents was fairly consistent across the regions, with Asia (99 respondents) having the highest percentage of female respondents (30% female and 70% male). In Australia (1386 respondents) the percentage of male respondents was 80.6% and female 19.4%. New Zealand (214 respondents) had 80% male and 20% female respondents. The other countries (46 respondents) had 82% male and 18% female respondents.

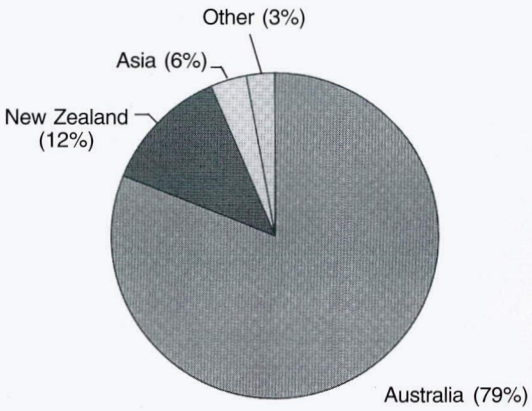
Age

No respondent was younger than 30 and only a few were older than 70. The majority of respondents fell into the 40-49 year age bracket. The average age of Australian respondents was 47.4 years. Of New Zealand respondents the average age was 48.3 years. Asian respondents had an average age of 46.2 years; respondents from other countries had an average age of 48.2 years.

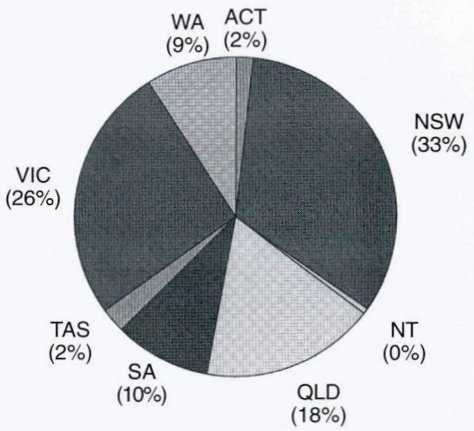
Country of Practice

The majority of respondents live in Australia. As the geographical spread of respondents is consistent with ANZCA records, responses are likely to be representative of the views and work patterns of active ANZCA Fellows.

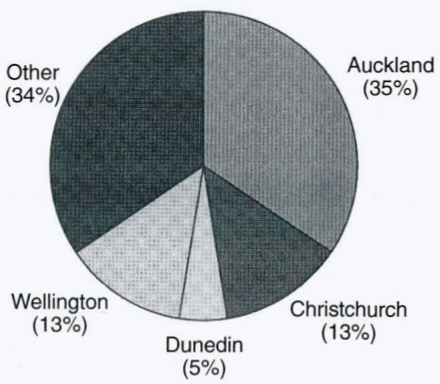
Respondents by Region



Distribution in Australia

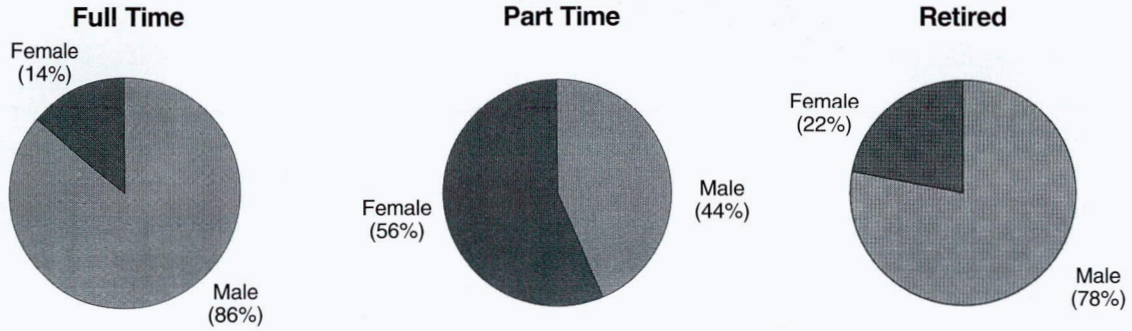


Distribution in New Zealand



Work Practices

83.5% of respondents worked full time, 14.5% part time, and almost 2% were retired.



Hours Worked

	All Fellows (1740)	Females (349)	Males (1391)	Rural by hospital type (403)	Fellows doing private work (1343)	Fellows doing public work (1458)	Fellows working full time (1455)	Fellows working part time (255)	Intensive Care Fellows (144)	Pain Medicine Fellows (42)
On Call	28.9	22.4	30.5	32.4	29.0	29.3	30.5	14.7	51.2	22.6
After Hours	10.6	8.5	11.1	10.4	10.6	9.8	11.1	4.3	13.9	8.1
Weeks/yr	45.9	45.8	46.1	45.8	46.3	46.0	45.3	43.7	46.7	46.1

Sessions per week

	All Fellows (1740)	Females (349)	Males (1391)	Rural by hospital type (403)	Fellows doing private work (1343)	Fellows doing public work (1458)	Fellows working full time (1455)	Fellows working part time (255)	FFICANZCA (144)	FFPMANZCA (42)
Private Clinical	4.8	3.7	5.0	4.7	4.8	4.2	5.0	3.3	4.0	3.0
Public Clinical	4.7	4.8	4.7	4.6	4.1	4.7	4.9	3.7	5.8	6.1
Anaesthesia	7.1	6.3	7.2	7.3	7.5	7.1	7.1	5.2	4.5	4.6
Pain Medicine	2.8	2.9	2.7	2.3	2.8	2.6	2.8	2.5	2.6	4.5
Intensive Care	4.2	4.6	4.2	2.8	3.8	3.7	4.3	3.3	6.1	1.7
Preoperative Assessment	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.3	1.2	1.0
University/ Postgraduate	1.9	1.6	2.0	1.4	1.6	1.8	1.8	3.0	1.9	1.8
Administration	1.7	1.5	1.7	1.5	1.5	1.7	1.7	1.3	2.0	1.5
Other Professional Duties	1.4	1.4	1.4	1.2	1.3	1.4	1.3	1.8	1.8	1.4

Numbers of Anaesthetists

The majority of respondents (68%) believed that there were about the right number of anaesthetists in practice. 20% believed there were too few, and 12% believed there were too many.

Satisfaction with current workload

66% of respondents were satisfied with their current workload. 7% would prefer a little more work and 1% would like much more work. 24% would like a little less work and 2% would like a lot less work.

Summary

The ANZCA Workforce 2000 survey generated a reasonable response rate (60%); there was disappointingly no improvement in the response rate compared with the 1994 survey, although much useful data has been obtained. This data will be added to that from subsequent surveys to give trends in the anaesthesia workforce. The data can be used by both ANZCA and government bodies to improve the match of supply to demand for specialist anaesthesia services. The next survey will be sent out with the subscription notices for 2002.

We encourage all Fellows to return each survey to help us obtain a continuing picture of the anaesthesia workforce.

If you have any questions relating to workforce matters please contact Dr Diana C Strange Khursandi, (Chair, ANZCA Workforce Committee) via the College.

Special Interest Groups Annual Reports

Rural

Executive Members:

Dr Daryl Catt, (SA)
Dr John Henshaw, (Tas)
Dr Di Khursandi, (Qld)
Dr David Kinchington, (ACT)
Dr Wilson Lim, (WA)
Dr Mike Miller, (New Zealand)
Dr Frank Moloney, (NSW)
Dr Mark Tuck, (Vic)

The issues facing rural practice have been discussed a number of times by the SIG Executive. Unfortunately there has been little resolution of the main issues.

There continues to be significant shortages of specialist anaesthetists in rural areas; this is especially profound in New South Wales and Queensland. There are multi-factorial reasons for these shortages. ANZCA has responded to the Australian Medical Workforce recommendations by increasing trainee numbers, however the increase seems unlikely to satisfy workplace demand in the rural areas.

NSW and other areas are now also facing particular staffing difficulties due to changes relating to GP Anaesthetists (GPAs). GPAs are facing enormous increases in medical defence costs. They are also being required by the NSW Medical Board to participate in a MOPS program to maintain medical registration.

The Joint Consultative Committee on Anaesthesia (JCCA), of which ANZCA is a member, has determined that the ANZCA Maintenance of Professional Standards (MOPS) program is the most suitable vehicle to ensure MOPS for GPAs. The cost to non-ANZCA Fellows for the MOPS program is $500.

These changes, together with the increases in the cost of indemnity premiums, have created significant difficulties for GPAs who provide much needed Anaesthesia services in non-metropolitan areas deficient in specialist anaesthetists. The provision of their essential service in small rural centers may be financially non-viable. Many are considering their future in anaesthesia. Given the already critical shortages of anaesthetists in some rural areas, the retirement of GPA's will be devastating.

The JCCA continues to facilitate training of GPAs, as well as placement of locums in a number of rural areas.

Because the last ANZCA ASM was in Hong Kong, the Rural SIG did not participate in a presentation or workshop. In the forthcoming ASM in Brisbane the SIG hopes to have a Workshop based on the continuing Crisis in Rural Practice. It is hoped that there will be input from relevant Heath Departments.

The Rural Anaesthesia Recruitment Service (RARS) needs to increase its "Recruit" pool, and has plans to streamline its processes to make it easier for potential employers. There are also plans for the College to establish a recruitment service in New Zealand, and offer a recruitment service to rural Intensivists.

I have been fortunate to be Chairman of the SIG for one year under the previous Constitution and for three years under the current Constitution and am appropriately required to retire. I would like to thank all the members of the SIG Executive for their support and assistance. Individually they are also involved in many other important areas of College affairs. Dr Mark Tuck will be the next Chairman. I wish him well and join with the other members of the Executive to offer him support. I would also like to thank Ms Helen Morris at ANZCA for her dedication to Rural SIG affairs.

DARYL CATT
Chairman

Obstetric Anaesthesia

During the period of July 2000- June 2001 the interim Executive Committee (Drs Alison Lilley and Andrew Ross (Melbourne), Dr Scott Simmons (Adelaide), Drs David Crooke, Stephen Gatt and David Elliot (Sydney), Dr Graham Sharpe (Wellington), Dr Richard French (Christchurch) and Dr Michael Paech (Perth), and a small group of other interested members, corresponded about a number of matters.

Meetings of the OA SIG were held in conjunction with the ASA Congress in Perth in October 2000 and the ANZCA / Hong Kong College meeting in Hong Kong in May 2001.

The call for nominations for a duly elected Executive Committee (for 3 years) was made in early 2001 and a ballot held in mid-year. Due to problems related to adequate notification time for members it was not possible to complete the poll before the Hong Kong OA SIG meeting. However, an elected Executive was determined on 27th June 2001 and the declaration of the poll will be made at the OA SIG Annual General Meeting to be held during the ASA National Scientific Congress in Canberra in October 2001. Thereafter formal meetings and

teleconferences will commence. The 9 elected members of the Executive have the capacity to co-opt 2 non-voting members and with time it is hoped that a fair representation of all regions will be achieved.

Continuing education has been a prominent initiative of the SIG this year and enjoyable and successful plenary sessions were held at the Perth ASA conference and the Hong Kong / ANZA conference. My thanks to colleagues involved in the organization of these sessions. The SIG has received offers from Scientific Convenors of involvement in forthcoming national conferences through until May 2003. These are being addressed. A firm commitment was made to organize a SIG plenary session at the Brisbane ANZCA Scientific Meeting in May 2002. Professor Joanne Douglas from Vancouver, Canada has been invited as the ASM International Anaesthesia Speaker and we are delighted to take the opportunity to have her participate in our session, as a keynote speaker and panelist. This session will cover several topics, provide ample time for discussion, and be consistent with the meeting theme of "the Challenge of Change".

Potential activities of the SIG with respect to Web-site development and audit were deferred until an Executive was elected. As a method of determining and prioritizing activities and spheres of interest of members, a survey of the SIG membership is planned and in development. The potential for SIG links with similar groups in the Asia-Oceanic region is high. I would like to thank Helen Morris of ANZCA for her continued help with administrative matters and to invite comment from members as to the future direction of the group.

MICHAEL PAECH
Acting Chairman

Day Care Anaesthesia

Executive:
The Day Care Anaesthesia SIG Executive has had a number of changes of personnel over the last 12 months. Dr Steve Watts (WA) has inherited the Chairman's role from Dr David Kinchington, who stays on as ACT representative. Dr Hugh Spencer has retired as the NZ representative after many years of dedicated service to the SIG. His contribution is acknowledged and warmly appreciated. Dr Joe Novella (Vic) has also left the Executive in order to concentrate his time on Virtual Congress duties. Their places have been taken by Drs Carolyn Fowler (NZ) and Rowan Thomas (Vic). The remainder of the Executive comprises Drs Colleen Kane (NSW), Michael Fong (Qld), Ruth Matters (Tas), Robin Limb (SA) and Andrew Bacon (ADSC).

Sedation Guidelines:
The Executive has been actively involved in a number of documents relating to safe sedation practice. ANZCA policy PS9 (Guidelines on Sedation for Diagnostic and Surgical Procedures) was promulgated in November and is an amalgamation of a number of previous College policy documents relating to sedation. In addition, the Executive provided comment to both the Australian Day Surgery Council and the Health Department of WA with respect to standards for office-based procedures. Emphasis was placed on the requirement for adequate patient assessment, minimum monitoring standards and the ability to effectively manage potential complications.

Continuing Education:
The SIG remains committed to the advancement of quality in the provision of Day Care Anaesthesia. The SIG Executive continues to provide input and support to the Day Care sessions at the major scientific meetings. A stimulating program targeting problems associated with setting-up and running a day surgery service was prepared for the Hong Kong ASM in May this year. The SIG expresses its gratitude to all those who contributed to making the session a success.

Professor Frances Chung (Canada) is a keynote speaker at the forthcoming ASA National Scientific Congress. She is widely published on issues related to Day Care Anaesthesia and will be speaking on new developments in ambulatory anaesthesia.

The SIG holds a single-theme meeting as a satellite to the College ASM every second year. The next meeting is planned for Brisbane on Friday 10 May 2002 (immediately preceding the main meeting). Invited speakers are Professor Kari Korttila (Finland) and Dr Greg Wotherspoon (NSW). The theme is "Setting the Standard" with the emphasis on best-practice in Day Care Anaesthesia. I urge you to attend what promises to be a valuable CME meeting.

Hornabrook Prize:
This prize was established in 1999 to recognize and encourage original research in aspects of ambulatory surgery and anaesthesia. The 2000 winner is Dr Bernard Lee (Perth) for his paper entitled "Effect of Anaesthetic Technique on PONV after Day Case Laparoscopy" presented at the ASA NSC in Perth last year. To be eligible for this award suitable papers must be presented at a major Australian or NZ scientific meeting. Applications for papers to be considered for this award are available via the ANZCA SIG secretariat (helen@anzca.edu.au)

Day Care Anaesthesia PFY:
In response to interest from trainees, the SIG has been exploring the issue of placements for post-fellowship registrars interested

in furthering their Day Care experience. Fellowships in Ambulatory Anaesthesia are available at some overseas institutions and we are in the process of investigating the possibility of providing similar experience in Australasia. Dr Carolyn Fowler is coordinating this project and will be contacting various institutions in our region to determine which ones may be able to support a Day Care PFY position. Your cooperation with this survey will be greatly appreciated.

Communication:

The Executive appreciates that a requirement to improve communication with members of the SIG and Fellows is a priority. There are a number of issues that arise each year where feedback from the "members at large" would be of importance in deciding on a stance for the SIG to adopt. Likewise the SIG members are a significant clinical experience resource that could be better utilized when preparing regional and national scientific meetings. We are attempting to resolve these issues by promoting the use of the SIG website as an information source, with regular updates from the Executive and the facility to contribute to discussion via the SIG secretariat. We look forward to the further development of these initiatives.

The AGM for the Day Care Anaesthesia SIG was scheduled during the Canberra NSC in October.

STEVE WATTS
Chairman

Diving and Hyperbaric Medicine

Executive Members:

Dr Chris Acott (SA)
Dr Mike Bennett (NSW)
Dr Mike Davis (NZ)
Dr David Griffiths (QLD)
Dr John Knight (VIC)
Dr Brian Spain (NT)
Dr Margaret Walker (TAS)
Dr David Wilkinson (SA)
Dr Robert Wong (WA - Chairman)

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

Dr Mike Davis who has served the SIG since its inception and contributed greatly has resigned from the Executive but remains an active member of the SIG. His replacement is Dr Alistair Gibson.

Formal Qualification in Hyperbaric Medicine

Currently, there is no formal qualification in this specialty. Through the initiatives of the SIG and ANZHMG, formal training courses have been established (*vide infra*). In contrast to any other medical disciplines, hyperbaric medicine is distinctly different in scope and dimensions. It crosses the boundaries of a number of medical specialties, but no undergraduate or post-graduate teaching is generally available. Most medical practitioners are not exposed to the area and are not acquainted with the use of hyperbaric oxygen therapy, its indications, contraindications, side effects and treatment end-points. Nonetheless, overseas countries in Europe and in the United States have established formal training courses and qualifications.

Members of the Executive have worked towards establishing a formal qualification in this specialty, which they feel is absolutely essential. Currently, with this aim, the group has formulated

1) Objectives of Training
2) A Training Syllabus

We anticipate that this should adequately satisfy the requirements of the Certificate of the College. The Chairman will be writing to the President and Council requesting their support for the award of such a certificate.

Diving & Hyperbaric Medicine Course

The second two-week full-time course was conducted at the Prince of Wales Hospital, Randwick in March, 2001 under the stewardship of Dr Mike Bennett. It was again well attended. The third course will be conducted at the Alfred Hospital in Melbourne on 25th February 2002, convened by Dr Ian Millar, Head of Hyperbaric Service at the Alfred Hospital.

Standards Australia

A number of Executive Members have served as Members of the SF/46 Committee of Standards Australia on "Non-diving Work in Compressed Air and Hyperbaric Treatment Facilities". The SIG members provided the medical expertise to formulate the Standards on tunneling work and hyperbaric treatment facilities. Members of this Committee, comprising of industry representatives such as engineers, tunneling work contractors, hyperbaric technicians and nurses, as well as WorkSafe representatives, unanimously agreed with the qualification

proposed by the SIG with respect to training and certification of hyperbaric physicians in this country. These are classified as Grade 1- Hyperbaric Medical Officers (trainees); Grade 2 - Hyperbaric Physicians (those with the Diploma of Diving & Hyperbaric Medicine awarded by SPUMS); Grade 3 - Senior Hyperbaric Physicians - those in possession of the ANZCA Certificate in Hyperbaric Medicine.

Expert Supporting Committee in Hyperbaric Medicine of the Medicare Services Advisory Committee (MSAC)
Members of the SIG Executive have assisted the MSAC in presenting scientific evidence in hyperbaric medicine to determine the medical conditions acceptable for management by hyperbaric oxygen therapy. The Committee however only accepted Levels I, II & III a & b evidence as relevant.

Appointments
Members of the SIG and its Executive have achieved a number of national and international appointments and awards.

The Undersea & Hyperbaric Medical Society (UHMS) has appointed the following SIG members to the various committees:
Oxygen Therapy Committee - Dr M Bennett
Education Committee – Dr M Bennett
Nominations Committee – Dr M Bennett
Scientific Committee - Dr S Mitchell
Adjunctive Treatments Committee - Dr S Mitchell
Diving Committee: Dr S Mitchell and Dr C Acott
Workshop Committee - Dr R Wong

Dr Chris Acott has been appointed to the Medical Advisory Committee of the *British Sub-aqua Club*.

Dr Ian Millar has been appointed as the Medical Advisor to the *Australian Divers Accreditation Scheme* (ADAS).

Dr Brian Spain has been appointed as the Director of Anaesthesia at the Royal Darwin Hospital.

Awards
"Albert Behnke Award" - the most prestigious award of the UHMS was presented to Dr Mike Bennett at the 2001 annual meeting in recognition of outstanding scientific contributions to advances in the hyperbaric biomedical field.

At the "Annual Neuroprotection in cardiac surgery conference", in Key West, USA" - Dr Simon Mitchell was presented with the "Outcomes 2000 Award" for the person who published the most influential papers in the world literature in the preceding twelve months.

Journals, Editorial Boards, book contributions and publications
Through the hard work of Dr John Knight, editor of SPUMS Journal, it has now been accepted for indexing as of 1 January 2001 by EMBASE, the Excerpta Medical database published by Elseiver Science.

Dr Simon Mitchell was appointed to the Editorial Board of the Journal of Extracorporeal Technology.

Dr Robert Wong was appointed to the Editorial Board of the Undersea & Hyperbaric Medicine Journal.

Dr S Mitchell and Dr R Wong have both contributed to chapters in the 5th edition of Bennett & Elliott's Physiology & Medicine of Diving, edited by T Neuman and A Brubakk.

Dr Robyn Walker is the new 4th co-author of the well known Australian Text book on diving medicine – the 5th edition of "Diving & Subaquatic Medicine" by Edmonds, Lowry, Pennefather and Walker.

Dr Chris Acott has contributed to the Australasian Anaesthesia in diving medicine – "How divers die".

Dr Robert Wong was the co-chairman and the co-editor of the UHMS Workshop in "empirical diving techniques of commercial sea harvesters" which was held in Vancouver. The Proceedings of the workshop was published in August 2001.

Various members have also contributed to a number of diving and hyperbaric medical articles.

Scientific Meetings
Members of the SIG have been active in attending scientific meetings and presented papers at the various national and international conferences. These were the meetings of the South Pacific Underwater Medicine Society (SPUMS), European Underwater & Baromedical Society (EUBS), Undersea & Hyperbaric Medical Society (UHMS), as well as the Australian Diving & Hyperbaric Medicine Meeting hosted by the Hyperbaric Technicians & Nurses Association (HTNA).

It is the intention of the SIG to have a session in Diving & Hyperbaric Medicine annually during the College ASM or the ASA NSC.

Dr Chris Acott was the guest speaker at the 1st National Abalone Divers Association Meeting held in Adelaide.

Retirement
Dr Ian Unsworth, the leading light and "grandfather" of hyperbaric medicine of this country, having contributed tirelessly to the specialty for over 30 years retired in July 2001. All members of the SIG wish him a long, happy and fulfilling retirement.

ROBERT M WONG
Chairman

Simulation and Skills Training

The inaugural Executive of the Simulation and Skills Training SIG comprises:

Dr Stephen Bignell (Qld)
Dr Brent Donovan (WA)
Dr Brendan Flanagan (Vic)
Dr Richard Morris (NSW)
A/Prof Kwok Fu Jacobus Ng (Hong Kong)
Dr Harry Owen (SA)
Dr Richard Riley (WA)
Dr Richard Waldron (Tas)
Dr Jennifer Weller (New Zealand)

Executive Members

Nominations for Executive positions took place earlier this year. Under the Constitution, subject to flexibility, this Executive aims to represent each state of Australia, the ACT, New Zealand and the Asia Pacific region. As the number of nominations of candidates for election to the Executive did not exceed the number of vacancies, the candidates so nominated were declared duly elected.

The role of this SIG is to discuss academic issues including assistance in the formulation of training syllabuses of Simulation and Skills Training courses; maintenance of standards, quality assurance, and research and teaching. Copies of the Special Interest Group's Constitution are available through the College.

During the past twelve months the SIG conducted its first Continuing Education Meeting in association with the ASA NSC 2000 in Perth, contributed to the May 2001 ASM program at the Combined Meeting in Hong Kong, and held its first AGM, also in Hong Kong.

Continuing Education Meeting: 2000

An inaugural meeting under the auspices of the SIG was held on September 29, 2000 in Perth, in conjunction with ASA 2000 National Scientific Congress. The daylong meeting had as its guest speaker Professor David Gaba, world pioneer in simulation and International Visitor at the NSC. The meeting consisted of contributions from each of the Simulation Centres in Australia and New Zealand. Session topics included: Simulation: Past and Future; Planning, Infrastructure and Economics; Human Performance Issues; and Broadening the Scope.

The meeting was convened by Dr Brent Donovan and was a great success. There were approximately 50 registrants who were treated to a series of excellent contributions from the speakers and the meeting showcased the then newly established Collaborative Training & Education Centre (CTEC) facility at the University of Western Australia. The meeting generated a surplus, the funds being available to support future SIG activities.

Hong Kong 2001 ASM Participation

A successful session was conducted on aspects relating to Simulation. Dr Brendan Flanagan spoke on Human Performance Issues, Dr Russell Jones gave a comprehensive Evaluation of the First Pilot EMAC Course, and Dr Wally Thompson delivered a paper on Debriefing: Lessons learned from Simulation. The session was well attended and generated some lively discussion.

Inaugural Annual General Meeting

The inaugural AGM of the SIG was also held during the ASM in Hong Kong. Attendance was understandably limited. Principle business involved election of the inaugural Executive of the SIG and update on progress of the Effective Management of Anaesthetic Crises (EMAC) Course.

In line with the SIG Constitution, it was noted that a Chairman will be elected by the Executive at its first meeting after 1 July. This meeting, by teleconference, occurred on September 11, 2001.

EMAC course

Although the development of this course does not fall directly under the responsibility of the SIG, it is the first evidence of the College's interest in formalising the prospect of simulation and skills based training. It has been developed with input from existing Simulation Centres. The Course is developing under the guidance of the College Courses Working Party, chaired by Wally Thompson, and is available to trainees as an alternative to the EMST course (see article in June 2001 *Bulletin*).

Future Meetings

Planning is underway to for the SIG to have a presence at the major upcoming meetings, namely the ASA NSC in Canberra in October 2001 and the ANZCA ASM in Brisbane in May 2002.

Concern has been expressed regarding the place of simulation workshops at these conferences - as at best such workshops represent an extremely simplified version of what is being offered at the Simulation Centres. After undertaking a brief simulation workshop at a conference, some participants perceived themselves to have completed a simulation "course". This matter requires further discussion by the Executive.

Membership

Enquiries regarding membership to the SIG can be made through Helen Morris at the College. Membership of this SIG is open to Fellows, and members of the ASA and NZSA. Fellows of other Colleges, practitioners and allied health professionals will also be encouraged to participate as Associate Members.

I would like to thank Helen Morris at ANZCA for her assistance in preparation of this report.

BRENDAN FLANAGAN
Acting Chairman

Welfare of Anaesthetists

Executive Members:

Dr Rob Burrell (New Zealand)
Dr Mary Cardosa (Malaysia)
Dr Margie Cowling (SA)
Dr Genevieve Goulding (NSW)
Dr Di Khursandi (Qld) (Chair)
Dr Phil Ogden (Tas)
Dr Lindy Roberts (WA)
Dr Jack Warhaft (Vic)

Since the founding of the Group in August 1995, we have filled an increasingly important and pro-active role in the area of doctors', and more particularly, anaesthetists', health. We are amongst the leaders in the field as far as Colleges are concerned, not only in our pro-active strategies, but in the breadth of our interests.

The USA has been another leader in the field of doctors' health, and there is fertile interchange of ideas in doctors' health issues between those working in this field in the United States and members of our Group. The anaesthetists in the UK are also very aware of the stresses of the job and have several publications with advice.

There are now regular international doctors' health conferences, and the AMA in Queensland is about to host the second *National Doctors' Health Conference* in Brisbane in November 2001, with input from several members of the SIG.

We also maintain close links with the Doctors Health Advisory Services in most states, as well as with those who are involved with health assessment activities in the State Medical Boards.

One of our Executive Members, Dr Jack Warhaft, is the inaugural Medical Director of the newly formed Victorian Doctors' Health Program.

We have had a session, workshop or talk on anaesthetists' health issues at nearly every national conference since 1995, and there have been many seminars and day meetings devoted to such topics; in nearly all these we have had the professional input of psychiatrists and/or psychologists. At the last meeting of the Group it was decided to make a formal approach to the College of Psychiatrists to establish an avenue for collaboration and consultation between their College and the Group.

The group is an educational body, but members are often approached for advice by an individual, or those concerned about another person. Legal advice has been obtained as to appropriate action in these circumstances: it is that members must make it clear that they are acting as private individuals when fielding enquiries. Suggestions as to the course of action of the enquirer are appropriate, but no counseling should be given. Facts of each contact should be documented, as well as the advice given with regard to avenues of help available.

An application for Quality Assurance legal status for the Group's activities is being sought.

The Welfare SIG Action Plans are being reviewed by the parent bodies to determine their status with regard to display on the parent bodies' websites. They have now been translated into Swedish for use in the department in Uppsala by Dr Torsten Gordh (jr) !

In the last year ANZCA has issued two new College Professional Documents relevant to doctors' health. One is Trainees With Difficulties (TE18), the other is the Statement on Fatigue and the Anaesthetist (PS43). Both documents have had a lengthy gestation and much consultation. The former may be helpful for those who have to deal with the occasional difficult trainee. The latter seems to have hit the intended "middle ground" as it goes much too far for some and not far enough for others !

A College Professional Document (a Statement on Welfare Issues and the Anaesthetist) is being developed, which will include mentoring. An extensive review of a document for the Supervisors of Training will include details of the process for trainees to assess the terms they undertake (in order to provide feedback to complete the training/learning loop).

Dr Phoebe Mainland, the WOAG Executive Member from Hong Kong has resigned from the Executive as she will be leaving to take up a post in the UK. I wish to record our thanks to Phoebe, for her work on behalf of the Group, and especially for organizing the Hong Kong ASM workshop in May – a stimulating session on anger management.

A replacement for Dr Mainland has not yet been nominated. If a member residing in Hong Kong would like to nominate/be nominated, please contact Helen Morris at ANZCA.

Dr Leona Wilson has also found that her increasing workload has meant she has less time and has resigned as the New Zealand representative of our Group. We would like to thank her too for her support and enthusiasm as the secretary of the Group. We welcome Dr Rob Burrell as her replacement.

I would like to thank all members of the Group, especially the Executive Members, for their continued support and interest.

Helen Morris has been enormously helpful to our Group from its inception and I would like to thank her again for all her enthusiasm and hard work.

If you have any queries, please do not hesitate to contact the chair or any Executive Member.

DI KHURSANDI
Chair

Dean's Message

Felicity Hawker

Establishment of the Joint Faculty of Intensive Care Medicine

After many meetings, much discussion, effort, controversy and hard work, I am delighted to advise the Joint Faculty will soon be established. In the 1970's and again in the 1980's attempts were made by the then Faculty of Anaesthetists, RACS and the RACP to form a common Training and Certification Program in Intensive Care. This proved to be impossible but thanks to the hard work and tenacity of our Fellowship, and the goodwill of the Colleges, it is now a reality.

Foundation Fellowship

An invitation to apply for Foundation Fellowship of the Joint Faculty of Intensive Care Medicine of the Australian and New Zealand College of Anaesthetists and the Royal Australasian College of Physicians is published in this edition of the Bulletin. By now all Fellows of the Faculty will also have received a letter inviting their application. A similar letter accompanied by the criteria for Foundation Fellowship has been sent to all ANZICS members inviting application from intensivists who meet these criteria. Invitations will also be published in the *RACP News* and *The Intensivist*, and posted on the Faculty, ANZCA and RACP websites. Applications close on January 31st 2002 and I urge you all to support this initiative. Although timing will be tight, I hope that Foundation Fellows will be admitted at the February Board Meeting.

Interim Board

The Interim Board of JFICM has been appointed by the Councils of both ANZCA and RACP. It is essentially the same as the current FICANZCA Board except that the two RACP coopted members, Ray Raper and Jonathan Gillis, will be full members with full voting rights. There will also be an additional member nominated by the RACP Council, Prof Napier Thomson. Its first meeting will be held in November and it is likely that the interim Board of JFICM will be appointed as the caretaker Board of FICANZCA until election of the inaugural Board of the Joint Faculty. Thereafter it is anticipated the elected Board will continue to govern FICANZCA until ANZCA Council deems it appropriate to terminate its existence.

Training Program

From the beginning of 2002, all trainees will be trainees of JFICM, supervised ultimately by the interim Board and then the elected Board. The training program for 2002 will be essentially the same as the current FICANZCA program. However it is hoped that a new training program will be introduced in the next few years. This program has been developed by the current FICANZCA Board and will be further refined by the interim Board of JFICM. It is likely to be divided into three basic training years and three advanced training years. The majority of trainees will undertake their basic training in either anaesthesia or medicine and then combine their advanced core training in intensive care with either anaesthesia or another medical specialty to obtain dual certification. However the training program will remain sufficiently flexible to allow combined training with other specialties such as Emergency Medicine or Surgery, or training in Intensive Care only. The Primary Examination remains a continuing source of discussion and it is likely the new Faculty will develop a specific examination for intensive care in the future.

The current FICANZCA Board has worked hard to ensure a smooth transition to the new body. It is now up to the intensive care specialists of Australia, New Zealand and Hong Kong, who meet the criteria listed in this edition of the Bulletin, to apply for Foundation Fellowship and demonstrate their support for this historic venture.

The Implications of "Oversight" for Anaesthetists Working in Intensive Care Units in New Zealand

As of the 1st of July 2001 the provisions of the Medical Practitioners Act 1995 for "oversight" have been a requirement for medical registration in New Zealand. Oversight created considerable anguish, anxiety, and confusion when attempts to interpret the requirements of the legislation for the intensive care setting were first made.

Vocational registration, a term that replaced specialist registration, permits doctors with appropriate specialist post-graduate qualifications in a recognized branch of medicine to practice independently. In New Zealand, Intensive Care Medicine only gained recognition as a vocational branch of medicine in 1999. At that time oversight legislation had already been passed, and there was some debate over the significantly overlapping boundaries of intensive care and anaesthesia.

Oversight involves an ongoing, supportive, educative and collegial relationship between two doctors, with benefits to both. Under the 1995 legislation the New Zealand Medical Council is required to assure the competency of registered medical practitioners. The concept of oversight was developed as a tool to help ensure that a doctor is practising competently, which in turn helps protect the public. There are also obvious professional benefits for a doctor in having a continuing collegial relationship with another doctor.

The "overseer" helps a doctor to an education and audit program, and supports the doctor as a colleague. Oversight is not supervision, although a supervisory role may be necessary in some circumstances.

Slightly more than one hundred doctors provide the senior medical staff cover for Intensive Care Units in New Zealand. With less than forty of these vocationally registered in intensive care medicine, the vast majority of the two dozen or so Intensive Care Units in the country would struggle to meet the staffing requirements for registration in intensive care if vocational registration was required for all.

Compounding this problem is the distribution of units. While two thirds of Australia's population is situated in cities of greater than one million people, less than one third of New Zealand's population live in cities of greater than 200,000. As a result the majority of Level one and Level two units provide the only intensive care services to geographically isolated population bases of about 100,000 people. This is in stark contrast to the dense population served by many of the metropolitan Level one and two units in Australia. This limits the ability of hospitals to share vocationally registered Intensivists. The closure of such units because of lack of vocationally registered intensive care staff was neither a practical nor politically acceptable solution.

The New Zealand National Committee, ANZCA, and the NZNC, FICANZCA, recommended to the Medical Council that the scope of anaesthesia practice may include "assistance with the management of patients in the intensive care unit", and that oversight should not be required for practitioners with vocational registration in anaesthesia who practise in intensive care within their individual capabilities.

However, the practice of medicine means more than just clinical work with patients. It embraces medical teachers, medical directorship, researchers and medical managers, in all contexts and practice situations. The New Zealand Committees also advised that the full range of responsibilities of a director of Intensive Care goes beyond the scope of the practice of anaesthesia." As medical directorship of an intensive care unit is practice in a vocational branch of medicine, either vocational registration or "oversight" should be required.

The New Zealand Medical Council has agreed that vocationally registered anaesthetists may work in intensive care without oversight so long as their re-certification programs included an intensive care component, with the following exceptions:

- anaesthetists working in Level Three ICUs should be under the oversight of vocationally registered intensivists;
- anaesthetists working as Directors of Level 1 and 2 ICUs should be under the oversight of vocationally registered intensivists.

The implications of this are that the Director of an Intensive Care Unit that does not hold vocational registration in intensive care medicine must develop an oversight relationship with a vocationally registered Intensive Care practitioner. The oversight should include attention to unit organization, audit and ongoing education, as well as the medical standards within the unit.

Medical practitioners requiring oversight in Level 3 units can have that provided by a vocationally registered colleague in the unit. All Intensive care medical practitioners need to be involved in a recertification program that includes Intensive Care (such as the FICANZCA MOPS Program).

Non-vocationally registered medical practitioners in Intensive care

For registered trainees enrolled in an approved vocational training program the requirements of that program will be all that is required for general oversight. The College and Faculty training posts meet such requirements.

Other medical practitioners without any vocational registration working in intensive care will require oversight. The New Zealand Medical Council requires them to work under the general oversight of a doctor who holds vocational registration in the same branch of medicine. Strictly applied this requires an overseer with vocational registration in intensive care medicine. Within the public hospital setting the supervision and assessment by a consultant is deemed to be sufficient oversight. Whether this oversight can or should be provided by another vocational branch is unclear and untested. Medical Officers of special scale holding senior medical officer posts will require oversight from an appropriately vocationally registered overseer.

Until recently, New Zealand public hospitals were required to compete commercially with each other. That environment discouraged any interactions between units. The oversight provisions, if successful, should help to develop two-way communication both between individual medical practitioners and between intensive care units.

Dr Ross Freebairn
Chairman,
New Zealand National Committee
Faculty of Intensive Care, ANZCA

Faculty of Intensive Care Board 2001-2002

Rear: *Ms C. Cunningham-Browne (Executive Officer), Drs J. Gillis, P.D. Thomas, R.L.S. Pascoe, R. Raper, P.V. van Heerden, G.F. Bishop, Mr A. Coghill (Administative Assistant)*

Front: Drs J.H. Havill, N.T. Matthews (Vice-Dean), F.H. Hawker (Dean). Prof T.E. Oh (President), Dr R.P. Lee

Faculty Of Intensive Care, Anzca

MEMBERSHIP OF COMMITTEES FOR 2001/2002

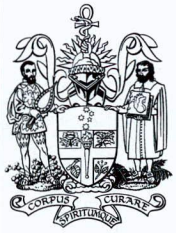
Fellowship Admissions Committee	
Dean	F.H. Hawker
Censor	N.T. Matthews
Chairman, Examinations	R.P. Lee
Fellowship Examination Committee	
Chairman	R.P. Lee
Deputy Chairman	P.T. Morley
	J. Tibballs
	S.A. Edlin
	J. Morgan
	J. Myburgh
	R. Young
Hospital Accreditation Committee	
Chair (Assistant Education Officer)	G.F. Bishop
Dean	F.H. Hawker
Education Officer	J.H. Havill
Censor	N.T. Matthews
Joint Specialist Advisory Committee - Intensive Care	
Dean	F.H. Hawker
Censor	N.T. Matthews
Education Officer	J.H. Havill
Chairman, Fellowship Examinations (as from Jan 02, P. Morley)	R.P. Lee
Rural Focus Group	
Chairman	D. Catt
	P.D. Cook
	A.R. Burrell
	A.D. Sutherland
	D.C.J. Wenck
	B. Power
	R.C. Freebairn
	G.J. McHugh
Working Party on Revision of FFICANZCA Training Program	
Dean	F.H. Hawker
Education Officer	J.H. Havill
Censor	N.T. Matthews
Chairman, Examinations	R.P. Lee

APPOINTMENTS TO EXTERNAL COMMITTEES AND ORGANISATIONS

Intensive Care Medical Liaison Committee	
Dean	F.H. Hawker
Censor	N.T. Matthews
Education Officer	J.H. Havill
Australian Casemix Clinical Committee	A. Holt
ACHS Clinical Indicators Working Party	M.J. O'Leary
	J. Tibballs
	G.K. Hart
Australasian Anaesthesia	B. Venkatesh
RACS Trauma Committee	D.J. Cooper
RACS CCrISP Committee	G.M. Clarke
Committee of Presidents of Medical Colleges	F.H. Hawker
Australians Donate	A.W. Duncan
CPMC Aboriginal Health Subcommittee	D. Stephens
ANZICS Safety and Quality Committee	M. Robertson
Medical Specialist Outreach Assistance Program	A. Sutherland

REPRESENTATION ON ANZCA COMMITTEES

Primary Examination Committee (as from Jan 02, P. Morley)	R.P. Lee
General Examinations Committee (as from Jan 02, P. Morley)	R.P. Lee
Education and Training Committee	J.H. Havill
Continuing Education & Quality Assurance Committee	J.H. Havill
Anaesthesia Continuing Education Co-ordinating Committee	J.H. Havill
ASM Committee	P.V. van Heerden
Communications Committee	R.L.S. Pascoe
House Committee	F.H. Hawker
Library Committee	R.P. Lee
Workforce Committee	F.H. Hawker
Constitution Review Committee	F.H. Hawker
Research Committee	A. Bersten
Salary Review Committee	F.H. Hawker
Asia Pacific Committee	P.D. Thomas
Information Technology Committee	M. Finnis
Board of Anaesthesia, Intensive Care & Pain Foundation	P.D. Thomas
New FANZCA Program Working Party	R.P. Lee
ANZCA/ACEM Liaison Committee	N.T. Matthews



Australian and New Zealand College of Anaesthetists

ABN 82 055 042 852

Foundation Fellowship of the Joint Faculty of Intensive Care Medicine

The Royal Australasian College of Physicians

ACN 000 039 047

The Joint Faculty of Intensive Care Medicine of the Australian and New Zealand College of Anaesthetists and the Royal Australasian College of Physicians will be formed early in 2002. It is expected that Foundation Fellows will be elected to Fellowship in February and that the first meeting of the inaugural elected Board will take place in June.

The criteria for Foundation Fellowship were determined by a working party consisting of members nominated by RACP and FICANZCA. The criteria are as follows:

1. FFICANZCA or FRACP (with two years training in intensive care accredited by SAC-IC SAC(P)/ CPPT or JSAC-IC).

2. Persons who commenced specialist training before 1989 or specific training in Intensive Care before 1995 and who have the qualifications FANZCA or FRACP when the applicant has:

   (a) spent two years in a training capacity in intensive care units (ICUs) approved by FICANZCA or the RACP (SAC-IC or SAC(P) / CPPT) for core training purposes, OR

   (b) practised as a specialist in ICUs approved by FICANZCA or the RACP (SAC-IC, or SAC(P) / CPPT) for core training purposes, full time for 5 years or more, or the sessional equivalent at 5/10ths or more over a longer period (example, full time for 5 years, 5/10ths for 10 years), OR

   (c) trained in intensive care outside of Australasia, provided that the training was equivalent in duration, structure and content, assessments and supervision to that required by the Australasian intensive care training bodies.

Persons who consider they meet the above criteria are invited to apply for Foundation Fellowship of the Joint Faculty of Intensive Care Medicine. Applications forms are available from:

The Executive Officer
Joint Faculty of Intensive Care Medicine
C/- ANZCA,
"Ulimaroa"
630 St Kilda Road
MELBOURNE VIC 3004

Ph: +61 3 9530 2861
Fax: +61 3 9530 2862
Email: ficanzca@anzca.edu.au

Applications close on 31st January 2002

Faculty Of Intensive Care

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

EXAMINATION CANDIDATES SUFFERING FROM ILLNESS, ACCIDENT OR DISABILITY

1. INTRODUCTION

The Fellowship examination process aims to provide candidates with conditions that allow and encourage performance to the best of their ability. Illness, accident or disability have the potential to compromise performance. General principles governing this situation include the following principles:

1.1 Candidates should not be disadvantaged unnecessarily as a result of events outside their control. Nevertheless, in seeking to redress any disadvantage, no action should be taken which could be construed to be unfair to other candidates.

1.2 Some guidelines can be formulated for the procedures to be followed in some cases of illness or disability in relation to the examinations. However, it is impossible to foresee every eventuality.

1.3 Where a problem arises which is not covered in the Regulations, instructions to examiners, or these guidelines, advice should be sought from the Executive Officer in association with the Chairman of the Fellowship Examination Committee.

2. ACUTE ILLNESS OCCURRING AT THE TIME OF EXAMINATION

2.1 In the event that an examiner becomes aware that a candidate is ill, he/she should notify the Chairman of the Court who will:

2.1.1 Determine whether, in his/her opinion, the illness is incapacitating.

2.1.2 If appropriate, advise the candidate to withdraw.

2.1.3 Notify the Dean in writing of this action.

2.2 In the event of illness or disability occurring prior to or during any part of the examination, no special consideration will be given to a candidate who elects to continue with the Examination.

2.3 Sudden illness which precludes a candidate from attending all or part of an examination, may provide grounds for a refund of the examination entry fee.

2.4 Application for this consideration must be made by the candidate and supported by a medical certificate. Such a medical certificate may be provided by a member of the Court of Examiners, but not by the candidate.

2.5 Further action is at the discretion of the Board, on the advice of the Chairman of the Fellowship Examination Committee.

3. ACUTE ILLNESS, ACCIDENT OR DISABILITY WHICH IMMOBILISES, BUT DOES NOT INCAPACITATE THE CANDIDATE

3.1 A candidate who is otherwise fit to participate in the written examination may be precluded from attending the venue for the written examination, by an unexpected illness, accident or disability.

3.2 Under these circumstances, the Chairman of the Court of Examiners and the Chairman of Fellowship Examination Committee should consider the possibility that the Written Section of the Examination could be taken at some other appropriate place at the same time as other candidates in the region. An appropriate invigilator should be appointed for that purpose.

3.3 Limited concession is possible for the Oral Section, so that if action under 3.2 is contemplated, it must be dependent on the likelihood that the candidate will be fit to participate in the Oral Sections.

4. CHRONIC ILLNESS OR DISABILITY

Candidates with a chronic illness or disability will not normally be granted any concession with respect to any part of an examination. If a candidate believes that extraordinary consideration should be given to particular circumstances, a fully documented application should be submitted to the Chairman of Fellowship Examination Committee at least four (4) calendar months prior to the advertised closing date. Further action is at the discretion of the Board, on advice from the Chairman of Fellowship Examination Committee.

5. OTHER CIRCUMSTANCES

5.1 A candidate who has been prevented from completing an examination by illness, accident or disability will not be exempted from any part of a future examination.

5.2 A candidate who has been prevented from completing an examination by illness, accident or disability, will remain eligible for awards and prizes at a future examination.

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

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

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

Promulgated: February 1996
Date of current document: July 2001

Award Of G.A. (Don) Harrison Medal 2000

Congratulations to the Winner of the G.A. (Don) Harrison Medal for 2000, Dr Brett McFadyen.

The Medal was presented at the John Hunter Hospital Departmental Meeting Dinner held in early July.

The Dinner was a great success and a memorable experience for Dr McFadyen. Professor Don Harrison presented the Medal.

Dean's Message

Michael J Cousins, AM

Dr. Patrick D Wall

A GIANT IN PAIN MEDICINE PASSES ON

On August 8, 2001, Patrick Wall discharged himself from hospital, informing medical staff that his clinical experience indicated that he was close to death and wished to die at home. He died that very evening. Thus ended a career of more than forty years in pain research that arguably had a greater impact on the field of pain medicine than any single individual before him.

Inevitably Patrick Wall has been linked to his close friend and collaborator in the "gate control theory" because of the enormous impact of their joint paper "Pain Mechanisms: a new theory" published in *Science* in 1965. This theory was the catalyst for an extraordinary turning point in the field of pain medicine. It threw out a strong challenge to the existing model of pain as a specialised sensation with its own receptors and nervous system pathways to the brain. It suggested for the first time that the experience of pain could utilise extensive areas of the nervous system and that pain could be modulated *at the level of the first synapse in the spinal cord and also at other levels of the neuraxis.* This was truly a revolutionary idea and not surprisingly was met by enormous resistance from prominent neuroscientists to the point of overt and hostile attack. I well remember quite scathing articles by powerful individuals, including Professor Ainsley Iggo from the University of Edinburgh who dissected the paper published in Science and concluded that it essentially had no merit. By a strange turn of fate, Iggo became the third President of IASP and thus interacted very closely with Patrick Wall as the first Editor of the journal "Pain". Not surprisingly, Melzack and Wall described themselves as "two iconoclasts" and neither of them were at all daunted by the criticism that was hurled at their new theory. The paper became a science citation classic with almost unparalleled resilience since it continues to have a much higher citation rate than virtually any other classic from the mid 1960s. Interestingly Melzack and Wall had previously published a paper in the Journal *Brain* in 1962, embodying some similar ideas to the gate theory and this paper was largely ignored.

It would be wrong to link the work of Patrick Wall too closely to that of Ronald Melzack although they collaborated in many projects over more than forty years. Melzack and Wall shared an endearing quality of being extremely generous and enthusiastic about the work of others, provided it was of high quality and added to knowledge. However from this point they departed in that Patrick Wall was prepared to mercilessly attack the work of any individual, no matter how eminent, if he felt that the work was flawed and particularly if unwarranted conclusions had been drawn. In this regard he was quite fearless and his intentions were sometimes misinterpreted as being discourteous. This was never the case since his sole intention was to maintain scientific integrity. Thus he was sometimes described as an "anarchic neuroscientist". On many occasions I can remember him taking apart the work of eminent individuals and usually history proved that his criticisms had been quite correct. He was also quite prepared to stand up at major clinical meetings and admonish clinicians of various disciplines for their apparent ignorance about fundamental aspects of pain mechanisms. This was always done in a constructive vein but sometimes was received with incredulity by the clinical societies that had invited him to be their major guest.

Patrick Wall's research extended far beyond the gate control

theory. After he qualified in medicine at Christchurch Oxford he went to the United States in the late 1950s and had a number of distinguished appointments at the Universities of, Yale, Chicago, Harvard and finally the Massachusetts Institute of Technology. He met Ronald Melzack while the two of them were in Boston and this gave them the opportunity to develop the gate control theory. Incidentally the initial diagram for the theory was written on a table napkin whilst they were having dinner together. Wall had the good fortune whilst in Boston to work with some of the intellectual giants of the time, including McCulloch, Pitts, Shannon, Lettvin, Wiener, Chomsky and others. He was already working on spinal cord mechanisms, but also had a diverse interest in neuroplasticity within the nervous system. In 1967 he was appointed as Professor of Anatomy and Director of the Cerebral Functions Research group at University College London, where he remained until his "retirement". In typical Patrick Wall style, his retirement consisted of taking up an appointment at age 67 as Visiting Professor at the hospitals of King's, Guy's and St Thomas's, with a laboratory in St Thomas's Medical School building. Perhaps one of his most important contributions was to draw the attention of researchers in the field of pain to the concepts of neuroplasticity, particularly with respect to neuroanatomical reorganisation in the spinal cord caused by nerve damage. He also did a great deal to increase our knowledge of the physiology and pharmacology of damaged nerve tissue, including the properties of neuromas, especially the spontaneous firing and pharmacological manipulation of such firing. His research was always strongly oriented towards the solving of important clinical pain problems. I can well remember the enormous stir that the first nerve injury models caused at the IASP Council. The description of the phenomenon of "autotomy" caused strident criticism, from some individuals with no insights into the value of animal research. To his credit, Pat Wall vigorously defended the nerve injury model and has been a consistent supporter of the contribution of animal research to pain medicine. His extraordinary range of research publications are complemented by some excellent books: The Textbook of Pain (4 editions); The Challenge of Pain; The Puzzle of Pain and most recently "Pain: the science of suffering (1999)

When I first met Patrick Wall in 1969 during my clinical fellowship at McGill University in Montreal, he seemed to be an extremely daunting figure and I still remember my amazement as he dismantled existing specificity theories, demonstrating how investigators had conveniently ignored research findings that just did not fit their conclusions. This was only a few years after the publications of the gate control theory and opened my eyes to the enormous lack of knowledge in this new field of pain and the potential for its development. When I met Pat during my early years on the IASP Council in the late 1970s, I realised what a warm, delightful and sometimes amusing individual he could be. He had a great lack of respect for bureaucracies and delighted in firing harpoons at any individuals or organisations that attempted pomposity. On the other hand, he was enormously generous to enumerable research students from throughout the world and was always willing to consider new approaches even if they diverged markedly from his own current views. A very large number of individuals who trained in his laboratories have now become leaders in pain research worldwide. Such individuals include luminaries in the pain field, including Alan Basbaum, Clifford Wolfe, Marshall Devor and many others.

Because Patrick was an intensely private person, few would be aware of some of the extraordinary things that he did outside of the field of medicine and medical research. During World War 2, he provided extraordinary assistance to refugees, sometimes at great risk to himself. He actively campaigned against the British Army's treatment of prisoners in Northern Ireland and was a consultant to the RSPCA. He had a deep commitment to humanitarian issues and was a great supporter of Dame Cicely Saunders in her development of the hospice movement. Since I had a strong conviction that his revolutionary work in the field of pain fostered a sea change in the management of pain and suffering, it was my great pleasure to join a number of others in nominating him for the Nobel Prize on more than one occasion. It is my understanding that he was short-listed and it seems a great pity that he did not receive the prize. However he was eventually made a Fellow of the Royal Society in 1989. At the IASP World Congress in Adelaide 1990 the 25th anniversary of the gate control theory was honoured with a special presentation to Wall and Melzack. At the most recent IASP World Congress in Vienna the entire meeting was dedicated to Pat Wall.

Pat Wall has made numerous important contributions to major scientific meetings in Australia which ranged from the field of neurosciences, pain, medicine, physiotherapy, rheumatology, rehabilitation medicine. He was always informative, provocative and never dull. He has left a legacy of many basic scientists and clinicians who have benefited greatly from their interaction with him. He should also rest secure in the knowledge that his work has contributed substantially to development of important new treatments such as Transcutaneous Electrical Nerve Stimulation, spinal cord dorsal column stimulation and spinal drug administration aimed at exploiting the neuromodulation which the gate control theory introduced.

MICHAEL J COUSINS AM

Highlights from the Board Meeting

HELD ON AUGUST 23, 2001

Admission to Fellowship by Training and Examination

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

PARISOD Eric	Switzerland	FMH Anaest

Admission to Fellowship by Election

The following were admitted to Fellowship by election:

CHEN Phoon Ping	Hong Kong	FANZCA
CRAIGIE Meredith	SA	FANZCA
REILLY Peter	SA	FRACS
SHIPTON Edward	NZ	FANZCA

Education

Survey of Fellows

It was agreed that the survey of Fellows be undertaken with assistance from the Education Department which will be undertaken by email.

Integrated Pain Oriented Examination

It was agreed that the Education Committee continue its development of formalising a process on behavioural aspects of a pain physical examination.

Reading List Material for Trainees

It was noted that the College Library has now collated all the reading materials.

Examination

Dr Penny Briscoe, Chairman Examination Committee confirmed the examination is to be held at Royal Adelaide Hospital on November 1 and 2. The closing date for candidates for this examination was August 23, 2001.

The pre-examination short course was held on August 30 and 31 at Royal Adelaide Hospital.

Registration of Trainees

It was agreed the Faculty write to all Medical Directors and Supervisors of Training advising that in future when an appointment is made to fill the recognised Faculty training position, that the trainee must register at that time with the Faculty. Their training year will not commence until they have registered with the Faculty. This will ensure that trainees receive their training materials early in their training.

Hospital Accreditation

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

Sir Charles Gairdner Hospital, WA
Westmead Hospital and the Children's Hospital, NSW
Geelong Hospital, Vic.

Training Program

It was agreed that effective from the commencement of the 2002 hospital year:

1. The two year training program continue.
2. The mandatory year of training will not commence until trainees have registered with the Faculty.
3. Trainees are to undertake one mandatory prospectively approved multidisciplinary year of structured training in a Faculty accredited multidisciplinary pain management unit prior to being eligible to present for examination.
4. That the non-mandatory year of training can be retrospectively approved but will not be automatic and will depend on the relevance of the previous experience of pain medicine.
5. Treatises to be completed and satisfactorily assessed as well as satisfactory assessment of Quarterly/Final Reports prior to candidates being approved to present for the examination.
6. The examination to be held earlier in the year, possibly March.

   Trainees will be encouraged to register early for training in Pain Medicine, prior to the mandatory year in a Pain Centre. Those registering early will be required to pay only 10% of the annual training fee, with the remaining 90% deferred until the commencement of the mandatory year in a Pain Centre.

   Advantage of early registration will be:

   - Receipt of educational materials including the Training Manual and Objectives of Training/Reading List with references.
   - Eligibility to attend the annual self-funded pre-examination short course during their non-mandatory year of training.
   - Access to a mentor should this be requested by the trainee.

Professional Documents

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

PM1 *Guidelines for Trainees and Departments Seeking Faculty Approval of Posts for Training in Pain Medicine*

Palliative Medicine

The Board agreed that the Palliative Medicine working party convene a teleconference and one of the issues to be discussed is the areas of overlap and discrete specialist activity in Pain Medicine compared to Palliative Medicine.

It was agreed that when this information is available, it will be useful to provide to both the Federal Minister for Health and the State Ministers for Health. It will also be useful information to provide to Fellows and Trainees.

FPM/PMC HKCA Meeting, May 2001

The Board accepted the Minutes of the Meeting held between the Faculty and the HKCA Pain Management Committee in May 2001 in Hong Kong.

White Papers

It was agreed to concentrate on a few topics and establish task forces to develop the white papers. A nominated Board Member is to drive each of the task forces. The format for these documents will be modeled on PS41 *Guidelines on Acute Pain Management*. Initial white papers underway include: Implantable Spinal Drug Delivery Systems; Spinal Cord Stimulation; Epidural Steroid Administration; Medial Branch Blocks and Radiofrequency Lesioning.

Annual Scientific Meeting, May 2002, Brisbane

It was noted that Professor Kim Burchiel, Department of Neurological Surgery, Oregon University, USA has agreed to be the Faculty's Foundation Visitor. Dr G Rice reported that the Faculty's two day program is progressing well.

ASM, May 2003 Hobart

The Board was delighted that Dr Hilton Francis FRACP has accepted the invitation to be the FPM Scientific Convenor for this meeting.

Continuing Professional Development

The Board discussed the issue of conducting regional education meetings and it was agreed that this be pursued. It was agreed that when these meetings have been more formally developed that they be advertised in the newsletters of the participating Colleges.

Professor Patrick Wall receiving a special IASP award on the occasion of the 1990 IASP World Congress in Adelaide; this congress was dedicated to the 25th Anniversary of the "Gate Control Theory of Pain".

Tribute to Dr Loughman and Dr Mainland – pages 41-42

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9. Mainland JF, Dudley H., Editors. *Safety in the Operating Theatre*. Melbourne. Edward Arnold (Australia) Pty Ltd. 1976. 167pp.
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Australian And New Zealand College Of Anaesthetists

ABN 82 055 042 852

COLLEGE PROFESSIONAL DOCUMENTS

College Professional Documents are progressively being coded as follows:

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

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

RECOMMENDATIONS *– defined as 'advisable courses of action'.*

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

STATEMENTS *– defined as 'a communication setting out information'.*

These documents have been prepared having regard to general circumstances, and it is the responsibility of the practitioner to have express regard to the particular circumstances of each case, and the application of these documents in each case.

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

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

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

Review EX1 (2001)

POLICY ON EXAMINATION CANDIDATES SUFFERING FROM ILLNESS, ACCIDENT OR DISABILITY

1. INTRODUCTION

1.1 Candidates should not be disadvantaged as a result of events outside their control. Nevertheless, in seeking to redress any disadvantage, no action should be taken which might be held to be unfair to other candidates.

1.2 Guidelines can be formulated for procedures to be followed in some cases of illness in relation to the examinations. However, it is impossible to foresee every eventuality.

1.3 Where a problem arises which is not covered in the Regulations, instructions to examiners,

or these guidelines, advice is to be immediately sought from the Registrar in discussion with the Chairman of Examinations.

2. ACUTE ILLNESS OCCURRING AT THE TIME OF EXAMINATION

2.1 In the event that an examiner becomes aware that a candidate is ill, he/she should notify the Chairman of the Court who will:

2.1.1 determine whether, in his/her opinion, the illness is incapacitating.

2.1.2 if appropriate, reschedule the candidate's program within the existing examination or advise the candidate to withdraw.

2.1.3 notify the Registrar in writing of his/her action.

2.2 In the event of illness or disability occurring prior to or during any part of the examination, no special consideration will be given to a candidate who elects to continue with the examination.

2.3 Sudden illness which precludes a candidate from attending all or part of an examination may provide grounds for remission of the examination entry fee.

2.4 Application for this consideration must be made by the candidate and supported by a medical certificate. Such a medical certificate may be provided by a member of the Court of Examiners but not by the candidate.

2.5 Further action is at the discretion of the Council on the advice of the Chairman of Examinations.

3. ACUTE ILLNESS, ACCIDENT OR DISABILITY WHICH IMMOBILISES, BUT DOES NOT INCAPACITATE THE CANDIDATE

3.1 A candidate who is otherwise fit to participate in the written examination may be precluded from attending the venue for the written examination, or require special assistance due to illness, accident or disability.

3.2 Under these circumstances, the Chairman of the Court of Examiners and the Chairman of Examinations should consider the possibility that the written examination could be taken at some other appropriate place, and/or special assistance provided at the same time as other candidates in the region. An appropriate invigilator must then be appointed for this purpose.

3.3 No such concession is possible for the oral examination, so that if action under 3.2 is contemplated, it must be anticipated that the candidate will be fit to attend the vivas.

4. CHRONIC ILLNESS OR DISABILITY

Candidates with a chronic illness or disability will be considered for assistance appropriate to their disability provided that it does not impair the fairness and reliability of the examination. If a candidate believes that extraordinary consideration should be given to particular circumstances, a fully documented application should be submitted to the Chairman of Examinations at least four (4) calendar months prior to the advised examination closing date. Further action is at the discretion of the Council, on advice from the Chairman of Examinations.

5. OTHER CONCESSIONS

5.1 A candidate who has been prevented from completing an examination by illness, accident or disability will not be exempt from any part of a future examination.

5.2 A candidate who has been prevented from completing an examination by illness, accident or disability will remain eligible for awards and prizes at a future examination.

Promulgated: *1984*
Reviewed: **1991, 1996**
Date of current document: Sept 2001

Review TE13 (2001)

GUIDELINES FOR THE PROVISIONAL FELLOWSHIP YEAR

1. INTRODUCTION

1.1 Trainees in anaesthesia must complete a four year training program, pass the Primary and Final Examinations of the College, complete other specified training requirements and undertake a further year of experience - the **Provisional Fellowship Year** - to be eligible for admission to the Fellowship of the College.

1.2 Trainees must seek approval from the College before commencing their **Provisional**

Fellowship Year. The trainee is responsible for making application to the College with the written support of the appropriate Departmental Head.

1.3 Trainees in this year are known as Provisional Fellows. They must be registered with the College and pay the annual training fee.

1.4 The Provisional Fellow:

1.4.1 Is not a specialist anaesthetist

1.4.2 Must be supervised appropriately

1.4.3 Must work in posts approved by the College

1.4.4 Should achieve widened experience and maturity

2. DETAILS

2.1 The Provisional Fellowship Year will allow for the development of:

2.1.1 A consultant approach

2.1.2 An interest in continuing education

2.1.3 An interest in teaching

2.1.4 An understanding of research methods and techniques

2.1.5 Responsibility and commitment to the training of other staff

2.2 Provisional Fellowship posts must satisfy the above requirements and must be either:

2.2.1 Specifically approved by the College as part of its training programs; or

2.2.2 Specially approved by the College on prospective application to the Assessor

2.3 Approved Provisional Fellowship posts may allow:

2.3.1 Recognition for intensive care training

2.3.2 Recognition for pain medicine training

2.3.3 Experience in a field of special interest

2.3.4 Experience in a deficient area of training

2.4 Provisional Fellows should be involved in teaching and supervision of other trainees provided that the clinical situation is appropriate and that supervision as specified in College Policy Document TE3 *Policy on Supervision of Clinical Experience for Trainees in Anaesthesia* is available.

2.5 Provisional Fellows should ordinarily work only in situations where work is supervised as noted above. Distance supervision will not ordinarily be permitted for more than three months.

2.6 The Assessor (on behalf of Council) has discretionary powers to approve specific proposals for the Provisional Fellowship Year and will be flexible in considering a proposal. Any such program must have prior approval. Training outside Australia and New Zealand is to be encouraged.

Promulgated: *1988*
Reviewed: **1991,1996**
Date of current document: **Sept 2001**

Review PS6 (200)

RECOMMENDATIONS ON THE RECORDING OF AN EPISODE OF ANAESTHESIA CARE (THE ANAESTHESIA RECORD)

INTRODUCTION

The anaesthesia record is an essential part of the patient's medical record. The record should allow the anaesthetist to chart all aspects of the anaesthesia management, including the pre and post-operative management, that are of relevance to the anaesthetist. The record should follow a logical sequence. It must include prompts to show essential information regarding the anaesthetic technique and drugs used, sufficient space to allow the anaesthetist to make more detailed comments when necessary, and a chart for graphically recording data and attaching appropriate automated records if available.

The anaesthesia record provides information, which may be helpful to all staff involved in the care of the patient and is of great use to subsequent anaesthetists (both specialist and trainee). It may also be of medico-legal importance and can be used for quality assurance and research purposes. The record must be signed by the anaesthetist/s.

THE ANAESTHESIA RECORD IS A GENERIC DOCUMENT AND AS SUCH IT SHOULD ALLOW PART OR ALL OF THE FOLLOWING INFORMATION TO BE RECORDED. Not all the information listed below may be relevant or significant in every case. The information may be on a single record or may be covered by separate records for the pre-anaesthesia,

anaesthesia and post-anaesthesia phases of the patients care. The anaesthesia record is an essential part of the patient's medical record and all hospital medical records departments should have a proper system for the filing and collating of the pre-operative, anaesthesia and post anaesthesia records for each hospital admission.

1. **Basic Information**
   - 1.1 The name of the patient and the hospital, the hospital record number, the age, gender and weight of the patient.
   - 1.2 The dates of the pre-operative consultation and the anaesthesia.
   - 1.3 The name(s) of the anaesthetist(s).
   - 1.4 In the case of trainees, the name of the supervisor and the level of supervision as defined in College Professional Document TE3 *Policy on Supervision of Clinical Experience for Trainees in Anaesthesia.*
   - 1.5 The name of the surgeon or other proceduralist.
   - 1.6 The procedure(s) planned to be performed and actually performed plus appropriate anaesthesia coding such as ICD 10.

2. **Information Prior to Anaesthesia**
   - 2.1 Documentation of pre-anaesthesia assessment of the patient, including the category of patient as defined for example by the American Society of Anesthesiologists. (College Professional Document PS7 *Recommendations on the Pre-Anaesthesia Consultation).*
   - 2.2 Summary of general medical status by relevant systems and diseases.
   - 2.3 Concurrent therapy and any known drug or other sensitivities.
   - 2.4 The history of previous anaesthesia and relevant surgery.
   - 2.5 Assessment of the airway, dental condition and risk of gastric reflux.
   - 2.6 Results of relevant laboratory data and other investigations.
   - 2.7 The pre-medicant drugs, time given, route of administration and description of any unusual response (if not recorded elsewhere).
   - 2.8 Documentation of discussion with the patient or guardian on the anaesthesia plan, possible therapies and possible outcomes and risks (if not recorded elsewhere). See College Professional Document PS26 *Guidelines on Providing Information About the Services of an Anaesthetist.*

3. **Anaesthesia Information**
   - 3.1 **Medication**: The details of administration of all drugs including any used by the surgeon, and a description of any unusual response.
   - 3.2 **Technique**: The full details of the anaesthetic technique used, whether general, regional or sedation with monitored anaesthesia care, and a description of any problems encountered.
   - 3.3 **Time**: The time of significant anaesthesia and operative events, observations and interventions including administration of drugs.
   - 3.4 **Airway**: The size and type of any artificial airway used, a description of any airway problems encountered and the method of their solution.
   - 3.5 **Fluid Therapy and Vascular Access**:
     - 3.5.1 **Intravenous infusion**: Details of intravenous solutions including the site, type of cannula and the nature and volume of fluids infused.
     - 3.5.2 Details of central venous and arterial access.
   - 3.6 **Blood loss**: An estimate of blood and fluid loss.
   - 3.7 **Position**: The position of the patient during the procedure.
   - 3.8 **Monitoring**: The monitoring methods used and regular documentation of relevant information obtained. Information provided as a monitor print-out must have correct patient identification. See College Professional Document PS18 *Recommendations on Monitoring During Anaesthesia.*
   - 3.9 Other Interventions.

4. **Post-Anaesthesia Information (if not recorded elsewhere)**
   - 4.1 Respiratory, cardio-vascular and neurological status and any other relevant information.
   - 4.2 Incidents arising during this period and their management. Refer College Professional Document PS4 *Recommendations for the Post-Anaesthesia Recovery Room.*
   - 4.3 Plan for pain management, fluid therapy and oxygen therapy for first 24 hours if appropriate, but certainly for guidance of Recovery Room Staff.
   - 4.4 Space for documenting/recording outcome data, including Clinical Indicators, audit and quality assurance information as decided by the anaesthesia department/anaesthetists
   - 4.5 Space for documenting the post-anaesthesia visit.
   - 4.6 Time and discharge destination on transfer from operating theatre or recovery room.

CORE INFORMATION

As the anaesthesia record is a generic document that will be used for a wide variety of patients and procedures, some of the prompts on the record may not be relevant and/or essential to a particular case.

The completed record should contain relevant details of the patient, procedure, proceduralist, documentation of pre-anaesthetic assessment, detailed management during anaesthesia, any abnormal reactions or complications, post operative instructions from the anaesthetist and documentation for the postoperative visit (if not recorded elsewhere.

The following is the suggested core information:

5.1 Patient identification details or patient's hospital label.
5.2 Dates of pre-operative consultation and anaesthesia
5.3 Name and signature of anaesthetist/s
5.4 Name of the surgeon/proceduralist
5.5 Procedure performed

6.1 Documentation of pre-anaesthesia assessment
6.2 Documentation of pre-medicant drugs (if not recorded elsewhere)
6.3 Documentation of discussion with patient or guardian/s. See College Professional Document PS26 *Guidelines on Providing Information About the Services of an Anaesthetist.*

7.1 Details of administration of all drugs and description of any unusual responses.
7.2 Details of anaesthesia technique used and a description of any problems encountered.
7.3 Time and details of significant anaesthesia/operative events, observations and interventions including administration of drugs.
7.4 Description of any artificial airway used, a description of the airway, any airway problems encountered and the method of their solution.
7.5 Details of vascular access and the nature and volumes of fluids infused.
7.6 Details of significant blood and fluid losses.
7.7 Details of patient position
7.8 Details of monitoring methods used and regular documentation of observations. See College Professional Document PS18 *Recommendations on Monitoring During Anaesthesia.*

8.1 Documentation of respiratory, cardiovascular and neurological status in recovery room (if not recorded elsewhere)
8.2 Documentation of incidents arising in the recovery room and their management(if not recorded elsewhere). See College Professional Document PS4 *Recommendations for the Post-Anaesthesia Recovery Room.*
8.3 Instructions to the Recovery Room Staff and/or ward staff on the management of pain, oxygen therapy and fluid therapy.
8.4 Documentation of outcome data as required by the anaesthesia department (if not recorded elsewhere)
8.5 Documentation of post-anaesthesia visit (if not recorded elsewhere).

Specific information that the anaesthetist considers is particularly relevant to a particular case should also be recorded.

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Reviewed: **1996**
Date of current document: Sept 2001

Review PS12 (2001)

STATEMENT ON SMOKING AS RELATED TO THE PERIOPERATIVE PERIOD

The Australian and New Zealand College of Anaesthetists recognises that tobacco smoking is addictive and can damage both the health of smokers and those passively exposed to tobacco smoke. The College supports all measures to decrease tobacco consumption and involuntary exposure to tobacco smoke (i.e. passive smoking).

Some adverse effects of smoking are considerably lessened following cessation of smoking.[1,2] These benefits are particularly relevant in the perioperative period.

1. Smoking increases the blood concentration of carboxyhaemoglobin. This has an average elimination half-life of four hours [3] and therefore abstinence of only 12 hours will greatly reduce carboxyhaemoglobin concentrations, improve oxygen content and availability, and reverse negative inotropic and arrhythmic effects. Smokers' polycythaemia and increased blood viscosity take a few days to reverse.[4]
2. Nicotine increases heart rate, blood pressure and peripheral vasoconstriction.[5] These adverse effects

generally improve following 12 - 24 hours of abstinence.[6]

3. In the respiratory system, smoking causes hypersecretion of mucus, impairment of tracheobronchial clearance, and small airways narrowing. Smokers have a greater tendency to develop hypoxia in the postoperative recovery period.[10] If smoking is stopped, sputum production declines over a six week period. Half of this occurs in the first two weeks.[1] Small airways function improves after one month, with further improvements up to six months.[7] The high incidence of chest infection in smokers following coronary artery surgery is reduced if smoking is stopped two months preoperatively. Six months of preoperative abstinence will reduce the incidence to that of non-smokers.[8,9]
4. Smoking may adversely affect immune mechanisms.[11-15] Decreased levels of immunoglobulins and cells involved in the immune response in smokers apparently return to normal following a six month period of abstinence.[1]
5. Perioperative analgesic requirements are increased in smokers.[16,17] This may be due to increased enzyme induction[16] or withdrawal of endogenous opioid stimulation. Improvement is seen 6 - 8 weeks after cessation of smoking[18].
6. Postoperative complication rates are higher in smokers[19], particularly following plastic and reconstructive surgery.[20] Smoking has adverse effects on the microcirculation[21] that may impair wound healing.[22] There is also evidence of increased respiratory complications in children exposed to environmental tobacco smoke.[23]

CONCLUSION

Tobacco smoking is an identifiable major risk factor relating to surgery and the perioperative period.

Patients who smoke should be encouraged to stop smoking at least six to eight weeks before surgery. In the short term, smoking should not be permitted 12 hours before surgery.

The College supports all reasonable measures to reduce tobacco use in the community.

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Review PS16 (2001)

STATEMENT ON THE STANDARDS OF PRACTICE OF A SPECIALIST ANAESTHETIST

In defining the attributes and qualities necessary for the high standards of practice in anaesthesia that are expected of a specialist anaesthetist, it is necessary to consider both the anaesthetist and the environment in which he/she works.

1. THE SPECIALIST ANAESTHETIST

1.1 Specialist Anaesthetists are registered medical practitioners who have completed a period of graduate training in Anaesthesia and hold the Diploma of Fellowship of the Australian and New Zealand College of Anaesthetists, or who have been assessed and supported as specialists by the College.

1.2 Specialist Anaesthetists are required to cultivate and maintain high standards and ethical behaviour in their professional practice of anaesthesia and other branches of medicine. They recognise that the knowledge, skills and attitudes as stated in the College's *Objectives of Training in Anaesthesia* and in its Professional Documents form an appropriate model for the practice of their profession.

1.3 Specialist Anaesthetists recognise that:

1.3.1 Regular work in anaesthesia of appropriate volume and complexity is necessary to maintain clinical skills.

1.3.2 Continuing professional development is essential. This should be evaluated by participation in the ANZCA Maintenance of Professional Standards Program.

1.3.3 Re-training will be necessary after a period away from normal duties or on taking up a different pattern of practice.

1.3.4 Physical and mental health will impact on their ability to maintain high standards of practice and accept that advice and treatment may be necessary to maintain health.

1.3.5 Chemical dependence is a health problem of particular relevance to anaesthetists that is likely to adversely affect professional practice.

1.3.6 Ageing may lead to a decline in standards of practice and review by appropriately skilled colleagues may be necessary as part of a decision to continue professional practice.

2. THE WORK ENVIRONMENT

2.1 Clinical anaesthesia is an exacting task. Specialist anaesthetists, and where appropriate their employers, must recognise that high standards of practice require a balance between duties related directly to patient care and those related to maintenance of competence. This will require a balance of time allocation between patient care, education and quality assurance activities. The allocation will vary according to individual circumstances.

2.2 To enhance high standards of practice, the job description and professional activities of a

specialist anaesthetist must allow time for interaction with colleagues in order to avoid professional isolation. One of the functions of non-patient care time is to allow for maintenance of professional contacts.

2.3 Performance of anaesthesia at a high standard requires appropriate rest periods from day to day as well as leave from normal duties for vacation purposes. It is the responsibility of specialist anaesthetists and their employers to ensure that fatigue is not allowed to impair standards of clinical performance.

This Document should be read in conjunction with the following College Professional Documents.

TE6 *Guidelines on the Duties of an Anaesthetist*
TE9 *Guidelines on Quality Assurance*
PS42 *Recommendations for Staffing of Departments of Anaesthesia*
PS43 *Statement on Fatigue and the Anaesthetist*

Promulgated: *1994*
Reviewed: **2001**
Date of current document: Sept 2001

Review PS19 (2001)

RECOMMENDATIONS ON MONITORED CARE BY AN ANAESTHETIST

INTRODUCTION

The Australian and New Zealand College of Anaesthetists endorses the concept of monitored care provided by an anaesthetist for a procedure performed under local anaesthesia or sedation. Monitored care may also be required in special situations such as the intravascular administration of contrast medium in a suspected susceptible patient.

Monitored care may be requested by a surgeon, dentist, obstetrician, physician, endoscopist, radiologist, radio therapist, or other proceduralist.

Because of the general condition of the patient and, in some cases poor access, the provision of monitored care may be exacting and time consuming.

GENERAL PRINCIPLES

1. Monitored care shall include:
   - 1.1 Performance of a pre-anaesthetic consultation in accordance with College Professional Document PS7 *The Pre-Anaesthesia Consultation.*
   - 1.2 Monitoring of the patient, as appropriate, in accordance with College Professional Document PS18 *Recommendations on Monitoring During Anaesthesia.*
   - 1.3 Administration of intravenous sedation, if required, in accordance with College Professional Document PS9 *Guidelines on Conscious Sedation for Diagnostic, Interventional Medical and Surgical Procedures.*
   - 1.4 Other therapeutic measures as required.
   - 1.5 Transfer of the patient, if required, to an appropriate Recovery Area in accordance with College Professional Document PS4 *Recommendations for the Post-Anaesthesia Recovery Room.*
2. A record of clinical observations and of drugs administered shall be kept.
3. To ensure that standards of patient care are satisfactory, equipment and staffing of the area in which the patient is being managed should satisfy the requirements in the appropriate College Professional Document regarding recommended Minimum Facilities for Safe Anaesthesia Practice in:

In Operating Suites	(T1)
Outside Operating Suites	(T2)

Promulgated: *1990*
Reviewed: **1995**
Date of current document: Sept 2001

RECOMMENDATIONS FOR RESPONSIBILITIES OF THE ANAESTHETIST IN THE POST-OPERATIVE PERIOD

1. The anaesthetist has major responsibility for the management of the patient recovering from anaesthesia. During this time, responsibility is shared with the surgeon or other consultants for advice regarding:
   - 1.1 clinical observations and monitoring
   - 1.2 pain relief
   - 1.3 management of complications, particularly post-operative nausea and vomiting
   - 1.4 fluid therapy
   - 1.5 respiratory therapy
   - 1.6 discharge from the recovery ward
   - 1.7 on-going care related to anaesthesia matters

2. The anaesthetist has responsibility for ensuring that the patient recovers safely from anaesthesia in an area appropriately equipped and staffed for that purpose. College Professional Document PS4 *Recommendations for the Post-Anaesthesia Recovery Room.*

   This responsibility includes:
   - 2.1 A formal handover of responsibility to suitably trained recovery area staff with appropriate briefing on management protocols. Such handover of care should only occur when the anaesthetist considers that the patient's condition is stable, particularly with regard to cardio-respiratory status
   - 2.2 Availability to deal with any unexpected problems or ensuring that another nominated anaesthetist or other consultant is available and has access to necessary information about the patient.
   - 2.3 A care plan to ensure that the patient remains in the recovery facility until safe for discharge to a ward or home.
   - 2.4 Care during transfer to an intensive care unit or high dependency unit if necessary. The anaesthetist or another qualified and informed delegate remains responsible until transfer is complete.
   - 2.5 Ensuring there are plans for adequate post-operative care of the patient after discharge from the recovery area.

3. When a patient is to be discharged from medical care on the same day that sedation or anaesthesia has been administered, the anaesthetist must ensure that the patient and caregivers understand the principles of post-anaesthesia care. See College Professional Document PS15 *Recommendations for the Peri-operative Care of Patients Selected for Day Care Surgery.*

4. The anaesthetist has a responsibility to:
   - 4.1 Recognise, appropriately manage and document any adverse effects that may be related to anaesthesia.
   - 4.2 Audit outcomes of anaesthesia care and include these in quality assurance or peer review processes.
   - 4.3 Inform patients and/or caregivers of any future health care matters relevant to the conduct of sedation or anaesthesia.

RELATED PROFESSIONAL DOCUMENTS

TE6 *Guidelines on the Duties of an Anaesthetist*
TE9 *Guidelines on Quality Assurance*
PS4 *Recommendations for the Post-Anaesthesia Recovery Room*
PS15 *Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery*

Promulgated: *1990*
Reviewed: **1996**
Date of current document: **Sept 2001**

POLICY FOR THE IN-TRAINING ASSESSMENT OF TRAINEES IN ANAESTHESIA

1. **Introduction**

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

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

2. **Objectives**

The objectives of ITA are to:

2.1 Assess and assist with the Trainee's progress towards appropriate goals.

2.2 Provide regular feedback to Trainees.

2.3 Develop any remedial activities for the Trainee that may be required.

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

3. **Process**

Each Trainee must maintain a training portfolio throughout their training. It should include originals or copies of formal documents related to training as well as voluntary documentation such as a log-book. It MUST contain the original signed copy of the ITA – 2 form from each final assessment with a SOT, and SHOULD contain all self evaluation of performance forms.

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

The initial interview between the SOT and the Trainee will review the Trainee's previous performance, and set appropriate goals for the next training term. This will involve review of the Trainee's Training portfolio, and self evaluation, which is to be completed using an ITA – 1 form. The SOT will contact other SOTs if necessary to assist with this process.

3.2 At the final assessment interview, the SOT and Trainee will review and discuss performance during the completed attachment.

3.3 The formal assessment of the Trainee's performance over the previous attachment should be based upon;

3.3.1 An assessment by the three senior staff who are best placed to provide that assessment. Each must complete an ITA – 1 form, and/or:

3.3.2 An assessment by a consensus meeting of the senior staff of the Department in writing using an ITA – 1 form.

The SOT should use this information to complete the ITA – 2 form. Prior to the final interview, the Trainee should be asked to complete an ITA – 1 form as self evaluation. This information will be used to discuss the past term and to establish goals for the next one. The ITA-2 form must be signed by the Trainee and the SOT, after the Trainee has had an opportunity to add comments.

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

3.4 The signed original copy of the ITA – 2 form will be retained by the Trainee, along with any self evaluation forms the Trainee completed.

A copy of the signed ITA – 2 form should be submitted to the Regional Education Officer (REO) by the SOT within two weeks of the assessment.

The REO will review these forms before forwarding them to the College where they will form part of the Trainee's central record.

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

3.5.1 If there is a performance less than that "consistent with level of experience" in any of the skills/attitudes/abilities listed on form ITA-2 (indicative of a consensus view of the senior staff involved), then this matter must be discussed with the trainee with a view to establishing remedial strategies. An isolated "unsatisfactory" attribute does not necessarily constitute an unsatisfactory assessment.

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

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

3.5.4 Advice as to remedial strategies can be obtained from REOs or from the Education Unit at the College.

4. Unsatisfactory ITA Performance

When a Trainee consistently performs at a level which is considered to be below that to be acceptable for a developing specialist anaesthetist, not withstanding repeated documented attempts at remediation, then the provisions outlined in College Professional Document TE18 *Guidelines for Assisting Trainees with Difficulties* section 7 should be considered. This will require that processes outside In-Training Assessment are invoked. Advice can be obtained from REOs or the College's Chief Executive Officer.

Promulgated (as E14): *1994*
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Date of current document: **Nov 2001**

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*
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 (2000) Guidelines for Intensive Care Units Seeking Faculty Accreditation for Training in Intensive Care *Bulletin Nov 98, pg 70*
IC-4 (2000) The Supervision of Vocational Trainees in Intensive Care *Bulletin Mar 2000, pg 57*
IC-5 (1995) Duties of Regional Education Officers in Intensive Care *Bulletin Nov 95, pg 50*
IC-6 (2001) The Role of Supervisors of Training in Intensive Care Medicine *Bulletin June 2001, pg 67*
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 (2001) Examination Candidates Suffering from Illness, Accident or Disability *Bulletin Nov 2001, pg 63*
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*

FACULTY OF PAIN MEDICINE

PROFESSIONAL DOCUMENTS

PM1 (2001) Guidelines for Trainees and Departments Seeking Faculty Approval of Posts for Training in Pain Medicine
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

College Professional Documents adopted as Faculty Professional Documents with the amendment to the title for PS1 5 (2000)

EX1 (2001) Examination Candidates Suffering from Illness, Accident or Disability
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
PS 15 (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"
PS1 8 (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

PROFESSIONAL DOCUMENTS

E = Educational P = Professional T = Technical
EX = Examinations PS = Professional Standards TE = Training and Examinations

TE1 (2001) Guidelines for Hospitals Seeking College Approval of Posts for the First Four Years of Vocational Training in Anaesthesia *Bulletin June 2001, pg 92*
TE3 (1999) Supervision of Clinical Experience for Trainees in Anaesthesia *Bulletin Nov 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*
TE13 (2001) Guidelines for the Provisional Fellowship Year *Bulletin Nov 2001, pg 76*
TE14 (2001) Policy for the In-Training Assessment of Trainees in Anaesthesia *Bulletin Nov 2001, pg 84*
TE17 (1999) Advisors of Candidates for Anaesthesia Training *Bulletin Nov 99, pg 66*
TE18 (2000) Guidelines for Assisting Trainees with Difficulties *Bulletin Mar 2001 pg 76*
EX1 (2001) Examination Candidates Suffering from Illness, Accident or Disability *Bulletin Nov 2001, pg 75*
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*
PS6 (2001) Recommendations on the Recording of an Episod of Anaesthesia Care (the Anaesthesia Record) *Bulletin Nov 2001, pg 77*
PS7 (1998) The Pre-Anaesthesia Consultation *Bulletin Mar 98, pg 73*
PS8 (1998) The Assistant for the Anaesthetist *Bulletin Mar 98, pg 75*
PS9 (2001) Guidelines on Conscious Sedation for Diagnostic, International Medical and Surgical Procedures *Bulletin June 2001, pg 88*
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 (2001) Statement on Smoking as Related to the Perioperative Period *Bulletin Nov 2001, pg 79*
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*
PS16 (2001) The Standards of Practice of a Specialist Anaesthetist *Bulletin Nov 2001, pg 81*
PS17 (1997) Endoscopy of the Airways *Bulletin Nov 97, pg 80*
PS18 (2000) Recommendations on Monitoring During Anaesthesia *Bulletin Nov 2000, pg 78*
PS19 (2001) Recommendations on Monitored Care by an Anaesthetist *Bulletin Nov 2001, pg 82*
PS20 (2001) Recommendations for Responsibilities of the Anaesthetist in the Post-Operative Period *Bulletin Nov 2001, pg 83*
P21 (1996) Sedation for Dental Procedures *Bulletin Mar 97, pg 56*
P24 (1997) Sedation for Endoscopy *Bulletin May 97, pg 78*

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