

Australian and New Zealand College of Anaesthetists

ABN 82 055 042 852

Faculty of Intensive Care
Faculty of Pain Medicine



Bulletin

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

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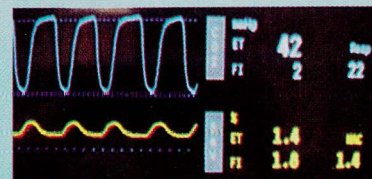
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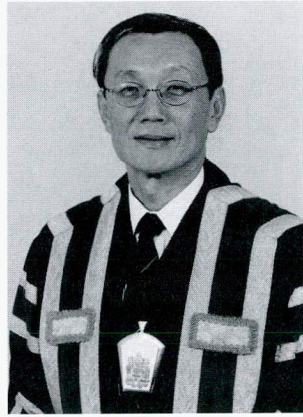
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President's Message

Teik Oh

Overseas-Trained Specialists

Generations of immigrants helped build Australia and New Zealand, and contributed to the rich multicultural tapestries of our societies. Today, we continue to welcome to our shores newcomers who have come to seek a better life as Aussies and Kiwis. However, with landed immigrants, come foreign qualifications. How should these qualifications – in our case those of anaesthesia, intensive care or pain medicine – be regarded? The simplest approach would be to accept all without question. That would be hailed by bureaucrats and the public as being non-restrictive in respect to the Australian Trade Practices Act. But if we do not know the standing of each and every foreign qualification, we would be derelict in our duty to fulfil our College's mission to foster safe and quality care. Granting automatic specialist recognition to a doctor who may not be 'up to scratch' cannot be an act of public benefit. Hence, as the professional certifying body in our disciplines, we have to assess new overseas-trained colleagues. The next step is not so easy.

Health authorities say that an overseas-trained specialist (OTS) should be assessed for equivalence, but what does that really mean? For an OTS to be truly 'equivalent' to a FANZCA, he/she must have completed the equivalent of two Resident Medical Officer years (PGY1 and PGY2) and five vocational training years, and pass the FANZCA Primary and Final examinations. Some Fellows strongly advocate this, and indeed ANZCA policy has been framed along this approach. On face value, it also appears simple to administer, but this is not so. Medical graduates of other countries start specialist training after completing internship, without undertaking PGY2. Also, apart from some Commonwealth countries, foreign

anaesthesia training programs, although teaching physiology and pharmacology, do not conduct a distinct 'Primary' examination. While we are proud of the quality of our FANZCA graduates and the high standard of their practice, it would be facile and arrogant to say that every OTS *sans* PGY2 or a Primary ticket is somehow less well trained. Then, what about those overseas programs, for example in Britain, Hong Kong, Singapore, Malaysia, and South Africa that have Primary examinations? Are they equivalent to our Primary? How can one corroborate otherwise? There are also 'entry' qualifications conferred before completion of (advanced) training and 'exit' qualifications conferred after completion of all training. Thus rulings by the College on whether an OTS must complete PGY2, additional vocational training, and present for the Primary, Final or both FANZCA examinations, have depended on the extent that such variables were deemed by Council to be equivalent. As professional experiences are never exactly alike, it is hardly surprising that some rulings were perceived to be inconsistent and unfair, and have attracted unfavourable attention to the College.

This issue of the Bulletin presents the new College document *Overseas Trained Specialists – Assessment Process* and the related *Anaesthesia Services for Areas of Need*. For the past three years, the College has had discussions with the Australian Medical Council, the Commonwealth Department of Health and Aged Care, State Medical Boards, and other Colleges on OTS and area-of-need (AON) doctors. These discussions encompassed formal and personal meetings and large workshops. All parties want a common process to deal with OTS and AON doctors, with objectives to identify those equivalent to Australasian-trained specialists and to fast-track suitable OTS into AON

posts without eroding high standards of practice. Our new process distinguishes OTS from trainees – a respect they are due as they were specialists in their countries of origin – and assesses them primarily on clinical performance with a separate OTS examination. The process upholds the principles of *consistency, objectiveness, transparency, and procedural fairness.*

It provides for a non-discriminatory, consistent, standardised assessment of all OTS, which minimises any bias that are inherent in subjective processes, such as approval of applicants from selective countries or by local hospital co-workers. The ANZAC spirit embodies noble qualities such as championing

fair play, and I shall with you welcome into Fellowship all future successful overseas-trained colleagues.

I extend my personal best wishes to all Fellows, Trainees, Staff and their families for a joyous Christmas.

Good health and prosperity in the New Year.



Admission to Fellowship

BY EXAMINATION

Charles Norton	BRADFIELD	NZ	Elli	TUTUNGI	VIC
Troy Stuart	BROWNE	SA	Monique Frances	WELLS	QLD
Kim Narelle	GRAY	NSW	Patricia	YEO	HK
Jonathan Grant	HARDMAN	QLD	By Examination through OTD System.		
Pik Lin, Monica	LEE	HK	Robert Paul	MCKINNON	SA
John	MORRIS	VIC	Jonathan Mark	SOMERVILLE	WA
Claire Elaine	NIGHTINGALE	VIC	Petrus Johannes Du Plessis	VERMEULEN	NZ
Gerald Edmund	POWER	QLD			
Richard John	SCOLARO	WA			
Thomas	THEODOROU	NSW			

Honours and Appointments

Council congratulated the following Fellows on their honours and appointments:

Dr Peter D Pullen (NSW) – Member of the Order of Australia (AM)

Dr Roger A Capps (SA) – Member of the Order of Australia (Military Division) Reserve Forces Decoration (AM, RFD)

Professor Anthony J Cunningham (Ireland) – Elected President, College of Anaesthetists, RCSI

Professor Teik E Oh (WA) – Elected to Fellowship, Academy of Medicine of Singapore

Dr Richard G Walsh (NSW) – Honorary Fellowship, College of Anaesthetists, RCSI, and elected Treasurer, World Federation of Societies of Anaesthesiologists

Dr Stephen J (Butch) Thomas, USA – Fellowship, Royal College of Anaesthetists by Election

Dr T C K (Kester) Brown (Vic) – Elected President, World Federation of Societies of Anaesthesiologists

Dr Peter M Kempthorne (NZ) – Member, Executive Committee, World Federation of Societies of Anaesthesiologists

Dr Michael J Hodgson AM (Tas) – Elected President, Australian Society of Anaesthetists

Professor Bruce Cullen, USA – Elected President, American Board of Anesthesiology

Dr Jerrold Lerman (Canada) – Siemens Chair in Paediatric Anaesthesia, University of Toronto, Hospital for Sick Children

Professor G A (Don) Harrison AM (NSW) – Roll of Honour, Australian Resuscitation Council

Dr John Warden (NSW) – Chairman, Australian Day Surgery Council

Douglas Joseph Professorship 2001

GUY LUDBROOK

Dr Ludbrook has been elected the Douglas Joseph Professor of Anaesthetics for 2001. The Professorship is awarded quadrennially at the discretion of the College Council, to Fellows who are making an outstanding contribution to the advancement of the specialty to pursue scholarship and research in human anaesthesia in Australia and/or New Zealand.

Guy Ludbrook received his secondary education at Norwood High School in Adelaide, and went on to study medicine at Adelaide University, graduating in 1985. He entered anaesthetic training at the Royal Adelaide Hospital in 1988, and received his Fellowship from the Australian and New Zealand College of Anaesthetists in 1994. He was appointed a Lecturer in Anaesthesia at Adelaide University in 1994, and a Senior Lecturer in 1998.

His interest in research began early in his anaesthetic training through a part-time research fellowship offered by the Department at Adelaide University and the Royal Adelaide Hospital. He went on to receive an NHMRC Postgraduate Medical Research Scholarship for work on pharmacokinetics, and continued this line of research to study for the degree of Doctor of Philosophy during the latter part of his anaesthetic training. His PhD was conferred in 1997 for a thesis entitled 'The cerebral pharmacokinetics and pharmacodynamics of propofol in sheep'.



He has remained active in research as part of a team at the Royal Adelaide Hospital and University of Adelaide, with the major focus being on pharmacology. This group receives regular competitive research funding and produces numerous papers in peer reviewed journals. The central theme of this work is the fundamental principles of drug distribution and effect throughout the body, and its implications for drug administration in anaesthesia and pain management.

He is involved in teaching at a number of levels, from problem based learning with undergraduate medical students through to teaching for the anaesthetic Fellowship examinations. He is a practicing clinician in the fields of anaesthesia and pain management, with a particular interest in neuroanaesthesia, and has a major administrative role in hospital department management.

He recently spent 18 months at the University of Washington, USA as the Lennard Travers Professor of the ANZCA. This provided an opportunity to use the Department of Anesthesiology's expertise in neuroanaesthetic monitoring to undertake research into human cerebral pharmacology. Furthermore, it allowed him to gain exposure to new neuroanaesthetic techniques, and to experience the US system of teaching and clinical practice.

Guy Ludbrook recently returned to Adelaide to take up a new appointment as the Professor of Anaesthesia at Adelaide University, Royal Adelaide Hospital.

Improvements in National Anaesthetic Data

Concern has been expressed by a number of Fellows about the introduction of anaesthesia coding by the National Centre for Classification in Health from July this year. The sequence of events leading up to this decision, from the College's point of view, is that the President wrote to the Chairman of the National Health Information Group in 1999, at the request of the Consultative Councils and Special Committees on Anaesthetic Mortality, requesting inclusion of anaesthetic data in ICD-10. Until this year, anaesthetic data have not been encoded, making it impossible to relate anaesthetic mortality or adverse events to valid statistical epidemiological data.

The National Centre for Classification in Health agreed to the request, but indicated that the first version would require further refinements to make it more comprehensive and to respond to issues arising from its use. The time frame for production of ICD-10-AM meant that the Anaesthesia Coding and Classification Group, a joint committee of the Australian Casemix Clinical Committee and NCCH, had little input to the process. Feedback to the College to date points out several issues:

- There are multiple codes for epidural, spinal and caudal.
- There are no codes for other regional blocks.
- The codes do not demonstrate the attendance of an anaesthetist.
- Adverse events are not encoded.

The College has requested significant input into the development of the revision to be published in 2002. Fellows are requested to assist the Clinical Coders as best they can and to provide constructive feedback to the College.

Despite problems with the present version, data are now being collated which have never been collated previously. Hopefully, the 2002 version will be refined to be more user friendly and to record more useful data.

Professor Garry Phillips
Director of Professional Affairs

Deaths

Council noted with regret the death of:

Dr Grant James Freear (SA) – FANZCA 1999

Dr Mark Graham Somerville (NZ) – FFARACS 1984, FANZCA 1993

Dr Daniel Brodie Hogg (Qld) – FFARACS 1963, FANZCA 1992

Highlights of Council

FROM THE OCTOBER 2000 COUNCIL MEETING

WELCOME

The President welcomed Professor John Horvath, Chairman of the Australian Medical Workforce Advisory Committee to Council. Professor Horvath spoke on the workings and information gathering of AMWAC.

In attendance:

Dr Malcolm Futter, Chairman, New Zealand National Committee

Dr Kerry Brandis, Chairman, Queensland Regional Committee

EDUCATION

Objectives of Training in Anaesthesia

The revised edition of "Objectives of Training in Anaesthesia" was approved for publication.

Anaesthetics Framework for PGY 1 and 2/Clinical Training Portfolio

The Graduate School of Medicine, University of Queensland received Commonwealth funding to establish a Prevocational Medical Education Program in Australian hospitals. The purpose of this program is to enable junior doctors to have more portability in their training and develop an understanding that all junior doctors are receiving training in the same areas, though perhaps at different times. The brief of the Prevocational Medical Education Program was to promote on-the-job education, benchmark types of skills and learning opportunities. The Training Portfolio Program is available on palm-holders and disk and has been distributed to junior doctors throughout Australia for 2000. The program is also available on the web for downloading, which provides an opportunity for adaptation to local environments. There are general objectives within the training portfolio but other areas of practice may be included. The purpose of the program is the acceptability of the process rather than specifics.

ANZCA has now identified core items for anaesthesia and prioritised the important aspects of on-the-job training for inclusion in the program.

Guidelines for the Selection of Trainees

Council has approved in principle the publication of "Guidelines for the Selection of Trainees" which will be forwarded to all approved hospitals.

Self-Development Modules

The Education Committee is developing web-based Self-Development Modules on a list of topics for trainees.

Preoperative Care Clinical Practice Guidelines

The development of Preoperative Care Clinical Practice Guidelines is progressing well and the first draft will be forwarded to all Committee members for review. Any amendments will be included in the document which will then be circulated to Regional Committees and the New Zealand National Committee for feedback and then returned to Council. It is anticipated that the final version should be available in early 2001.

EXAMINATIONS

Final Examination – Section Pass Criteria

In order to be successful at the College Final Examination candidates must pass the anaesthesia Viva section and at least one other section of the examination, and achieve a score of at least 50%.

FINANCE

Daily Living Allowance/Expenses Reimbursement and GST

Following the introduction of the GST, local Fellows acting on College business who would previously have claimed a part DLA, will now either have their expenses (including meals) related to the activity paid by the College or be reimbursed upon submission of receipts.

Airfares – Business Class Travel

Council has resolved that Business Class airfares may be utilised for those travelling on College business for direct flights greater than four hours and that the continuation of discounted airfares be supported.

Subscriptions 2002

The annual subscription for 2002, due and payable on 1st January 2001 is

\$990 + GST where applicable, for all Fellows.

Fees for 2001

- The Examination Entry Fee for 2001 remains at A\$1,900 and must be remitted to the Melbourne office.
- The Register of Training Fee for all Trainees for 2001 remains at A\$950 and must be remitted to the Melbourne office.
- The Annual Training Fee for 2001 will be retained as follows:
 - Australia and Hong Kong A\$925
 - New Zealand NZ\$925 + GST
 - Singapore/Malaysia \$925 (local currency converted into A\$)

- The fee for Non-Fellows participation in the Maintenance of Professional Standards Program is \$500 + GST where applicable.
- The Occupational Training Visa Assessment Fee for 2001 will be retained at \$75
- The OTS Assessment Fee for Australia for 2001 is A\$1,200

CONTINUING EDUCATION AND QUALITY ASSURANCE

CME Modules on the Web

Council has requested the CE&QA and IT Committees develop web-based CME modules.

Foundation Visitors

In view of the establishment of the Faculty of Intensive Care and Faculty of Pain Medicine, the College has resolved to reduce the number of Anaesthesia Foundation Visitors to the Annual Scientific Meeting to one. Therefore, as from 2001 there will be one Foundation Visitor for each of the three scientific programs, in addition to the Australasian Visitor.

INTERNAL AFFAIRS

President's Monthly Teleconference

The President will conduct a monthly teleconference with Regional Committee Chairmen and the Chairman of the New Zealand National Committee. The teleconference will provide an opportunity for the President to update the Chairmen on College activities and for matters of concern or interest to be raised.

Director of Education

Council has received an excellent response to an advertisement for the appointment of a Director of Education as a full-time position. This appointment will provide assistance in the review and development of all College education, examination and maintenance of standards activities. It is envisaged that the incumbent will also assist in the development of web-based modules. It is anticipated that, following interviews, an appointment will be made prior to the end of the year.

Prioritising College Draft Documents

It is College policy to circulate documents to Regions for input prior to promulgation. There are occasions when a speedy response is required and Council has now developed a priority rating system for feedback on draft documents as follows:

- Priority Urgent – Reply within four weeks.
- Priority Standard – Reply within six weeks.

In making these decisions, Council is aware of the difficulty in obtaining input from Regional/National Committees when a request does not coincide with meeting dates.

Certificates of Expertise

Council has agreed to award certificates in special areas of expertise not generally possessed by specialist anaesthetists,

following completion of specified training. Areas identified were hyperbaric medicine and trans-oesophageal echocardiography. A Certificates Committee has been established to further develop appropriate processes. It is likely that Special Interest Groups will be requested to develop guidelines and standards for consideration and approval by Council.

Multi-Centre Trial Secretariat

Council has resolved that the College establish a Multi-Centre Trial Secretariat under the direction of the Research Committee. It is anticipated that this Secretariat will be available for all multi-centre trials.

Joint Consultative Committee on Anaesthesia (JCCA)

Council has approved a Certificate of Participation for General Practitioners in the JCCA/MOPS Program.

Review of College Strategies and Structures Workshop

On Friday afternoon during Council, a Review of Strategies and Structures Workshop was conducted with Council and senior staff. A review of the progress of matters highlighted at the workshop held three years ago was conducted, together with identification of important new initiatives. Tasks with specific time frames were allocated to various Councillors and Committees for development.

The four areas examined were:

- Increasing the level of education for trainees and Fellows
- Increasing education services to rural regions
- Asia Pacific relationship
- Communication with Fellows

College and Faculties' Association with Scientific Journals

A statement on the College position of such association was approved, a copy of which appears elsewhere in this "Bulletin".

Personal Professional Performance Monitoring (Palm Pilot) Project

The College is working with Drs Steve Bolsin, Andrew Patrick and Bernie Creati from the Geelong Hospital in the development and appraisal of a Personal Professional Performance Monitoring Project for trainees. Currently this pilot project involves trainees at the Geelong (Victoria), Gold Coast (Queensland) and Green Lane (Auckland) Hospitals. The outcome of this pilot study will be reviewed at the end of the year when the College will consider the feasibility of involving all first year registrars. The purpose of this initiative is to encourage data collection, analysis and feedback on performance. Anticipated reduction in adverse incidents of all kinds will result from improved performance monitoring in training and as specialist anaesthetists.

Overseas Trained Specialists Assessment

Council has approved an assessment process for all overseas trained specialists. The objective of the OTS process is to assess

the proficiency of the OTS to practise in Australia or New Zealand so as to provide the community with the highest standard of care. The process determines whether the OTS is able to perform unsupervised as a specialist in Australia or New Zealand at a comparable standard to that of a FANZCA. It is not an alternate specialist training program but can be regarded as a recertification of specialists from non Australasian training backgrounds.

The assessment comprises:

- Interview
- Performance Assessment
- Clinical Assessment Period
- Review

The OTS Committee will review candidates who are unsuccessful in their assessment for the second time. This review is to facilitate help and counselling, with the possible appointment of a mentor. A copy of details of the process appears elsewhere in this "Bulletin".

RESEARCH

Research Awards for 2001

Recommendations from the Research Committee were noted by Council and details of the Research Awards for 2001 are published elsewhere in the "Bulletin".

Douglas Joseph Professor 2001

The Douglas Joseph Professorship for 2001 was awarded to Dr Guy Ludbrook, SA.

PROFESSIONAL

NHMRC Document – Acute Pain Management Scientific Evidence

Council has established a Working Party to review the NHMRC document "Acute Pain Management Scientific Evidence".

Membership comprises Dr Pam Macintyre (Chair), Dr Penny Briscoe and Dr Suellen Walker representing the Faculty of Pain Medicine, and Dr Paul Christie, Dr Michael Cooper and Dr David Scott representing the Acute Pain SIG.

VicRoads "Medicines and Driving – A Code of Practice for Health Care Professionals"

The College supported the document "Medicines and Driving – A Code of Practice for Health Care Professionals".

Skeletal Muscle Testing for Malignant Hyperpyrexia

The Council has agreed that the College will maintain a Register of Sites which conduct skeletal muscle testing for malignant hyperpyrexia.

Professional Documents

The following Professional Documents were approved and promulgated:

- PS4 "Recommendations for the Post-Anaesthesia Recovery Room"
- PS15 "Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery"
- PS18 "Recommendations on Monitoring During Anaesthesia"
- PS41 "Guidelines on Acute Pain Management"
- TE16 "Requirements for Multidisciplinary Pain Centres Offering Training in Pain Medicine" was withdrawn following of the promulgation of PM2.

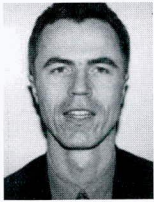
College Statements

Council resolved to withdraw the following Statements:

- "Statement on Continuous Intravenous Opioid Infusions"
- "Statement on Patient-Controlled Intravenous Opioid Analgesia"

2001 Research Awards

The following Research Grants for 2001, recommended by the Research Committee, were awarded by Council at the October 2000 meeting:



Dr Michael Barrington
(Vic)
\$21,000

A clinical study investigating the role of epidural anaesthesia in coronary artery surgery.



Professor Laurence Mather (NSW)
\$35,000

Inotropic effects of thiopentone enantiomers and propofol.



Dr Neil Pollock (NZ)
A\$20,000

Genetic and biochemical characterisation of malignant hyperthermia susceptibility.



Dr Tony Chow (Vic)
\$20,000

A prospective, double blinded, randomised controlled trial using ketamine and morphine to prevent chronic post-operative pain.



Dr Des McGlade (Vic)
\$36,000** Three year funding allocated (\$12,000 x 3 years)

The comparative effects of two analgesia techniques on outcome from lower limb vascular bypass surgery.



Clinical Associate Professor Bala Venkatesh (Qld)
\$11,860

A study of the dynamics and temporal profile of cortisol secretion in critical illness.



Dr Mark Fajgman (Vic)
\$27,466

Should pregnant patients have open or laparoscopic surgery? Effect of laparoscopy on fetal well being.



Dr Allan Molloy (NSW)
\$35,000

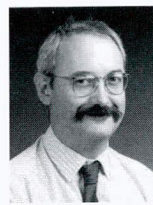
Functional magnetic resonance imaging and magnetic resonance spectroscopy of brain regions in acute and chronic pain states.

** Subject to satisfactory Progress Reports in subsequent years.



Dr Roman Kluger (Vic)
\$13,800

Effect of perioperative atenolol on adverse cardiac outcomes after noncardiac surgery.



Associate Professor Harry Owen (SA)
\$20,000

Improving teaching and learning of essential airway skills of medical students.



Dr Kate Leslie (Vic)
\$30,000

Avoiding awareness during anaesthesia: a randomised controlled trial of BIS monitoring.



Dr Michael Paech (WA)
\$78,750 ** Three year funding allocated (\$26,250 x 3 years)

Prophylaxis against postoperative nausea and vomiting; the efficacy of dexamethasone and ondansetron.

The Harry Daly Research Award was awarded to **Dr Mark Fajgman** for his project: "Should pregnant patients have open or laparoscopic surgery? Effect of laparoscopy on fetal well being."

The Florence Marjorie Hughes Research Award was awarded to **Dr Des McGlade** for his project: "The comparative effects of two analgesia techniques on outcome from lower limb vascular bypass surgery".

Special Interest Groups

Annual Reports 2000

Acute Pain

Executive Members

Dr Mary Cardosa	Malaysia
Dr Paul Christie (Chair)	ACT
Dr Arthur Doughty	TAS
Professor Colin Goodchild	VIC
Dr Richard Halliwell	NSW
Dr Pam Macintyre	SA
Dr Jenny Parslow	QLD
Professor Stephan Schug	NZ
Dr Grant Turner	WA



Dr Paul Christie

In October 1999, the College Council ratified the formation of the Acute Pain Special Interest Group under the revised structure and new Constitution approved by ANZCA, the ASA and NZCA. The major objective of this SIG is the promotion of science and education by:

- (a) the exchange of ideas between anaesthetists with a particular interest and involvement in acute and acute-on-chronic pain states.
- (b) Interaction with other individuals/groups, who share an interest in acute and acute-on-chronic pain states.

Together with the Board of the Faculty of Pain Medicine, the Executive of the SIG made major contributions to the drafting of College Guidelines for:

- (a) Patient Controlled Intravenous Opioid Analgesia.
- (b) Continuous Intravenous Opioid Infusions.
- (c) The Policy Document "Acute Pain Management" - PM3 (1999).

The SIG and the Faculty of Pain Medicine will jointly contribute members of a subcommittee to revise the NHMRC Document "Acute Pain Management: Scientific Evidence". Another subcommittee of the SIG is currently preparing draft guidelines for anticoagulation and thromboprophylaxis for patients receiving epidural infusions for pain relief. A draft document on "A Recommended Minimum Data Set for Audit of Acute Pain Management in Adults" has been forwarded to the College and distributed to Regional Committees and to the Faculty of Pain Medicine for comment. The recommendations were based on a survey of hospital-based Acute Pain Services, conducted by Drs. Richard Halliwell and Grant Turner, the results of which were published in *'Anaesthesia and Intensive Care'* in November 1999.

In May of this year, the Acute Pain SIG contributed a session to the Annual Scientific Meeting of the College in Melbourne. The session, titled "New Therapies for Acute Pain", was a case-based panel discussion and was well received by a large audience. The SIG will be holding its next biennial Continuing Medical Education Meeting, "Acute Pain Management - A Look Outside the Postoperative Square", on 11-12 November, 2000 at the Hyatt Hotel Canberra. An AGM will also be held at this time and an Election of a new Executive will take place as required by the new Constitution.

PAUL J CHRISTIE
Chair

Cardiothoracic, Vascular and Perfusion

Executive Members

Dr Malcolm Anderson	TAS
A/Professor Peter Klineberg (Chair)	NSW
Dr Lisa McEwin	SA
Dr John Murray	QLD
Dr Paul Myles	VIC
Dr David Scott	VIC
Dr Ken Williams	WA
Dr Leona Wilson	NZ

The CVP SIG continues to offer a forum for education and the establishment of standards within our specialty areas. With increased emphasis on CME and QA, we are adapting the format of our meetings to satisfy the standards required by the College MOPS program. Simultaneously, we are following the rapid development of practice changes and working with the Council to establish training and standards for practice in sub-specialty areas. The Executive has state representatives and members are strongly encouraged to work with their delegates and participate in the work of this SIG.

The Executive has also functioned to provide information on practice areas (eg the incidence of profound hypotension with newer Angiotensin II inhibitors) via an effective E-Mail network.

ANZCA ASM Melbourne - May 2000

Two conjoint sessions with surgeons were presented at the ASM for CVP SIG participation. One was a session on "perioperative cardiac risk and assessment for vascular surgery (May 8) and the other "Risks and outcomes in Cardiac surgery" (May 9). Both sessions were well attended and were an excellent forum for our SIG.

Biennial CVP - SIG Meeting Uluru (Ayres Rock) , July 6-8, 2001

Our next SIG meeting promises to be an excellent update at an exciting venue. The program planning is well underway with emphasis on the areas of Thoracic trauma, diagnosis and management of coagulation disorders, monitoring for major surgery and including BIS monitoring. We will have sessions on TOE emphasising the role of this technique in our practice (both cardiac and non cardiac) and on perfusion.

The venue is already booked and enquires regarding accommodation etc. should be made via Helen Morris at the College office in Melbourne.

Participation in the Hong Kong CSM, May 5-9, 2001

We will be presenting two sessions at the combined CSM in Hong Kong in May 2001. A vascular session will present data on monitoring and techniques and a session on cardiac anaesthesia, looking at OPCAB techniques.

TOE Accreditation

With a dramatic increase in interest and use of TOE by anaesthetists in our SIG, we are now committed to education and development of standards in this area. A draft proposal has been presented to Council describing recommendations for a standardised TOE certification. The document makes recommendation for the procedure itself and for training and MOS of proceduralists in this area. We have accepted material developed by the American Society of Anesthesiologists and the SCA Task Force on transoesophageal echocardiography in our recommendations.

Members felt it was important to progress with training and certification in T.O.E. and the Council Executive at its meeting of 19 August 2000, supported this principle.

Medical Perfusion

This area is always difficult for the Executive because of the widely differing practices in different states. We continue to review our policy document but have not yet settled on a recommendation.

Presentations on aspects of perfusion will continue to feature in our SIG meetings. We are hoping to have the perfusion simulator at Uluru.

CVP SIG Executive

The Executive, which is made up of regional representatives, has teleconferences from time to time to discuss matters of policy and our educational programs. We

also communicate via an email network via Helen Morris - this has proved very effective for specific issues.

Members need to communicate with your regional representative to ensure broad input to the Committee.

We have had a busy year with our participation in College meetings, early preparation for our biennial meeting at Ulura 2001. Discussions about standards for TOE have also taken much time. I wish to thank the Executive members for their great co-operation and input to our meetings. The work of Helen Morris at the College is pivotal and we greatly appreciate Helen's contribution.

PETER. L. KLINEBERG
Chair

Day Care Anaesthesia

Executive Members

Dr Andrew Bacon	ADSC
Dr Michael Fong	QLD
Dr Colleen Kane	NSW
Dr David Kinchington (Past Chair)	ACT
Dr Robin Limb	SA
Dr Ruth Matters	TAS
Dr Joe Novella	VIC
Dr Hugh Spencer	NZ (retired)
Dr Stephen Watts (Chair)	WA

Major Items Of Business

1. The Rupert Hornabrook Prize for research in day care anaesthesia.

The inaugural Hornabrook Prize was awarded to Dr Brian Anderson from the Starship Children's Hospital in Auckland for "The dose effect relationship for morphine and vomiting after day stay tonsillectomy in children". The SIG is promoting original research in the field of day surgery by offering a prize of A\$300 for research presented in the forum of the ASMs of ANZCA, ASA or NZSA. One prize may be awarded each year to a paper of suitable standard. Details of the prize and its assessment are available on the SIG website or your local Executive Member.

2. Conversion of an inpatient procedure to a day care procedure

The SIG spent considerable time discussing this conversion process. Much of this work was undertaken by Dr Andrew Bacon and Dr Robin Limb of the SIG Executive. A draft document for this conversion process is being currently assessed at a College and Regional Committee level.

3. Sedation in a day surgery office setting

The SIG has been involved in discussion relating to the credentialing of both site and personnel involved in the provision of sedation in an office or day care unit setting. Much discussion centred on minimum standards of training and equipment. ANZCA, RACS and the Australian Day Surgery Council continue to discuss these issues. Dr Steve Watts of the DCA SIG has played a prominent role in these discussions.

Meetings

1. "Day Care Anaesthesia: Now and into the Future" Day Care Anaesthesia Satellite Meeting to ANZCA ASM, Melbourne 2000

Dr Ian Smith, Senior Lecturer in Anaesthesia, Keele University, Stoke-on Trent, UK and Dr Glenda Rudkin, Anaesthetist, Adelaide were the International and Australasian Visitors respectively. This one day meeting looked at issues of where

we are going in Day Care Anaesthesia along with issues of common practice. This meeting was well attended and well received by over 160 participants.

2. ANZCA ASM, Melbourne 2000

The SIG organised one session and two workshops for this ASM. The session was a panel discussion featuring the invited speakers from our satellite meeting. Workshops on "Preoperative investigation" and "Day care quality assessment" were undertaken by Dr Watts and Dr Kinchington. All sessions were well attended with positive feedback.

3. ANZCA ASM, Hong Kong 2001

The SIG is currently developing its participation in this meeting

4. ASA NSC, Canberra 2001

This meeting will have significant day care anaesthesia input with one of the international invited speakers being Dr Frances Chung, Toronto, Canada.

5. Day Care Anaesthesia SIG Satellite Meeting, Brisbane May 2002

The SIG is already planning this meeting prior to the Brisbane ASM.

General Comments

The last year has continued to be a busy one for the DCA SIG. Teleconferences are well attended and considerable effort continues to be undertaken by all on the Executive. Changes in Executive personnel have continued with Hugh Spencer resigning. The Executive thanks Dr Spencer for his longstanding work and commitment to the Day Care Anaesthesia SIG. I would also welcome Dr Steve Watts as the new Chairman of our SIG.

The new Constitution of the SIG has endeavoured to connect the SIG Executives to their members. While formal means of contact via elections is essential, it is even more essential that the SIG members participate actively in the SIG by informal discussions with ones state representative about issues of importance. All of the Executive is contactable and this information is available via the College or its website. The Executive needs the members input.

Once again the Executive would like to thank Helen Morris for her contribution to the smooth running of this SIG. We continue to benefit enormously from her constant efficiency and organisation. I would like to thank all the members of the Executive for their efforts during the year.

DAVID KINCHINGTON
Chair

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 Simon Mitchell	SPUMS
Dr David Smart	ANZHMG
Dr Brian Spain	NT
Dr Margaret Walker	TAS
Dr David Wilkinson	SA
Dr Robert Wong (Chair)	WA



Dr Robert Wong

There has been a change in membership in the past 12 months. Having contributed and provided strong, continuous support since its inception, Dr Ian Unsworth (NSW) and Dr Chris Lourey (Vic) have stepped down from the Executive Committee.

Introductory Course in Diving and Hyperbaric Medicine -

This inaugural full-time course was held at the Prince of Wales Hospital, NSW from 21 February to 3 March 2000. It was a very well subscribed, and successful course sponsored by ANZHMG and supported by the SIG. The faculty included most of the directors and staff of the hyperbaric units in Australasia. The course will be conducted annually, with the next course scheduled to begin on 5 March 2001 and is recognised for 70 hours of Category 1 CME points from the United States' Undersea and Hyperbaric Medical Society.

Training Positions Available

Currently a number of positions are available for training in diving and hyperbaric medicine suitable for the DipDHM:

- NSW – at the Prince of Wales Hospital, one 6 month full time (anaesthetic Provisional Fellow); one 3 month part-time anaesthetic registrar. (RAN: at HMAS Penguin for naval medical officers only).
- QLD – no funded position available in Brisbane or Townsville.
- SA – one 6 month anaesthetic rotation at the Royal Adelaide Hospital.
- TAS – at the Royal Hobart Hospital, one position suitable for the DipDHM available for anaesthetic registrars.
- VIC – one 6 month position available for Intensive Care Physician or Emergency Medicine Trainee at the Alfred Hospital
- WA – one 12 month part-time training position for Emergency Medicine Registrar; one 6 month part-time position for anaesthetic registrar and one full-time position (either 12 months or two 6 month full-time rations) at Fremantle Hospital
- NZ- one position for Emergency Medicine trainee at the RNZN Slark Hyperbaric Unit in Auckland.

Formal Qualification in Hyperbaric Medicine -

In March 1999, the American Board of Preventive Medicine received approval to change the name of its subspecialty certification in Undersea Medicine (1993) to Undersea and Hyperbaric Medicine. This title more accurately reflects the expansion of practice during the past decade to include the use of hyperbaric oxygen therapy for a variety of disorders. An annual examination will be held. Similarly, the European Committee for Hyperbaric Medicine and the European Committee for Diving Technology have agreed upon a common training goal, with the ultimate aim of reciprocal recognition of the respective diplomas from various countries in Europe.

A formal qualification is considered desirable and essential by the SIG Executive Committee, as well as by members of the wider community. As it is an emerging field, it has its own indications, treatment side effects and hazards. Hyperbaric Medicine is not taught in the undergraduate curriculum, nor is it generally available in the post-graduate training program. By having a formal qualification, it will raise the level of education in hyperbaric medicine, as will the standard of training. Furthermore, it was felt that the safety of patient care will be ascertained and the appropriate indications of treatment will be observed. Research will be encouraged to provide adequate level of evidence for therapy. The core sciences which underpin the specialty are similar to that of anaesthesia, thus it will provide unique learning opportunity in applied physiology.

Currently, the only qualification available is the Diploma of Diving and Hyperbaric Medicine (DipDHM) awarded by the South Pacific Underwater Medicine Society (SPUMS). It is recognised by Medicare, and is also accepted by Standards Australia as an entry qualification. The SIG Executive considers this qualification on its own as inadequate training to manage a hyperbaric department in a hospital, or indeed in a solo specialist practice. However, the definition of a specialist hyperbaric physician is somewhat vague, but is currently recommended by the SIG to include those physicians who have specialist qualifications such as FANZCA, FACEM, FRACP or a MD/PhD in a relevant field, together with DipDHM. A formal qualification in hyperbaric medicine will delineate the training and qualification required to practise as a specialist hyperbaric physician.

ANZ Certificate in Hyperbaric Medicine

The SIG has approached ANZCA to request the granting of a certificate in diving and hyperbaric medicine.

A detailed course syllabus is available, and is awaiting ratification by the College Council. It is envisaged that the course will take 18 months to complete. During this time, a candidate is expected to have attended both a Diving Medicine Course conducted at the Royal Adelaide Hospital or the Royal Australian Navy and the ANZHMG/SIG Hyperbaric Medicine Course. Each is of two weeks duration. The other requirements include the completion of the Diploma of Diving and Hyperbaric Medicine awarded by the South Pacific Underwater Medicine Society. This requires a candidate to have completed 6 months full-time work in a recognised hyperbaric department and to produce a thesis from a research project approved by the Education Officer of the South Pacific Underwater Medicine Society. After which, another 12 months work in an approved hyperbaric medical department is required. During this time, a candidate is required to complete a workbook detailing the experience in the management of various conditions. Finally, an exit examination is envisaged.

Medicare Services Advisory Committee (MSAC) - Hyperbaric Medicine Supporting Committee

Dr Mike Bennett, representing ANZHMG, and Dr Robert Wong representing ANZCA, with Dr David Wilkinson as a coopted member, are members of MSAC Supporting Committee, which discusses the indications of hyperbaric oxygen therapy, and advises the Committee on evidence based medicine and the relevance of hyperbaric medicine.

Standards Australia SF/46 Committee

This Committee meets to discuss standards for work in compressed air and hyperbaric facilities; non-diving hyperbaric oxygen treatment facilities and tunnelling work. This is chaired by Dr John Knight, whilst two members of the SIG (Drs Bennett and Wong) are also members of the Committee.

ANZCA ASM

Due to the concurrent running of the ASM of SPUMS in Fiji in May 2000, there was an inadequate number of delegates present to conduct a session in hyperbaric medicine at the Melbourne ASM. The Executive has approached the organisers of the scientific meetings to request that future meetings be scheduled at different times. The SIG has planned to hold a scientific session at the 2001 ASA meeting in Canberra.

Most members of the SIG are very active participants in the annual scientific meetings, and most present papers at major meetings which include those conducted by the

1. Undersea and Hyperbaric Medical Society, usually held in mainland United States in June;

2. European Undersea and Baromedical Society, in Europe in September;
3. South Pacific Underwater Medicine Society, usually in the Indo-Pacific region in May;
4. Australian Hyperbaric Meeting hosted by the Hyperbaric Technicians and Nurses Association held in an Australian city in August/September. Concurrently with this meeting is the AGM of the ANZHMG. As most practitioners are anaesthetists, members also attend the College ASM and the Society NSC.

ROBERT M WONG
Chair

Medical Education

Executive Members

Dr Malcolm Anderson
 Professor Cindy Aun
 Prof Geoff Cutfield
 Dr Kerry Delaney
 Dr Patricia Goonetilleke
 Dr Vaughan Laurensen
 Dr Barrie McCann (Chair)
 Dr Margaret Wiese
 Dr Robert Wong

TAS
 HK
 NSW
 ACT
 QLD
 NZ
 QLD
 SA
 WA

At the teleconference in August, Dr Robert Wong tendered his resignation as Chair. Barrie McCann was elected as the new Chairman and the existing SIG Executive elected unopposed. A vote of thanks was extended to Dr Wong for his outstanding contribution to the group.

Meetings

The SIG participated in the ASA meeting and the ANZCA ASM in May. The Executive Committee held teleconferences in August, December and February and a face to face meeting at the ASM in May. Unfortunately, the meeting at the ASM provided little input from members of the SIG because the meeting was not well advertised. Additional use of email has helped to speed up communications between members.

Workshop

A Workshop on "Selecting a trainee - a hypothetical" was held during the Annual Scientific Meeting in Melbourne and was well attended. Drs Patricia Goonetilleke and Barrie McCann co-chaired the session and a panel comprising Drs Tony Weeks, Larry McNicol, Kerry Brandis, Michal Kluger, Mr Michael Gorton and Professor Teik Oh took part.

The subtleties of interview technique were demonstrated by Drs Tony Weeks and Larry McNicol who conducted live interviews of two applicants. However the difficulties of comparing two candidates with good but markedly contrasting CVs raised many issues. A sometimes heated discussion took place and demonstrated old prejudices and the lack of balance which can occur in selection panels if due process is not followed. Mr Michael Gorton highlighted the legal issues and the traps if strict guidelines are not followed. Dr Kerry Brandis gave an overview of the Queensland experience using a structured and weighted criteria selection process. Aspects of the psychological profile to the typical anaesthetist and the importance of identifying dangerous traits were discussed by Michal Kluger. Professor Teik Oh outlined the new College guidelines. He pointed out that these encompassed the recommendations of the Brennan Report emphasising the need for structured and transparent processes.

In Training Assessment

The Committee welcomes initiatives by the College on this topic and would support and encourage future meetings or workshops on this topic.

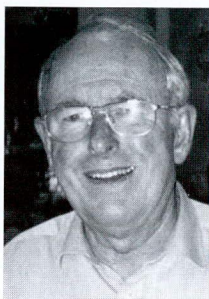
Participation in ASA meetings

It was agreed that when possible the SIG would take part in ASA meetings and in particular when educational themes were being discussed.

Training the Trainers

The Group is negotiating with the Education Committee of the College to arrange a training program for Fellows involved in teaching.

BARRIE McCANN
Chair



Neuroanaesthesia

Executive Members

Dr Winifred Burnett	VIC
Dr Ray Cook	ACT
Dr Kate Leslie	VIC
Dr Stephen Swallow (Chair)	TAS
Dr Elizabeth Tham	SA
Dr Wally Thompson	WA



The Executive Committee would like to thank outgoing Interim Executive Committee Members Assoc Prof David McConnel QLD, Drs Jennie Beckett-Wood NSW, and Neil Warwick NSW.

The Executive Committee currently has no representative in NSW, QLD, NZ or HK. We would be happy to accept nominations via e-mail from these four areas. The Executive finds e-mail the most effective medium for communication most of the time.

The Annual General Meeting

The AGM was held on Tuesday 9th May 2000 during the Annual Scientific Meeting.

Constitution

Discussions between Dr Ray Cook, Neuro SIG Executive and the College of Anaesthetists concerning the Constitution are ongoing. The current Chairman is most grateful to Dr Cook for his continuing work on the Constitution.

College Meeting 2000

The Executive Committee would like to thank Drs Peter Mitchell, Guy Ludbrook and Hilary Madden for their excellent presentations in the Neuroanaesthesia SIG session on Anaesthesia for Cerebral Artery Clipping. The workshops on neurological monitoring organised and run by Dr Tim McCulloch and Dr Guy Ludbrook were also most interesting and informative.

College Meeting 2001

Plans are underway for the neuroanaesthesia SIG sessions at the Hong Kong meeting. We hope to bring you a programme as interesting as the one in Melbourne.

One Day Neuroanaesthesia Meeting

Would you like us to organise one? Comments and suggestion via Helen Morris at ANZCA

STEPHEN SWALLOW
Chair

Obstetric Anaesthesia

Executive Members

Dr David Crooke	NSW
Dr David Elliott	NSW
Dr Richard French	NZ
Dr Stephen Gatt	NSW
Dr Alison Lilley	VIC
Dr Michael Paech (Chair)	WA
Dr Andrew Ross	VIC
Dr Graham Sharpe	NZ
Dr Scott Simmons	SA

In late 1998 I received a letter from the ASA asking about the status of the Obstetric Anaesthesia Special Interest Group (OA SIG). This group had been formed in the late 1980's and while active initially it had fallen quiescent for many years. After considerable canvassing of opinion around Australasia, it was decided to reform the group under the new generic constitution for SIGs that had been prepared in consultation between the ASA, NZSA and ANZCA. An application was made, nominating ANZCA as the parent secretariat provider, and the formation of an OA SIG was ratified by ASA, NZSA and ANZCA in October 1999. Copies of the Obstetric Anaesthesia Special Interest Group Constitution, dated 27 July 1999, are available through the College.

A call for membership has been issued through the College Bulletin and currently there are over 400 members. Membership is open to Fellows and Ordinary Members of the ASA or NZSA, and to Associate Members (eg. those who are Associate Members of the ASA or NZSA, registered trainees of ANZCA, allied health professionals or members of other related professional organizations). Further growth is welcomed and anticipated. In the near future, a call for nominations for a duly elected Executive Committee (for three years) will occur. Under the Constitution, subject to flexibility, this Executive aims to represent each state of Australia, the ACT, New Zealand and the Asia Pacific region.

In the meantime, some of the interim Executive and interested attendees of the ANZCA Annual Scientific Meeting in Melbourne in May 2000 held an informal meeting and a further meeting will be held at the forthcoming ASA National Scientific Congress in Perth. In addition, two sessions of the ASA meeting (on the morning of Tuesday October 3) have been organised under the auspices of the OA SIG. This scientific meeting includes several presentations by local, national and international speakers, with discussion sections, on the themes "Infection - A Festering Problem in Obstetric Anaesthesia" and "Complications of Obstetric Anaesthesia".

Over the past year I have dealt with correspondence from various sources. It is clear the opportunity exists for the new OA SIG to play an active role in many spheres of science and education, including national data collection, exchange of ideas and continuing education. Similar groups have recently formed in the Asia-Oceanic region and mutual interest exists in forming links.

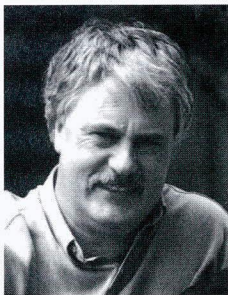
I would like to thank Helen Morris of ANZCA for her help in the formation of this group and my colleagues who have contributed to its re-birth.

MICHAEL PAECH
Acting Chair

Rural

Executive Members

Dr Daryl Catt (Chair)	SA
Dr John Henshaw	TAS
Dr Di Khursandi	QLD
Dr David Kinchington	ACT
Dr Wilson Lim	WA
Dr Mike Miller	NZ
Dr Frank Moloney	NSW
Dr Mark Tuck	VIC



Firstly the Rural SIG would like to thank the ANZCA Council for its continued support and interest in rural issues. Special mention and thanks are also due to Mrs Joan Sheales and Ms Helen Morris for their continued efforts.

The Melbourne ASM 2000 Rural Issues Workshop was well attended and focused on Recruitment, MOPS GP Training and RARS. Details of this workshop have appeared in an earlier edition of the Bulletin. The presentations have also been available on the Virtual Congress website. All participants are congratulated for their contribution.

The Virtual Website is to be congratulated as a benefit to distance learning, which rural practitioners will find especially useful.

The role of the JCCA in GP Anaesthesia in recent times has been boosted by the balanced representation of ANZCA, RACGP and ACRRM. The JCCA is now able to make effective executive decisions and see them followed through without significant delays. MOPS changes are a good example. Face to face assessments and or rural aligned Simulator sessions now form the basis of Q/A points for GP anaesthetists. Special mention should be made of Drs Peter Keast and Brendan Flanagan (Monash Medical Centre) for their on site visits and two day simulator sessions enabling Victorian rural GP anaesthetists to attain needed QA points. Different regions manage reaccreditation in different ways but it has become generally accepted for GP anaesthetists to participate in the JCCA MOPS program.

The Committee of Presidents of Medical Colleges Rural Sub-committee has been quiet but has recently become active, wanting to assist member colleges with rural issues such as staffing, CME and rural health policies. A questionnaire has been developed as a basis for starting to understand the broad spectrum of specialist services across Australia.

Filling positions in rural areas is still difficult. Rural areas are often turning to contracted overseas trained specialists. ANZCA Council has developed Areas of Need Policy aimed at assisting in the selection of "best fit" candidates for the available position as well as an alternative pathway to Fellowship. There have also plans to modify the ANZCA examination process so overseas trained anaesthetists will sit a modified exam without a reduction in quality. These efforts are applauded. It is preferable for ANZCA to be involved in the process when overseas specialists are being employed in hard to recruit areas.

The Rural Anaesthetic Recruitment Service (RARS) has been successful in filling eight locum places and one permanent position. There are 13 requests from potential employers still unmet. Currently 17 anaesthetists have applied to be "on the books" as being available while another 76 have responded with expressions of interest. It is planned for RARS to have a separate location on the ANZCA Website. It is also planned to extend the RARS to New Zealand. Ms Jennifer Ellis, our Project Officer, is to be congratulated for her efforts.

The Executive is keen to have feedback from members and indeed all Fellows about the future directions and goals of the Rural SIG.

DARYL CATT
Chair

Simulation & Skills Training

Interim Executive Members

Dr Stephen Bignell	QLD
Dr Brent Donovan	WA
Dr Brendan Flanagan (Chair)	VIC
Dr Sandy Garden	NZ
Dr Richard Morris	NSW
Dr Harry Owens	SA

In January 1999 the Education Committee of the College resolved that institutions with high-fidelity patient simulators be encouraged to develop as Anaesthesia Skills Laboratories and be encouraged to collaborate with their surgical and other local colleagues in developing such laboratories. It was considered that Skills Laboratories could allow for the development of a wide range of education and training opportunities to complement and enhance those already existing within Simulation Centres. In June 1999 Council invited The Australasian Association of Simulation Centres to consider the formation of a Special Interest Group under the generic constitution of the Anaesthesia Continuing Education Coordinating Committee.

After a series of meetings it was resolved that a Simulation and Skills Training Special Interest Group would form with ANZCA as the parent secretariat. The formation of the SIG was ratified at February Council.

The role of this SIG is to discuss academic issues including formulation of training syllabuses of Simulation & Skills Training courses; maintenance of standards, quality assurance, and research and teaching. It is not the intention of this group to take over the current role of The Australasian Association of Simulation & Skills Centres. Copies of the Special Interest Group's Constitution are available through the College.

A call for membership has been issued through the College Bulletin. Membership of this SIG will be open to Fellows, members of the ASA and NZSA. Fellows of other Colleges, practitioners and allied health professionals will also be encouraged to participate as Associate Members. A call for nominations for a duly elected Executive Committee (for 3 years) will occur. Under the Constitution, subject to flexibility, this Executive aims to represent each state of Australia, the ACT, New Zealand and the Asia Pacific region.

Some members of the interim Executive met informally at the ANZCA ASM in Melbourne in May 2000. An inaugural meeting under the auspices of the SIG will be held in conjunction with upcoming ASA National Scientific Congress in Perth – on Friday September 29. This will be a daylong meeting on Simulation, with its guest speaker being Professor David Gaba, world pioneer in simulation and International visitor at the NSC. The meeting will consist of contributions from each of the Simulation Centres in Australia and New Zealand.

I would like to thank my colleagues who have contributed to the formation of this group and to Helen Morris of ANZCA for her assistance in preparation of this report.

BRENDAN FLANAGAN
Acting Chair

Welfare of Anaesthetists

Dr Mary Cardosa	Malaysia
Dr Margie Cowling	SA
Dr Genevieve Goulding	NSW
Dr Di Khursandi (Chair)	QLD
Dr Phoebe Mainland	HK
Dr Phil Ogden	TAS
Dr Lindy Roberts	WA
Dr Jack Warhaft	VIC
Dr Leona Wilson	NZ

The activities of the Welfare of Anaesthetists Special Interest Group have continued to expand, in tandem with increasing world-wide interest in the importance of doctors' health issues. Members of the group are contacted frequently by colleagues and trainees for advice and information on diverse issues.

Several regional seminars (South Australia, Western Australia, Victoria and New Zealand) and sessions at national meetings have continued to address welfare issues. Orientation and welfare information seminars for trainees are held in some regions. Questions on welfare and ethics issues have been included in several recent final FANZCA examinations.

The WOAG Action Plans are on the ANZCA and ASA websites; it is planned to update these in the near future. All anaesthetists and intensivists are encouraged to look at the Action Plans, and download them for use in their departments. We suggest that each department and group of anaesthetists designate a particular person to be responsible for welfare issues.

The group prepared a report for ANZCA on the NSW Doctors Mental Health Program document "Strategies for (NSW) branches of Medical Colleges". Work on several other documents is in progress, including those on fatigue, welfare issues for the anaesthetic department, and mentoring; members have also provided input on how to deal with the difficult trainee.

Two excellent sessions on impairment and competence excited much interest at the Cairns ASA NSC; they included presentations from Dr Steve Bolsin and Dr Jillann Farmer, the Queensland Health Assessment Program Coordinator.

The ANZCA ASM in Melbourne in May contained a plenary session in which Dr Jeanette Strong, doctor extraordinaire, and Dr William Wilkie, a psychiatrist from Brisbane, were invited speakers.

Several Australians and New Zealanders attended the World Congress of Anesthesiology in Montreal in June 2000, where the theme of "The Sociology of Anaesthesia" ran over the whole week of the Congress. The topics for the five days were Medico-legal issues, the Anesthesiologist's Life Cycle, Ethics, The Challenged Anesthesiologist, and History.

A session on "Making Healthy Choices" is to be held at the Perth NSC, and Professor David Gaba will explore the problem of the effects of physician fatigue on performance, and "How to Break Bad News".

Dr Phoebe Mainland is coordinating plans for doctors' health sessions for the Hong Kong ASM.

A teleconference of the group's Executive Committee was held in January 2000, and an Annual Business Meeting at the Melbourne ASM. At the latter meeting Dr Chris Acott's resignation from the SIG Executive as South Australian representative was tabled; he will be replaced by Dr Margie Cowling, to whom we extend a warm welcome. The group would like to thank Chris for his work on Executive and his support for the work of the group.

The Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists have now endorsed the WOAG constitution.

The Victorian Doctors Health Service was launched early in 2000, funded by the AMA and the Victorian Medical Board, although it will function at separately from these bodies. Drs Jack Warhaft and John Paull are to be congratulated on their contribution to this initiative.

We would like to thank ANZCA for its continued support in providing the secretariat; a special thank you is extended to Ms Helen Morris for all her hard work in assisting the activities of the group, and to Ms Shanti Nadarajah, who has obtained for the ANZCA library many excellent books on doctors' health issues.

DIANA C STRANGE KHURSANDI
Chair



Law Report

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

What is negligence?

The practice of medicine is not perfect. Many patients suffer from disease or conditions for which there may be no, or no adequate, treatment. Nonetheless, patients have come to expect perfect results.

Much has been stated of the 'adverse medical outcomes' which patients may suffer within the health system. These more often are a result of natural outcome from the disease or condition which they suffer, the inherent risks and side-effects of a procedure or administration (ie; drug) or some other systemic error which is unrelated to the doctor's care and attention.

The health system is a cumbersome, sophisticated and technical system, which at times operates under great pressure and stress. Patients may not achieve perfect results for many reasons which have nothing to do with the negligence or lack of care of doctors.

At law, doctors are only responsible for their own want of care, or the failure to apply the proper standard of skill and attention that might be expected in the circumstances.

Examples of obvious negligence are death or injury resulting from:

- administration of the wrong drug or an excess of a normal drug being administered;
- administration of a drug in the wrong area of the body;
- the wrong limb being operated on;
- tourniquet remains too long with vascular complications;
- pressure areas or burns or other injuries to an anaesthetised patient.

Liability can arise under different causes of action.

1 Negligence

In addition to a failure by the doctor to exercise proper care and attention, the doctor could also in some circumstances be negligent in failing to obtain informed consent (informing the patients of all material risks relevant to the procedure).

2 Assault/Trespass

If a doctor treats a patient without proper consent, the doctor is technically committing a trespass or assault on the patient.

3 Breach of Fiduciary Duty

In rare cases, the Courts have recognised a fiduciary duty arising from the 'special relationship' between the patient and the doctor. Where a doctor fails to act in the best interests of the patient, and fails to disclose any conflict of interest, it is sometimes argued that this fiduciary duty is breached.

4 Breach of Contract

In common with a negligence claim, it is sometimes argued that the failure by the doctor to exercise due care is also a breach of the contract between the patient and the doctor.

In a negligence claim, the courts will usually assess three elements:

- (i) the duty of the doctor to take reasonable care of the patient;
- (ii) whether there has been a breach of duty by the doctor; and
- (iii) whether the damage that the patient has suffered is a result of the doctor's failure of care.

Doctors are generally asked to exercise the standard of care expected of doctors of good quality and standing, and with the requisite degree of skill and experience in the relevant specialty of the doctor.

A specialist practitioner in a certain field is required to have that skill 'of the ordinary skilled person exercising and professing to have that skill.' Previously, if a responsible body of medical practitioners would have acted as the defendant did, then the defendant was not negligent. The law recognises the variability of individual practitioner's skills and does not demand that doctors always perform at the highest standard of their peers. However, in *Naxakis v Western General Hospital*, the High Court has explained that it is the court, not the medical profession, which is the ultimate arbiter in deciding whether the requisite standard of care has been reached. Evidence of medical experts will have an important role in aiding the court to decide if a medical practitioner had been negligent.

The standard of care is that which a 'reasonable person' would have taken in the circumstances. The courts will determine whether that standard has been met. Whilst the court may have regard to the practices and procedures of other doctors in similar circumstances, the court will determine whether the standard has been met, having regard to the skills of the doctor, general practices in the profession, the level of knowledge and research available and the other relevant factors.

Negligence can arise for positive conduct, but can also apply where the doctor has failed to undertake any action.

Compensation

Patients will be entitled to claim compensation for loss or damage which they suffer as a consequence of the negligence of the doctor.

Patients have always been able to claim for physical injury. It is more difficult to maintain an action for mental injuries. Such claims relate to 'nervous shock'. Nervous shock is not grief or depression. It is often limited to sudden psychiatric illness that results from an extremely distressing sight, or hearing or reading distressing news, rather than an accumulated affect. For secondary victims (persons not physically injured), the injury must be foreseeable. Doctors must, therefore, be careful to pass on correct information to patients or relatives.

The patient must show that the loss or damage would not otherwise have arisen if the doctor had not been negligent. This distinguishes between negligence and merely an 'adverse outcome'.

As the High Court of Australia has recently said:
'The onus is upon the plaintiff to prove that the breach alleged was the cause of the damage shown...'

'If the damage of which the plaintiff complains could have occurred without the intervention of the negligent behaviour,

it will often be possible to conclude that the negligent behaviour was not a cause of that damage...'

'If, however, the damage of which the plaintiff complains would not have happened without the intervention of the negligent behaviour, it will often be possible to conclude that the negligent behaviour was a cause of that damage.'

Trainees

Training or junior doctors like other professionals are required to exercise the skill 'of the ordinary skilled person exercising and professing to have that skill'. This test is satisfactory for patients who choose their physicians. But public hospital patients cannot choose their practitioners. A junior officer is only required to fulfil the skill required of their position. But this junior will be liable, if they negligently perform a duty outside their range of skill or fail to refer a question beyond their capabilities to another practitioner. (The hospital may be directly liable under its non-delegable duty of care if the junior doctor escapes liability by referring a situation to their superior and the negligent treatment is not dealt with soon enough.)

The State of Medical Knowledge

Other factors may affect whether the requisite standard of care has been reached in diagnosis and treatment. A medical practitioner is only expected to have the knowledge of an 'ordinary skilled' person in their field. If the state of medical knowledge means that a failure of equipment could not be predicted, preventative measures such as were required to prevent injury were not regularly taken at the relevant time, or the dangers of a type of treatment were unknown, there may not be a breach of duty.

The law accepts that, in order for medicine to progress, new techniques must be tested. However, if such techniques are used, there is a very high standard of disclosure required that demands patients be informed of alternative forms of treatment. After the 'Aids Virus' broke out, there was much litigation over injuries that arose from infections that arose from blood transfusions. Now, if certain procedures are followed, legislation protects the Red Cross Society and hospitals from liability arising from transfusions.

Res Ipsa Loquitur

'Res Ipsa Loquitur' is translated to 'the event speaks for itself'. In such a situation, the events themselves which lead to an injury may imply that the incident could not occur without negligence on the part of a defendant. For example, in the case of *Mahon v Osborne*, a swab was left in the stomach of a patient. It was held more likely than not that the swab was there because of the negligence of the surgeon or staff who performed the operation.

Failure to Disclose Risks ('Informed Consent')

Doctors must exercise reasonable care and skill in providing advice and treatment to patients. The standard of care and

skill required is that of the ordinary skilled person exercising the particular specialist skills of the doctor involved.

However, the law also recognises that a doctor has a duty to warn a patient of a material risk which is inherent in any proposed procedure or treatment. The High Court of Australia has formulated:

'A risk will be considered material if, in the circumstances of the particular case, a reasonable person in the position of the patient, if warned of the risk, would be likely to attach significance to it, or if the medical doctor is, or should reasonably be, aware that the particular patient, if warned of the risk, would be likely to attach significance to it.'

The doctor must therefore consider two separate matters:

- Would a reasonable person, in the position of the patient, be likely to attach significance to the risk?
- Is the doctor aware, or should the doctor be reasonably aware, that this particular patient would be likely to attach significance to that risk?

Doctors must warn of risks that meet these criteria.

Failure to Diagnose or Follow Up Tests

One of the obvious areas for negligence is failure to diagnose accurately or properly the particular disease or condition of the patient. Many celebrated cases involving the diagnosis of cancer (either the failure to diagnose or delayed diagnosis) highlight the issues.

These cases are an application of the simple test of negligence, requiring the doctor to exercise care and skill of the 'ordinary skilled doctor, exercising the particular specialist skills of that doctor'.

A recent case in South Australia has also highlighted the responsibility doctors have to ensure appropriate follow up on tests ordered or reports requested. It confirms that doctors must have appropriate systems in place to ensure that, when tests are ordered or reports requested, there is a follow up to ensure that any adverse outcomes are detected within time. Reports and test results can often go astray. The courts have now confirmed that 'it is unreasonable for a professional medical specialist to base his whole follow up system, which can mean the difference between death or cure, on the patient taking the next step'. Doctors cannot rely on patients contacting them again for follow up, and doctors must therefore have their own systems to ensure that follow up occurs.

Doctors therefore, when undertaking tests or requesting reports, should keep detailed notes of the tests undertaken and the reports requested, and have a follow up system to ensure that the results are received, the results are seen by the doctor and any further necessary action taken. The doctor has the prime responsibility for these matters. An administrative system is necessary to ensure that follow up occurs.

The system should be relatively sophisticated to cope with a range of exigencies, including change over in staff, computer failure, facsimile machine failure, holiday periods and all of the other administrative errors to which any office may be prone.

Doctors should also emphasise to patients, to a much greater extent, the need for the patient to call back to ascertain the results of tests, and should advise the patient of the implications of failing to follow up or failing to keep an appointment made, in detailed terms.

Vicarious Liability

At law, an employer may be held responsible for the negligence of its employee, acting in the course of his or her employment. Accordingly, hospitals and other health institutions are responsible for and will be liable for the acts or omissions of their staff.

The staff member nonetheless remains liable for their own negligence.

Additionally, doctors will therefore be liable for the actions of their own employees (locums, administrative staff, office staff, etc.). These issues are important in considering whether an insurance policy maintained by the employer will cover particular staff members. For example, in Victorian public hospitals, the common health insurance policy for all public hospitals includes all relevant medical and other staff. In New South Wales, it is not always the case that hospitals will cover medical staff specialists (if they are not employees).

Insurance

These issues highlight the need for medical practitioners to ensure that they have adequate and appropriate insurance for themselves, their practice, and for their employees (for whom they may be liable).

Extracted from: M Gorton '*Surgery, Ethics and the Law*'; Dooley Fearnside, and Gorton, 2000. Blackwell Science Asia Pty Ltd

'Ulimaroa' Extensions



The completion of the extensions to 'Ulimaroa', due early in 2001, will mark a significant milestone in the growth and status of Anaesthesia, Intensive Care and Pain Medicine in Australia, New Zealand and the Asia Pacific Region.

The need for more space and facilities for a wider range of activities and services to Fellows and trainees has been obvious for some time. Expansion was seen as essential to allow the College to grow with the needs of its Fellowship and the community.

The Fellowship figures demonstrate this. In 1985, when the speciality was a Faculty of RACS, there were 1,551 Fellows and 445 Financial Trainees. When the College was established, in 1992, Fellows numbered 2,115 and there were 475 Financial Trainees. By 2000, there are 3,089 Fellows and 796 Financial Trainees.

This large increase in numbers to be serviced by the College alone represented a challenge to Council and its advisers. There are now also Faculties of Intensive Care and Pain Medicine as well as an increasing number of Special Interest Groups established to meet the growing needs of speciality training and practice. Our growth also is driven by the needs of the community at large.

Significantly increased space is needed for administration, training, examinations, maintenance of professional standards, library and museum facilities, Intensive Care and Pain Medicine activities, and a range of other activities on behalf of Fellows and Trainees. Our headquarters provide the infrastructure for the College's work in training specialists, setting standards of clinical care, and maintaining professional standards in Australia, New Zealand and the Asia Pacific region.

The merits and the dimensions of any expansion, and the best way to accomplish it were exhaustively examined by Council. Prior to a final decision, there was more than 12 months of careful examination of alternatives, including relocating all or part of the College activities to another site. This examination involved both the College Council, selected Fellows and professional advisers. Options considered included purchase of another property in Melbourne or another capital city, renting space elsewhere, purchasing floors under strata title, expanding into an adjacent property or extending the existing building. Ultimately, an extension of the St Kilda Road property in Melbourne proved to be the best long term option, as the most economic, efficient and practical solution.

The new building, at the rear of the existing premises, is an excellent investment in the future of the specialty. Fellows and Trainees will benefit from the additional space – with room for future expansion – and state-of-the-art facilities for the College's education and training functions.

What, then, does this 'home of the future' offer to the Fellows and Trainees which the College and its Faculties represent? The new building is firstly a low maintenance structure, with low energy costs. There is a central 'void' that helps create the savings in energy and fire protection costs. There is an underground car park for 43 vehicles.

State-of-the-art features in the six-level building include comprehensive IT facilities throughout. College electronic communications to and from Fellows and trainees will be enhanced. There is a 200-seat auditorium on two levels, with

state of the art audio-visual presentation facilities. A bi-fold wall allows the creation of a space for industry displays associated with meetings, or a relaxation area during long meetings.

Because of the College's growing role in training, education and the maintenance of professional standards, the allocation of space has been purpose planned.

Examinations will be better accommodated. Identified rooms will offer improved facilities for meetings – the latter often now held, with associated costs, in hotels. The growing number of SIGs (now 11) will find appropriate room-space to meet here, too. Thus, the core education function of the College will be significantly enhanced. It is also hoped that other Colleges and specialties will find it economical to hire these purpose planned facilities for some of their own meetings, examinations and conferences.

Against the background of the College's rapid growth in its first eight years, two of the six levels in the new building initially will be spare – included at today's costs for the inevitable expansion the future will bring. Thus, the investment in the building is long-range, and will allow it to cope with growth for a considerable time ahead.

On a broader scale, the expanded facilities will offer greater opportunities for the College to be an international centre for meetings and the interchange of ideas and information essential to the continuing improvement of the specialty's performance and status. Beyond the conference, meeting and examination facilities, the building will allow an expansion of the College's already significant library. As well, the Geoffrey Kaye Museum, an excellent collection of anaesthesia-related artefacts and equipment, will have a fresh and more accessible venue.

All this has been achieved without any additional call on Fellows for financial support. The \$7 million cost of this purpose planned and immensely sensible facility has come from accumulated funds. It is a significant investment for a very significant asset for all Fellows and the specialty well into the future. With it comes greatly improved facilities, better accommodation for the two Faculties, and an enhanced ability to service all the administrative, training and educational needs of the specialty now, and in the years ahead.

All Fellows are invited to visit the College Headquarters at any time; use the facilities, or just have a coffee and meet the staff.

Australian and New Zealand College of Anaesthetists

ABN 82 055 042 852

ANAESTHESIA SERVICES FOR AREAS OF NEED IN AUSTRALIA

1. Introduction

An area-of-need (AON) post in anaesthesia is a post for which the employer is unable to recruit locally registered doctors, as a result of which local health services are adversely affected.

ANZCA's AON process involves working with employers, health authorities, and Medical Boards to recognize a position as an AON post, advise on the appropriateness of the post to provide sustainable anaesthesia services, assess the suitability of applicants to the post, and facilitate the provision of anaesthesia services in areas-of-need.

The AON process supports the principles presented in the AMWAC report (1998) "Sustainable Specialist Services - a Compendium of Requirements", the AMC report (1996) "A Structured System for Area of Need Registration", and the AMA Safe Hours Project.

The AON process complements ANZCA's overseas-trained specialist (OTS) assessment process for specialist recognition, if the AON appointee is an overseas specialist. (See ANZCA document "Overseas Trained Specialists - Assessment Process"). Service in an AON post should not be seen as an alternative pathway to specialist recognition.

The AON process relates to posts in Australia, but the general principles may be applied to the appointment of anaesthetists in parts of New Zealand. The New Zealand National Committee of ANZCA and relevant government agencies are expected to liaise with ANZCA in a similar manner to that described below.

2. Objectives

The objectives of ANZCA's AON process are:

- 2.1 To confirm that an AON post meets minimum standards to deliver safe anaesthesia services,
- 2.2 To facilitate the provision of suitably trained anaesthetists to work in identified areas-of-need,
- 2.3 To assess the standard and suitability of an applicant for the job description of the specific AON post,
- 2.4 To fast track appointments in AON posts in anaesthesia, and
- 2.5 To follow through to assessment for specialist recognition, those applicants who are overseas-trained specialists.

3. Area-of-Need Post

- 3.1 The establishment of a post in anaesthesia for AON status is a workforce issue and should be addressed by health authorities, local communities, AMWAC, the AMA, and ANZCA. An AON post is intended to meet identified anaesthesia service needs for which no ANZCA Fellow or Australian specialist can be appointed, and as such is generally intended as a limited-term provision.
- 3.2 Employers who have difficulties in filling a post should review their management strategies to address:
 - 3.2.1 Minimum standards for the delivery of safe anaesthesia services as defined in ANZCA documents (Appendix);
 - 3.2.2 Salary packages that appropriately remunerate for the anaesthesia services required having regard to the location of the post;
 - 3.2.3 Working hours that do not compromise patient safety because of fatigue;
 - 3.2.4 Opportunities for appointees to undertake continuing education and self-development;
 - 3.2.5 Requirements for oversight and supervision where appropriate. The purpose of oversight is to provide advice and support, and the purpose of supervision is to provide advice, support, and direct assistance in certain circumstances; and
 - 3.2.6 Other human resource issues such as accommodation and work environment.
- 3.3 ANZCA will support a post for AON status using the following criteria:
 - 3.3.1 Minimum standards for the delivery of safe anaesthesia services are met;
 - 3.3.2 The post has been difficult to fill, despite nationwide advertising and attention to the conditions of service outlined in 3.2;
 - 3.3.3 The distance from the nearest medical facility with anaesthesia services is excessive, such as a journey time by road of over two hours;
 - 3.3.4 Outreach services from regional hospitals are not available or appropriate; and
 - 3.3.5 Oversight, and where appropriate, direct supervision arrangements are available or can be organized.

- 3.4 The employer of a declared AON post is required to provide:
 - 3.4.1 A detailed job description of the post;
 - 3.4.2 A brief description of how it can provide oversight and supervision, and support for further education and self-development. ANZCA is willing to assist in these services; and
 - 3.4.3 A statement affirming that it has addressed all the issues noted in 3.2.
- 3.5 ANZCA will not recognize an AON post as being suitable to provide anaesthesia services if the criteria for support in 3.3 cannot be met.

4. Assessment of AON Applicants

Employers and local health authorities will seek registration from the regional Medical Board for their selected applicant. ANZCA welcomes requests by Medical Boards to advise on the suitability of selected applicants.

- 4.1 ANZCA's AON assessment is a fast-track paper assessment that applies to overseas-trained doctors with temporary or permanent resident visas. An early decision will be made following receipt of all relevant documentation.
- 4.2 The AON assessment does not require an interview and is distinct from the OTS Assessment process. An applicant to an AON post who is considered to be an OTS is eligible to be assessed for specialist recognition under the OTS Assessment.
- 4.3 The AON Assessment will be conducted by the Assessor, the Assistant Assessor, and a Fellow nominated by Council. The following criteria will be used to assess an AON applicant:
 - 4.3.1 Specialist qualification and practice as a specialist in the country of origin. Consideration is given to the *curriculum vitae*, references, and any other documents that portray the applicant's previous practice as a specialist anaesthetist;
 - 4.3.2 Anaesthesia training in comparison with ANZCA training in its duration, structure, content, assessments, and supervision;
 - 4.3.3 Experience as a specialist in terms of case mix, use of equipment and drugs, and compliance with standards of good anaesthetic practice; and
 - 4.3.4 Participation in continuing education and quality assurance activities.
- 4.4 The AON assessment will match the applicant's qualities with the requirements of the post as given by the job description. Consideration will be given to the probable complexity of anaesthesia procedures, the probability of emergency situations, and the

probability of having to work independently. As the AON assessment is a paper assessment, ANZCA cannot guarantee that the applicant's clinical performance will be suitable for the post.

- 4.5 ANZCA will recommend to the relevant Medical Board and advise the employer and AMC one of the following:

- 4.5.1 The applicant is suitable to practise as a non-specialist anaesthetist without supervision. He/she is eligible to proceed to OTS specialist assessment. The applicant is appointable if the post is able to provide for the following conditions:

- 4.5.1.1 A restriction on practising certain anaesthetic subspecialties considered deficient in the applicant's training and experience may be necessary.

- 4.5.1.2 Oversight must be provided by a specialist anaesthetist appointed by ANZCA for the first six months in post. This time can be accredited towards the Clinical Assessment Period of the OTS Assessment process. The overseer will submit reports to the employer or Medical Board if required;

- 4.5.1.3 An on-site visit of the appointee's practice by an ANZCA-nominated specialist after two months in the post is required. The aims of the visit are to review the appointee's performance in the post and to provide advice and support. The cost of the visit will be borne by the employer. ANZCA will forward the report of the visit to the employer and Medical Board;

- 4.5.1.4 If the visit reports the appointee's performance as being unsatisfactory, a repeat visit is required one month later. If there is no obvious improvement in performance, the conditions under 4.5.2 no longer apply to the appointment, and will be replaced by conditions under 4.5.3 below.

- 4.5.1.5 Following a satisfactory visit report, the appointee must proceed to OTS specialist assessment after six months in post.

- 4.5.2 The applicant is suitable for appointment to practise as a non-specialist anaesthetist but not in isolation. He/she is ineligible to proceed to OTS specialist assessment. The applicant is

appointable if the post is able to provide for the following conditions:

4.5.2.1 A restriction on practising certain subspecialty anaesthesia and complex anaesthesia procedures is obligatory; and

4.5.2.2 On-going supervision must be provided by a specialist anaesthetist who is available within the hospital or within 30 minutes' travelling time. The supervisor provides advice, support, and direct supervision in certain circumstances. He/she will submit reports to the employer or Medical Board if required;

4.5.3 The applicant is unsuitable for appointment because of inadequate training and experience for that specific post.

- Recommended Minimum Facilities for Safe Anaesthetic Practice in Organ Imaging Facilities
- Recommended Minimum Facilities for Safe Anaesthetic Practice in Dental Surgeries
- Recommended Minimum Facilities for Safe Anaesthetic Practice in Delivery Suites
- Recommended Minimum Facilities for Safe Anaesthetic Practice for Electro-Convulsive Therapy (ECT)
- Recommendations on Monitoring During Anaesthesia
- The Assistant for the Anaesthetist
- Guidelines for the Care of Patients Recovering from Anaesthesia
- Guidelines for the Perioperative Care of Patients Selected for Day Care Surgery
- The Standards of Practice of a Specialist Anaesthetist

5. Promotion of Rural Anaesthesia Services

5.1 Recruitment of overseas-trained anaesthetists to areas-of-need should be a temporary solution. ANZCA is committed to work with rural communities, health authorities, and Colleges to redress the maldistribution of doctors.

5.2 ANZCA fosters outreach programs whereby anaesthetists from larger regional hospitals serve small remote hospitals on a regular basis. Such visiting anaesthetists may provide oversight to AON appointees.

5.3 ANZCA with the ASA operate the Rural Anaesthesia Recruitment Service. ANZCA commits this service and its Workforce Committee, Rural Anaesthesia Special Interest Group, and Joint Consultative Committee on Anaesthesia to work with rural employers, health authorities, and medical bodies to promote the provision of anaesthesia services to rural communities and areas-of-need.

5.4 ANZCA fosters rural rotations and accreditation of rural training posts in its Fellowship program.

October 2000

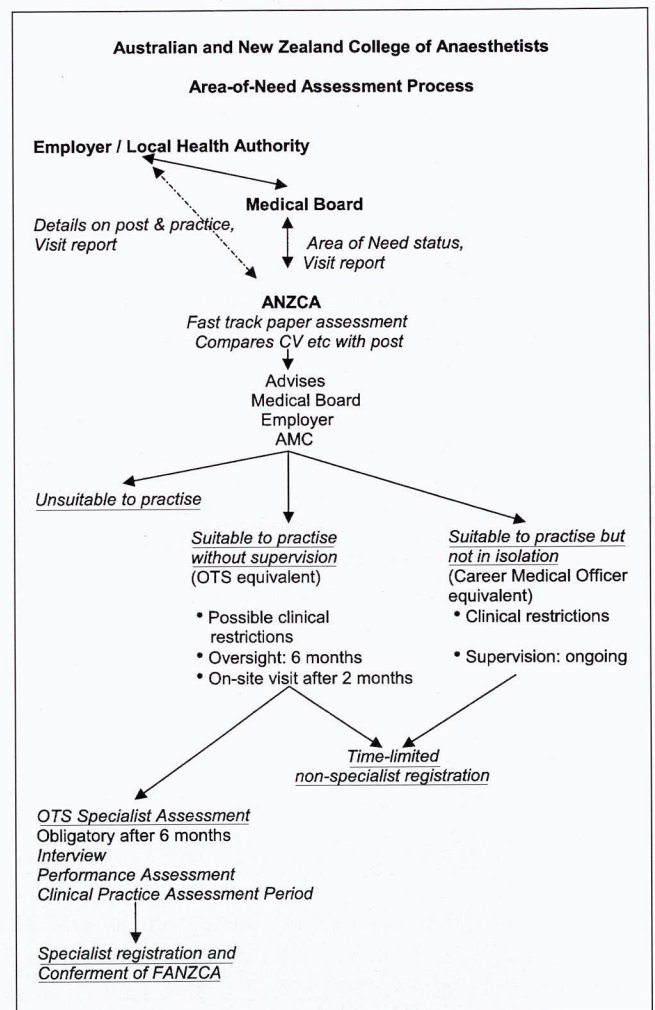
Appendix

The following document of the Australian and New Zealand College of Anaesthetists applies to assessment of overseas-trained specialists.

• Overseas Trained Specialists – Assessment Process

The following documents of the Australian and New Zealand College of Anaesthetists relate to minimum standards for safe anaesthetic practice.

- Recommended Minimum Facilities for Safe Anaesthetic Practice in Operating Suites



Australian and New Zealand College of Anaesthetists

ABN 82 055 042 852

OVERSEAS TRAINED SPECIALISTS ASSESSMENT PROCESS

Introduction

The Australian Medical Council (AMC) on behalf of Australian Medical Boards acts as a point of contact and clearing house for applications for assessment from OTS. The AMC will refer such applications for specialist recognition in anaesthesia to ANZCA for assessment. In New Zealand, the MCNZ will refer OTS applications for vocational registration to ANZCA for assessment, but is free to seek advice from any source. ANZCA will assess referred applications, but the Australian State or Territory Medical Boards and the MCNZ make the final decision on the appropriate category of registration. Applications made directly to ANZCA (including those from temporary resident doctors who have gained permanent residence) independent of the AMC or MCNZ, will be referred to those respective bodies. An offer of a job by a hospital or public health authority outside the AMC/MCNZ pathway is no guarantee for specialist recognition by ANZCA.

Objective of Assessment

The objective of the OTS Assessment Process is to assess the proficiency of the OTS to practise in Australia or New Zealand, so as to provide the public with the highest standard of care. The Assessment Process determines whether the OTS is able to perform as an unsupervised specialist anaesthetist in Australia and New Zealand, at a comparable standard to that of a FANZCA. The Assessment Process can be regarded as a recertification of specialists from non-Australasian training backgrounds. It is not an alternative specialist training program.

Process

The ANZCA OTS Committee will conduct the OTS Assessment Process, and make their recommendations to Council. There is sufficient flexibility to allow the assessment of OTS in Australia and New Zealand. The process upholds the principles of *Consistency, Objectiveness, Transparency, and Procedural Fairness*.

The OTS Committee shall comprise the following members:

- (i) Assessor, who shall be Chairman;
- (ii) Assistant Assessor for New Zealand Vocational Registration (NZVR);

- (iii) Chairman of Examinations;
- (iv) Chairman, Final Examination; and
- (v) Two other Fellows nominated by Council.

An application for assessment requires that the OTS applicant has a basic medical qualification that is recognized by the AMC or the MCNZ, if undergraduate training was in a medical school outside Australia or New Zealand respectively. A fee shall normally be charged for the OTS Assessment Process.

Applicants for assessment will be informed of:

- (i) The nature and methods of the OTS Assessment Process, including requirements to be satisfied, and the approximate time that will all take; and
- (ii) The standards of overseas training and clinical performance expected.

The OTS Assessment Process involves three components:

1. An interview;
2. A Performance Assessment comprising a Written and a Clinical Section; and
3. A Clinical Practice Assessment Period of at least 12, but up to 24 months.

Every candidate who meets the requirements of all three components will satisfy the OTS assessment.

1. Interview

- 1.1 The interview is conducted by an OTS Interview Panel of four members. In Australia, the Panel shall comprise the Assessor, any two members of the OTS Committee, and a member of the community nominated by the relevant Medical Board. The President should not normally be a member. The Assessor, or in his absence his nominee, shall be the Chairman. In New Zealand, the New Zealand National Committee (NZNC) shall form a Panel with the Assistant Assessor NZVR, two Fellows, and a member of the community nominated by the MCNZ as members. The Assistant Assessor NZVR, or in his absence his nominee, shall be the Chairman. The Chairman of the NZNC should not normally be a member.

- 1.2 The OTS Interview Panel will use the following criteria to assess a candidate:
 - 1.2.1 Specialist qualification and practice as a specialist in the country of origin. There must be certified documentation of medical registration as a specialist in anaesthesia in that particular country. Consideration is given to the *curriculum vitae*, references, and any other documents that portray the candidate's previous practice as a specialist anaesthetist. Stated experience and qualifications must be substantiated by statements and original diplomas from relevant bodies;
 - 1.2.2 Anaesthesia training in comparison with ANZCA training in its duration, structure and content (especially training in subspecialties), assessments, and supervision;
 - 1.2.3 Experience as a specialist in terms of case mix, use of equipment and drugs, and compliance with standards of good anaesthetic practice as promoted in ANZCA policy documents; and
 - 1.2.4 Participation in continuing education and quality assurance activities. A continuous involvement in recent years is particularly important.
- 1.3 The OTS Interview Panel will recommend one of the following:
 - 1.3.1 Ineligibility for further consideration if the candidate was not a specialist in his/her country of origin, or if a Clinical Practice Assessment Period of more than 24 months is considered necessary; or
 - 1.3.2 Eligibility to proceed to Performance Assessment and Clinical Practice Assessment
 - 1.3.2.1 Exemption from the Written Section of the Performance Assessment may be granted if the Panel is satisfied that the OTS has a prominent record as a specialist anaesthetist, in terms of clinical skills, research, teaching, and notable professional achievements;
 - 1.3.2.2 A Clinical Practice Assessment Period of between 12 to 24 months as determined from the candidate's training and experience will be recommended; or
 - 1.3.3 Exemption from Performance Assessment and Clinical Practice Assessment may be granted if an OTS has been appointed to a Chair in Anaesthesia of a recognized University in Australia or New Zealand, or as Head of a Department of Anaesthesia of a recognized Major Teaching Hospital in Australia or New Zealand.
2. Performance Assessment
 - 2.1 The Performance Assessment Panel of the OTS Committee will conduct Performance Assessment. This panel shall comprise the Chairman Final FANZCA Examination, who will be chairman, and two other members of the OTS Committee. The Performance Assessment Panel will present the candidates' results to the OTS Committee who will determine the outcome of Performance Assessment.
 - 2.2 Performance Assessment consists of a Written Section and a Clinical Section.
 - 2.3 The Written Section evaluates knowledge fundamental to anaesthesia practice, including clinical physiology and pharmacology and clinical measurement. It consists of a short-answer paper of 15 questions, each of equal marks. Time allowed is 10 minutes per question. General principles are emphasized.
 - 2.4 The Clinical Section evaluates clinical performance in a standardized setting. It uses the Oral Section of the Final FANZCA Examination. The oral vivas evaluate theoretical "know-how" and the medical examinations evaluate performance using standardized patients.
 - 2.5 When determining the outcome of Performance Assessment, the OTS Committee will take into consideration a candidate's preceding years' practice, if it was primarily or solely in a subspecialty (excluding intensive care or pain medicine).
 - 2.6 The Written and Clinical Sections will be conducted at the same time as the Final FANZCA Examination.
3. Clinical Practice Assessment Period
 - 3.1 The OTS must complete a Clinical Practice Assessment Period which the OTS Committee believes to be appropriate, having regard to the standing and experience of the OTS. This period should normally be between 12 and 24 *consecutive* months full-time in a hospital approved by Council. The OTS may commence the Clinical Practice Assessment Period before presenting for the written and clinical Performance Assessment. Work in Australia or New Zealand before the Interview will not be considered for Clinical Practice Assessment unless the OTS provides reports of his/her performance from supervisors and heads of departments that are equivalent to the reports in clause 3.4. The OTS Committee may extend the Clinical Practice Assessment Period where a recommendation is made pursuant to clause 3.4.
 - 3.2 The Interview Panel will determine the appropriate Clinical Practice Assessment Period for each candidate. The OTS Committee may, in certain cases, increase or decrease this period following the results

of Performance Assessment. The minimum period, however, remains at 12 months.

- 3.3 The Clinical Practice Assessment Period serves to familiarize the OTS with anaesthesia practice in Australia or New Zealand, and to assess the performance of his/her practice.
 - 3.4 The OTS Committee shall nominate an Advisor to oversee each Clinical Practice Assessment Period. The Advisor shall provide to the Assessor and in New Zealand, to the Assistant Assessor NZVR, a pro-forma structured report of the OTS' practice for the initial three-month period. Following this report, the Advisor shall provide further reports at intervals specified by the Assessor or Assistant Assessor NZVR, who may also seek comments from any health professional who works with the OTS. Based on these reports, they may recommend to the OTS Committee an extension of the Clinical Practice Assessment Period required by the OTS.
 - 3.5 The Assessor and the Assistant Assessor NZVR will notify the OTS Committee of the names of OTS who have satisfactorily completed the Clinical Practice Assessment Period.
4. Appeal Procedure
A candidate may appeal against an ANZCA decision on a matter of process. The appeal will be considered according to ANZCA's appeal procedure.
 5. Review
 - 5.1 The OTS Committee will review the cases of candidates who are unsuccessful in their assessment for the second time. The purpose of the review is to

facilitate help and counselling. A mentor may be appointed.

- 5.2 The OTS Assessment Process will be subject to ongoing review.
6. Conferment of FANZCA
 - 6.1 ANZCA will recommend a candidate who satisfies all the requirements of the OTS Assessment Process to the relevant Australian Medical Board or the MCNZ for recognition as a specialist in anaesthesia.
 - 6.2 Such an OTS is eligible to be considered by Council for admission to Fellowship of ANZCA in Anaesthesia, under Regulations 14 and 15.

Counselling

The OTS may seek advice and counselling from ANZCA on the Assessment Process, the MOPS program, and practice in Australia or New Zealand. Counselling is strongly recommended for those who have been unsuccessful in their assessments in two or more attempts.

Areas-of-Need

Special consideration in the Assessment Process is given to an OTS appointed to an area-of-need. This is considered in the complementary ANZCA document "Anaesthesia Services for Areas of Need in Australia".

ANZCA support for specialist recognition will not be granted when the OTS completes his/her appointment in an area-of-need without successful completion of the OTS Assessment Process.

October 2000

Examination Prize Winners

The Renton Prize for the period ending 31 December 2000 was awarded to:

Dr Gary Lewis Hopgood, New Zealand

The Court of Examiners of the Final Examination recommended that the Cecil Gray Prize for the half year ending 31 December 2000 be awarded to:

Dr Stephanie Louise Keel, New Zealand

TESS CRAMOND PRIZE



Emeritus Professor Tess Cramond presenting the Tess Cramond Prize for the best presentation in the Formal Project session at the 4th Annual Registrars' Meeting to Dr Pearl Cheung in Brisbane on Saturday 11 November.



Undergraduate Prize in Anaesthesia

The recipient of the inaugural 1999 ANZCA Prize for The University of Queensland is Dr Amy Wing See Tang. Dr Tang was presented with her award at the recent ANZCA/ASA Continuing Education Committee of Queensland Registrars Meeting held on 11 November 2000.

COUNCIL 2000



Back L to R: Drs Diana Khursandi, Leona Wilson, Mike Martyn, Wally Thompson, Stuart Henderson, Professor Garry Phillips (Director of Professional Affairs), Drs Michael Hodgson AM (President, ASA), Ian Rechtman, Mrs Joan Sheales (Chief Executive Officer).
Front L to R: Drs Rod Westhorpe, Richard Willis (Vice President), Dr Felicity Hawker (Dean, Faculty of Intensive Care), Prof Teik Oh (President), Professors Michael Cousins, AM (Dean, Faculty of Pain Medicine), John Gibbs, Associate Professor Greg Knoblanche.



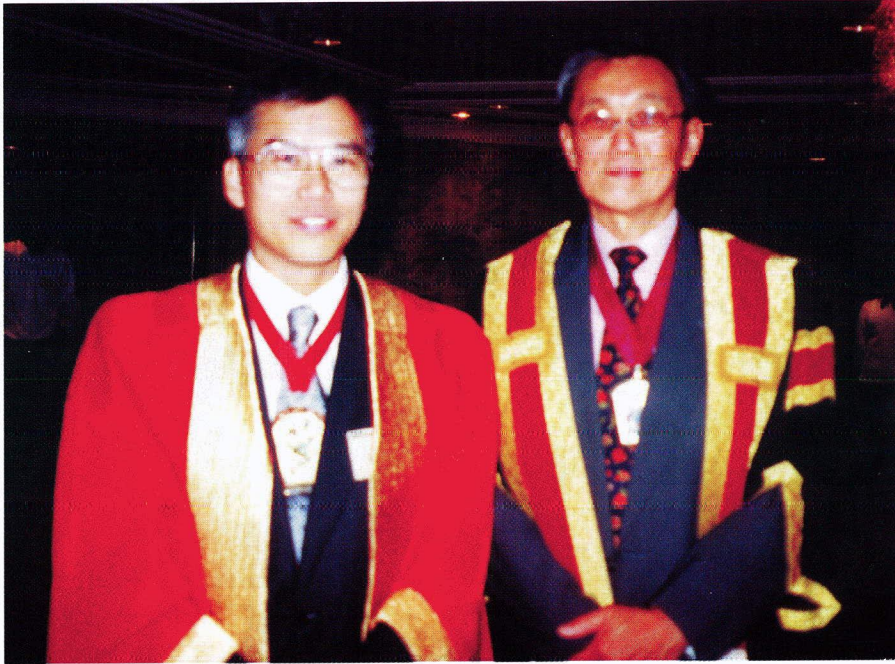
Members of the Executive of the World Federation of Societies of Anaesthesiology met at "Ulimaroa" recently.

Pictured with members of the College Executive:

Back L to R: Dr Richard Willis; Prof Garry Phillips; Dr Richard Walsh, Treasurer WFSA; Prof John Gibbs; Dr Rod Westhorpe.

Front L to R: Prof Michael Cousins; Prof Teik Oh; Dr Kester Brown, President WFSA; Dr Anneke Meursing, WFSA Secretary; Dr David Bevan, Chairman WFSA Executive.

VISIT TO HONG KONG



*Hong Kong College of Anaesthesiologists President Dr TW Lee
with ANZCA President Prof Teik Oh*



Members of the Hong Kong Training Committee and guests at the Hong Kong Organising Committee Meeting

*Back L to R: Prof Tony Gin, Dr SK Ng, Prof Teik Oh, Drs TW Lee, Joseph Lui, John Low, Clement Goh
Front L to R: Ms Jacquie Hubble, Ms Katerina Tam, Mrs Mary Rechtman, Ms Susanna Pang*



Delegates at the Running the Budget or Running the Gauntlet? Management Symposium held at the Fairmont Resort, Blue Mountains, in July. The Symposium was supported by Mallinckrodt Australia Pty Ltd

BOARD OF FACULTY OF INTENSIVE CARE – 2000



*Front: Dr Toby Thomas, Prof Teik Oh, (ANZCA President), Drs Felicity Hawker, (Dean), Neil Matthews, (Vice Dean) and Richard Lee.
Rear: Executive Officer Ms Carol Cunningham-Browne, Drs Alan Duncan, Ray Raper, Jack Havill, Jonathan Gillis,
Administrative Assistant Ms Lindy McPhee.*



Dean's Message

Felicity Hawker

All Fellows of the Faculty will have recently received a document entitled Joint Faculty of Intensive Care Medicine with a covering letter signed by Dr Ray Raper, Chairman of the Joint Specialist Advisory Committee for Intensive Care (JSAC-IC) and myself. The document is also published elsewhere in this edition of the Bulletin. The intensive care community should regard the agreement in principle by both RACP and ANZCA to proceed with the formation of the Joint Faculty as a major step forward in the development of the specialty of Intensive Care Medicine in Australia and New Zealand.

However, in a sense, the process has been underway for some time. Since its inception in 1996, JSAC-IC has worked to bring the two training schemes closer together. Some documents, such as 'Formal Project Requirements' and 'Guidelines for Intensive Care Units seeking Faculty Accreditation for Training in Intensive Care (IC-3)' are used for both training schemes. Other processes such as In-Training Assessment for trainees currently have minor differences for FICANZCA and RACP trainees in aspects such as the timing and form used, but are still compatible. Still other issues will remain challenges for the Board of the new Joint Faculty. These include prospective accreditation of training and accreditation of training in overseas units, which are respectively required and allowed by the RACP but not by FICANZCA. Nevertheless, given the groundwork already done by JSAC-IC and the fact that 27 trainees have undertaken conjoint training with both the RACP and FICANZCA, it should not be too difficult to develop a training scheme for the Joint Faculty that allows concurrent training with both ANZCA and RACP.

The far more challenging issue facing the new Joint Faculty is that of Foundation Fellowship. This is a question that has surely occupied the mind of everyone who has thought in depth about a single body for training and certification in intensive care.

Other bodies have developed criteria for Foundation Fellowship in recent times but our situation is unique. On the one hand, both the RACP and the Faculty of Anaesthetists, Royal Australasian College of Surgeons (now ANZCA and its Faculty, FICANZCA) have had training schemes in Intensive Care for over twenty years. Clearly those individuals who have undergone training and certification in intensive care through these two training schemes should be Foundation Fellows. However, on the other hand, many current intensive care practitioners took up intensive care on a full-time basis before these training schemes were fully developed, and workforce issues have allowed individuals who have not specifically trained in intensive care to continue to practise in the specialty over the years. The question is how can this latter group be divided into those who will be Foundation Fellows and those who will not without disadvantaging or alienating the more than 300 specialists who are trained and certified in intensive care.

A Working Party will be formed shortly to draw up the criteria for Foundation Fellowship. It is likely to comprise representatives of FICANZCA and the RACP, especially Fellows of FICANZCA who were admitted by Examination, and Fellows of the RACP who trained through the SAC-IC. Their job will not be easy and it is important that all contingencies are considered. To that end I will be happy to pass any comments, opinions or submissions from Fellows or other interested parties on to the Working Party. The Joint Faculty is a major initiative for us all. I would like all those involved to feel they can be part of the process.

A handwritten signature in black ink, which appears to read 'Felicity Hawker'. The signature is fluid and cursive, written over a white background.

Supervisors of Training at Accredited Intensive Care Units

Key:			
C24	= Unrestricted Period		
C12	= Core Training restricted to 12 months		
C6	= Core Training restricted to 6 months		
S3	= Core Training restricted to 3 months		
ACT			
The Canberra Hospital	C12	Dr I. Mitchell	
NSW			
Gosford Hospital	C6	Dr A.J. McDonogh	
Hornsby Ku-Ring-Gai Hospital	C6	Dr M. Whitty	
John Hunter Hospital	C24	Dr P. Saul	
Liverpool Hospital	C24	Dr A. Flabouris	
Nepean Hospital, Penrith	C12	Dr A. McLean	
New Children's Hospital	C24	Dr A.J. O'Connell	
NRMA CareFlight	S3	Dr A Flabouris	
NSW Newborn and Paediatric Emergency Transport Service	S3	Dr S. Jacobe	
Prince of Wales Hospital Repatriation and General Hospital, Concord	C24	Dr A. Belessis	
Royal North Shore Hospital	C12	Dr E. Fugaccia	
Royal Prince Alfred Hospital	C24	Dr R. Raper	
St Vincent's Hospital	C24	Dr D. Breen	
Sydney Children's Hospital	C24	Dr B. Smith	
The St George Hospital	C24	Dr G. Hill	
Westmead Hospital	C24	Dr J. Myburgh	
Wollongong Hospital	C24	Dr J. Gallagher	
NT			
Royal Darwin Hospital	C12	Dr S. Rachakonda	
QLD			
Cairns Base Hospital	C6	Dr D. Stephens	
Gold Coast Hospital	C6	Dr D. Wenck	
Greenslopes Private Hospital	C12	Dr R. Quinn	
Mater Children's Hospital	C6	Dr R.F. Whiting	
Mater Misericordiae Adult Hospital	C6	Dr B. Lister	
Nambour General Hospital	C6	To be advised	
Princess Alexandra Hospital	C6	Dr C. Anstey	
Royal Brisbane Hospital	C24	Dr C. Joyce	
Royal Children's Hospital, Brisbane	C24	Dr J. Morgan	
The Prince Charles Hospital	C12	Dr J. McEniery	
Townsville General Hospital	C6	Dr D. Mullany	
	C6	Dr M. Corkeron	
SA			
Ashford Hospital	S3	A/Professor A. Bersten	
Flinders Medical Centre	C24	Dr A. Holt	
Royal Adelaide Hospital	C24	Dr R. Young	
The Queen Elizabeth Hospital	C24	Dr S.L. Peake	
Wakefield Hospital	S3	Dr D. Clayton	
Women's and Children's Hospital	C12	Dr S. Keeley	
TAS			
Launceston General Hospital	C6	Dr S. Parkes	
Royal Hobart Hospital	C12	A/Professor A.J. Bell	
VIC			
Alfred Hospital	C24	Dr D.J. Cooper	
Austin and Repatriation Medical Centre	C24	Dr G. Hart	
Box Hill Hospital	C6	To be advised	
Dandenong Hospital	C6	Dr M. Buist	
Epworth Hospital	C6	Dr D. Ernest	
Geelong Hospital	C12	Dr D. Green	
Melbourne Private Hospital	C6	Dr P. Morley	
Monash Medical Centre	C12	A/Professor W.G. Parkin	
Royal Children's Hospital Campus	C24	Dr J. Tibballs	
Royal Melbourne Hospital	C24	Professor J.F. Cade	
St Vincent's Hospital	C24	Dr J. Santamaria	
The Northern Hospital	C6	Dr J. Green	
Warringal Private Hospital	S3	Dr G.K. Hart	
Western Hospital	C6	Dr P. Older	
WA			
Fremantle Hospital	C12	Dr I. R. Jenkins	
Princess Margaret Hospital for Children	C12	Dr A.W. Duncan	
Royal Perth Hospital	C24	Dr S. Edlin	
Sir Charles Gairdner Hospital	C24	Dr P.V. van Heerden	
HONG KONG			
Pamela Youde Nethersole Eastern Hospital	C12	Dr I.K.S. Tan	
Prince of Wales Hospital	C24	Dr T.A. Buckley	
Queen Elizabeth Hospital	C24	Dr K.W. Au-Yeung	
NEW ZEALAND			
Auckland Hospital	C24	Dr L. Galler	
Christchurch Hospital	C12	Dr G. Shaw	
Dunedin Hospital	C6	Dr M. Ramsay	
Green Lane Hospital	C6	To be advised	
Middlemore Hospital	C24	Dr N. Rankin	
Palmerston North Hospital	C6	Dr P. Hicks	
Starship Children's Hospital	C12	Dr D. Buckley	
Waikato Hospital	C24	Dr N. Barnes	
Wellington Hospital	C12	Dr J. Gowardman	

Items of Interest

FROM THE OCTOBER 2000 BOARD MEETING

EDUCATION AND TRAINING

Minimum Periods of Approved Training

The Administrative Instructions have been amended to specify the minimum period of anaesthetic, medical or elective training which will be accredited. Trainees must complete a block of at least three months training in anaesthesia, medicine or the elective component of training. The minimum period of core intensive care training required remains at six months.

In-Training Assessment Process

A working party is currently reviewing this process, and it was agreed that Supervisors' workshops will be encouraged to assist Supervisors in developing skills in formative assessment.

Director of Education

ANZCA is in the process of appointing a full-time Director of Education who will assist with the review and development of College and Faculty education, examination and maintenance of standards activities.

Web based Modules

It is planned to develop web based modules on general topics, such as communication skills, research etc, and to also use the Web to disseminate continuing education material.

Workshops for Supervisors of Training

Representatives of the Faculty and RACP will develop a package to assist in running workshops for Supervisors, which could be organised by Regional Committees. Topics would include handling of trainees, formative assessment and ways of providing feedback.

Review of Training Program

A number of aspects of the training program, such as prospective approval of core training, in-training assessment and the optimal period of medical training, will be considered by a working party which will undertake the review in the context of the new Joint Faculty training program.

Venue for Fellowship Examinations, 2001

The revised venues for the oral sections of the Examinations for 2001 were confirmed as follows:

General Fellowship Examination

May Sydney
September Melbourne

Paediatric Fellowship Examination

September Melbourne

The G.A. (Don) Harrison Medal – 2000

Congratulations to Dr Brett McFadyen, Newcastle, who has been awarded the G.A. (Don) Harrison Medal for his performance at the Fellowship Examination this year.

PROFESSIONAL AFFAIRS

Joint Faculty of Intensive Care Medicine

The Board resolved that a working party should be established to determine the criteria for Foundation Fellowship of a Joint Faculty of Intensive Care Medicine. The Councils of the RACP and ANZCA are currently formalising an agreement.

Recognition for Vocational Registration in Adult Intensive Care Medicine in New Zealand

The Board endorsed this document formulated by the New Zealand National Committee, published elsewhere in the Bulletin.

Associations of the College and its Faculties with Scientific Journals

The Board noted this policy developed by the College which details guidelines for such associations. A copy of the policy is available from the Faculty office.

Intensive Care Services in Rural and Remote Areas

The Board is keen to develop its interests in rural areas and plans to commission a working party to facilitate training and promote assistance for rural units.

Policy Documents

The following policy documents were reviewed and amended:
IC-2 The Duties of an Intensive Care Specialist in Hospitals Accredited for Training in Intensive Care
IC-8 Quality Assurance

These documents are published elsewhere in the Bulletin.

FINANCE

Fees for 2001

The Board ratified the following fees for 2001:

1. That the Faculty Registration Fee for trainees for 2001 remain at \$A 950, payable to the Melbourne Office.
2. That the Faculty Annual Training Fee and once-only Training Fee for conjoint trainees for 2001 be retained as follows:
Australia and Hong Kong - \$A 925 New Zealand - \$NZ 925 + GST (payable to NZ office) Singapore and Malaysia - \$925 (local currency converted into Australian dollars)
3. That the Faculty Examination Entry Fee for 2001 remain at \$A 1900 and must be remitted to the Melbourne Office.
4. That the fee for non-Fellows' participation in the Maintenance of Professional Standards Program be increased to \$A 500 for 2001.
5. That the Faculty Annual Subscription for 2002, due and payable on 1st January 2001, be \$A 990 + GST for all Fellows and payable to the Melbourne Office.
6. That the Overseas Trained Specialist Assessment Fee for 2001 be increased to \$A 1200.

INTERNAL AFFAIRS

Attendance at Board of Regional Committee Chairmen

The Board agreed that a Regional Committee Chairman would be invited to each Board meeting as an Observer.

Research Awards

The Board was pleased to note the following intensive care related projects were supported by ANZCA for 2001:

Clinical A/Professor B Venkatesh *A study of the dynamics and temporal profile of cortisol secretion in critical illness.* \$11,860

HONOURS AND APPOINTMENTS

The Board noted the following Honours:

Professor G.A. (Don) Harrison AM, NSW – Roll of Honour, Australian Resuscitation Council

Professor T.E. Oh, WA – Elected to Fellowship, Academy of Medicine of Singapore

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 Accredited for Training in Intensive Care *Bulletin Nov 2000, pg 53*
- IC-3 (1998) Guidelines for Intensive Care Units seeking Faculty Accreditation for Training in Intensive Care *Bulletin Nov 98, pg 70*
- IC-4 (1994) The Supervision of Vocational Trainees in Intensive Care *Bulletin Mar 2000, pg 57*
- IC-5 (1995) Duties of Regional Education Officers in Intensive Care *Bulletin Nov 95, pg 50*
- IC-6 (1995) Supervisors of Training in Intensive Care *Bulletin Nov 95, pg 46*
- IC-7 (1994) Secretarial Services to Intensive Care Units *Bulletin Mar 2000, pg 58*
- IC-8 (2000) Quality Assurance *Bulletin Nov 2000, pg 55*
- IC-9 (1997) Statement on Ethics and Patients' Rights and Responsibilities *Bulletin Nov 97, pg 68*
- IC-10 (1996) Minimum Standards for Transport of the Critically Ill *Bulletin Mar 96, pg 42*
- IC-11 (1996) In-Training Assessment of Trainees in Intensive Care *Bulletin Mar 96, pg 46*
- IC-12 (1996) Examination Candidates Suffering from Illness, Accident or Disability *Bulletin May 96, pg 66*
- IC-13 (2000) Minimum Standards for High Dependency Units Seeking Accreditation for Training in Intensive Care *Bulletin Mar 2000, pg 59*
- PS38 (1999) Statement Relating to the Relief of Pain and Suffering and End of Life Decisions *Bulletin June 99, pg 93*
- PS39 (2000) Intrahospital Transport of Critically Ill Patients *Bulletin July 2000, pg 84*
- PS40 (2000) Guidelines for the Relationship Between Fellows and the Healthcare Industry *Bulletin Mar 2000, pg 55*



Faculty of
Intensive Care
ANZCA
ABN 82 055 042 852

Joint Specialist Advisory Committee Intensive Care



The Royal Australasian
College of Physicians
ACN 000 039 047

The Joint Faculty of Intensive Care Medicine

Introduction

Approval in principle has now been received for the establishment of a Joint Faculty of Intensive Care Medicine of both the Australian and New Zealand College of Anaesthetists (ANZCA) and the Royal Australasian College of Physicians (RACP). The Faculty will be legally and administratively the responsibility of ANZCA. Now that a single body responsible for training and certification in intensive care is imminent, it is appropriate to review the recent history.

- 1994: Formation of a Conjoint FICANZCA/RACP/ANZICS Training and Certification Committee (subsequently renamed JSAC-IC)
- June 1998: circulation of FICANZCA Discussion Document entitled "Development of a Single Body for Intensive Care Certification and Standards"
- October 1998: Overwhelming support at ANZICS AGM for a motion stating that the establishment of a College of Intensive Care/Critical Care be explored (and by JSAC-IC)
- October 1998: Formation of Working Party by JSAC-IC
- July 1999: Circulation of a discussion paper and survey to 648 ANZICS members and Faculty Fellows who were not members of ANZICS and registered intensive care trainees of FICANZCA, ANZCA and RACP.
- September 1999: Survey results reported to JSAC-IC
 - 81% supported change from status quo (independent College or expanded Faculty)
 - 86% supported change within 5 years
- November 1999: Intensive Care Training Liaison Meeting chaired by Dr Don Cameron, President of the RACP and attended by representatives of FICANZCA, ANZCA, RACP and ANZICS. Concept of Joint Faculty of Intensive Care of both ANZCA and RACP supported.
- May 2000: Meeting of representatives of the FICANZCA, ANZCA, RACP, and ANZICS to refine the Joint Faculty model. Approval in principle by Presidents of ANZCA and RACP
- September 2000: Completion of approval in principle from both College Councils to proceed with formation of a Joint Faculty of Intensive Care of both ANZCA and RACP.

Procedure

It is envisaged that a number of steps will be necessary to form the Joint Faculty with minimum disruption to current trainees and to the various functions of the current Faculty.

1. A name for the Joint Faculty will be determined.
2. A Legal Agreement will be signed by both ANZCA and the RACP defining the relationship and the agreed way the new entity will operate.
3. Both ANZCA and RACP will incorporate reference to the Joint Faculty into their Regulations where required.
4. The current Faculty Board will be expanded by two members (it currently consists of eight elected Board Members plus an ANZCA Council Representative). As an interim arrangement it is proposed that the current RACP Co-opted Observers to the Board (nominated by the RACP) be elected to Fellowship of the current Faculty and thereafter appointed as the two additional Board Members. (This is necessary to pave the way for the other administrative steps required to establish the Joint Faculty.) It is also proposed that an additional RACP Council Observer be invited to join the Board.

5. The expanded Faculty Board will have representation on the Committee of Physician Training of the RACP, and the Dean will be included at both the ANZCA Council and the RACP Council.
6. The expanded Faculty Board will convene a Working Party to develop criteria for Foundation Fellowship. The working party will have a balance of members from FICANZCA, RACP and from regions. It will also include appropriate representation of FICANZCA Fellows who gained Fellowship by examination and RACP Fellows who trained through the SAC-IC. This will be followed by:
 - a. Publication of the criteria
 - b. Invitation to apply for Foundation Fellowship
 - c. Admission of Foundation Fellows

It is likely that the criteria will include:

- FICANZCA
- FRACP and completion of the training program of the JSAC-IC or the SAC(IC)
- FRACP together with training and or consultant level experience in intensive care medicine of an appropriate nature and duration

It is possible (even likely) that trainees undertaking the RACP training program who have not completed that program at the time that the Faculty is established will not be offered Fellowship of the Joint Faculty if they elect not to complete the entire training program. Fellowship of the RACP will, however, be available as is currently the case

7. At an appropriate time an election will be held for all Board positions with voting by the expanded Fellowship. There will be a form of proportional representation eg. a guaranteed number of RACP Board members, but with time this requirement may become irrelevant.
8. All Faculty documents will be modified to reflect involvement of the RACP and a mechanism will be developed for their acceptance by both Colleges.

Training Program

While trainees currently enrolled in training programs must not be disadvantaged by this development, those commencing intensive care training in 2001 will be bound by the new arrangements. There is likely to be some evolution of the training program as the Joint Faculty becomes established. Any change which does occur in the future will also be introduced so that current trainees will not be disadvantaged, as is currently the case when the FICANZCA and the RACP make changes.

For current FICANZCA trainees, there will be no immediate change to training arrangements except that mechanisms will be established to enable prospective approval of at least the two core years of training.

For RACP trainees:

- There will be no change in basic training
- All advanced and post-Fellowship training in Intensive Care will be supervised by the new Faculty. This will mean the NZ SAC-IC will cease to exist and all New Zealand trainees will be supervised by the Joint Faculty
- Each year of advanced training will require prospective approval as is currently required
- Accreditation of each year will be based on satisfactory in-training assessment with (probably) two assessments per year
- The Joint Faculty training program will consist of three years accredited training, a project report and an exit examination. (Two years of basic training will be accredited retrospectively to allow equivalence with the five year FICANZCA program.)
- Two years core training based on the current guidelines
- One compulsory year of anaesthesia training which may be undertaken as the sole elective year
- Training may be simultaneously supervised by another Specialist Advisory Committee as is currently possible

- A recommendation for admission to Fellowship of the RACP will be forwarded from the Joint Faculty to the Committee for Physician Training only at the completion of the entire Joint Faculty training program including successful examination candidacy.
- Trainees may apply to the CPT for admission to Fellowship of the RACP based on completion of three accredited years of advanced training according to current RACP regulations.

Other trainees: Access to the training program of the Joint Faculty will be available to Fellows of the RACS and ACEM as is currently possible within the FICANZCA.

Certification

Fellowship of the new Faculty will be assessed and awarded using the same mechanisms as currently operate within the FICANZCA. This will be based on completion of the entire training program of the Joint Faculty, whatever the route of entry.

Election to Fellowship

Criteria for election to Fellowship after the intake of Foundation Fellows will be determined by the new elected Board. However it is likely that this avenue will be open only to individuals who have made an exceptional contribution to the science and practice of intensive care and who have not had the opportunity to train through the Joint Faculty.

Specialist Recognition

The formation of the Joint Faculty will have no impact on any standing specialist recognition. It is anticipated that the Joint Faculty will assume the role currently undertaken by the JSAC-IC to provide advice to certifying authorities on the suitability of applicants for recognition as an Intensive Care Specialist. It is also anticipated that the current criteria will continue to apply to all applicants who have completed specialist training prior to the end of 2000. In the future, the only recognised Australasian training pathway to Intensive Care Specialist recognition will be Fellowship of the Joint Faculty. FRACP (CPT) will not be supported by the Joint Faculty as a recognizable qualification in intensive care, on the basis of non-equivalence of training, supervision and assessment.

October 2000

Admission To Fellowship

The following have completed all requirements for admission to Fellowship by examination and were admitted by the Board:

Paul David Cooper	NSW	Victor Yeo	HK
Emma Jane Merry	SA	Elizabeth Ann Keegan Connolly	SA
David Wayne Wrathall	UK	Sean Denis Newell	Qld



Faculty of
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ABN 82 055 042 852

New Zealand Joint Specialist Advisory Committee Intensive Care



The Royal Australasian
College of Physicians
ACN 000 039 047

RECOGNITION FOR VOCATIONAL REGISTRATION IN ADULT INTENSIVE CARE MEDICINE IN NEW ZEALAND

Introduction

Two training schemes in intensive care have been available in Australasia since 1976 and there are now training and certification systems in this specialty in additional countries.

The criteria set out below were developed as an internal guide for the training and certification bodies in intensive care who are asked to give an opinion as to whether or not a person is considered to be eligible for Vocational Registration in Intensive Care Medicine (ICM) in New Zealand. They are not used to maintain a specialist register by the NZJSAC-ICM. Fulfilment of the criteria below does not confer eligibility for Fellowship of the Faculty of Intensive Care, ANZCA (FFICANZCA) or the Royal Australasian College of Physicians (FRACP).

The criteria are identical to those developed for recognition as a specialist in adult ICM in Australia by the Joint Specialist Advisory Committee – Intensive Care (JSAC-IC), which is a joint committee of the Faculty of Intensive Care, ANZCA and the RACP. The JSAC-IC supervises ICM trainees in both Australia and New Zealand, and also makes recommendations on specialist recognition to the Australian Medical Council. In New Zealand, applications for Vocational Registration in ICM are referred from the Medical Council of New Zealand (MCNZ) to the NZJSAC-ICM for assessment. To maintain rights of practice reciprocal between the two countries, it is essential that criteria for specialist recognition in Australia and Vocational Registration in NZ are identical.

Criteria

1. FFICANZCA or FRACP (with 2 years training in intensive care medicine accredited by JSAC-IC or SAC-IC)
2. OVERSEAS SPECIALIST QUALIFICATIONS

Persons with specialist qualifications from outside of Australasia must have completed training equivalent in duration, structure and content, assessments and supervision to that required by the Australasian intensive care bodies.

Note: Under NZMC regulations, assessment of overseas trained specialists is undertaken by the relevant College and may include assessment of documentary evidence and interviews. A period of supervised clinical assessment and examinations are usually required.

Criteria 1 and 2 (above) are applicable to all practitioners who commenced specialist training after January 1, 1989 or core intensive care medicine training after January 1, 1995.

3. For persons who commenced specialist training before 1989 or specific training in ICM before 1995 and who have the qualifications FANZCA or FRACP, Vocational Registration in ICM will be supported by NZJSAC-ICM when the applicant has:
 - (a) spent 2 years in a training capacity in intensive care units (ICUs) approved by FICANZCA or the RACP (SAC-IC) for core training purposes, OR
 - (b) practised as a specialist in ICUs approved by FICANZCA or the RACP (SAC-IC) 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.

Faculty of Intensive Care

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

THE DUTIES OF AN INTENSIVE CARE SPECIALIST IN HOSPITALS ACCREDITED FOR TRAINING IN INTENSIVE CARE

1. PREAMBLE

These guidelines have been developed to indicate to hospitals what the Faculty of Intensive Care considers to be the duties of an intensive care specialist.

2. THE DUTIES OF AN INTENSIVE CARE SPECIALIST

2.1 *Clinical Duties include:*

- 2.1.1 Providing care and assuming responsibility for patients in the intensive care unit and, where appropriate, a co-located high dependency unit.
- 2.1.2 Supervising trainees in the intensive care unit and, where appropriate, a co-located high dependency unit.
- 2.1.3 Being available to medical colleagues for consultation and liaison as appropriate regarding patient care.
- 2.1.4 Being immediately available for urgent consultation and assistance in the resuscitation and subsequent management of critically ill patients.

The intensive care specialist may also be responsible for providing:

- 2.1.5 Acute resuscitation for trauma and other emergencies.
- 2.1.6 Transport of critically ill patients.
- 2.1.7 A parenteral nutrition service to patients in other areas of the hospital.
- 2.1.8 Advice on clinical and other matters relevant to intensive care to hospital management and to other bodies outside the hospital eg. to professional and regulatory bodies.

2.2 *Administrative and Educational Duties include:*

- 2.2.1 Ensuring that administrative duties relating to the proper functioning of the unit and the hospital are carried out.
- 2.2.2 Providing and participating in appropriate educational activities for:
 - 2.2.2.1 Trainee specialists.
 - 2.2.2.2 Intern and resident medical officers.
 - 2.2.2.3 Postgraduate nurses.

2.2.2.4 Medical students.

2.2.2.5 Undergraduate nurses.

2.2.2.6 Paramedical staff.

2.2.3 Preparing material to be used for teaching.

2.2.4 Ensuring and reviewing quality of patient care by participating in audit, peer review and quality assurance programs as outlined in Faculty Policy Document IC-8 "Quality Assurance".

2.2.5 Maintaining personal knowledge and skills by participating in continuing education and maintenance of professional standards programs.

2.2.6 Contributing to hospital committees, and the committees of health authorities and other organisations.

2.2.7 Contributing to activities of the Faculty, relevant Colleges and other professional associations. This may include acting as Supervisor of Training (refer Faculty Policy Document IC-6 "Supervisors of Training in Intensive Care").

2.3 *Research Activities*

Ensuring research is carried out in the unit by participating in or supporting research.

3. THE APPORTIONING OF TIME BETWEEN CLINICAL AND NON-CLINICAL DUTIES

All staff must have sufficient exposure to clinical duties to maintain their skills. They must also have sufficient time set aside for administrative and educational activities to ensure a high standard of practice both at a unit level and an individual level.

3.1 *The Director of Intensive Care*

3.1.1 The Director has a prime responsibility to ensure that the intensive care service functions effectively and efficiently. Administration comprises a significant part of the workload. A minimum of four sessions per week should be available for administrative, educational and other activities.

In larger units a Deputy Director should be appointed to assist the Director in its administration.

3.1.2 If the Director is not a full time appointee appropriate time must be provided for administrative duties and personal continuing educational needs.

3.2 *The Intensive Care Staff Specialist*

All intensive care staff specialists, part-time or full time, must have a commitment to personal continuing education, administration, audit and quality assurance and other educational activities such as a maintenance of standards program. Time must be allocated for these. The clinical duties of an intensive care staff specialist should not exceed, on average, seven half days per week when the clinical workload is distributed amongst the specialist staff in the unit.

3.3 *The Visiting Intensive Care Specialist*

Visiting intensive care specialists have similar needs to intensive care staff specialists and equivalent provision should be made for administrative and educational duties.

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 1994

Date of current document: October 2000

These guidelines should be interpreted in conjunction with the following Policy Documents of the Faculty of Intensive Care, Australian and New Zealand College of Anaesthetists:

IC-1 "Minimum Standards for Intensive Care Units"

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

IC-6 "Supervisors of Training in Intensive Care"

IC-8 "Quality Assurance"

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Faculty of Intensive Care

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

QUALITY ASSURANCE

1. INTRODUCTION

- 1.1 Quality Assurance can be defined as “an organised process that assesses and evaluates health services to improve practice or quality of care”.
- 1.2 The objective of Quality Assurance programs is to ensure that high standards of clinical practice are maintained by individuals, Units, and Hospitals or Institutions through regular assessments. The results of such assessments should be reported to appropriate Departmental meetings for evaluation and action as necessary.
- 1.3 All Intensive Care Units should participate in Quality Assurance activities. Smaller Units or Intensive Care services in institutions which do not have formally structured departments, should link their programs with nearby larger Departments.
- 1.4 All Intensive Care Units should appoint a Quality Assurance Coordinator, who will be responsible for the implementation and supervision of the Quality Assurance programs.
- 1.5 Wherever possible, the Intensive Care Quality Program should be interfaced with, or part of, an institution-wide Quality Program.
- 1.6 Quality Assurance programs must evaluate clinical care as being consistent with accepted professional standards, including relevant policy documents issued by the Faculty.

2. PROCESS OF QUALITY ASSURANCE PROGRAMS

Steps in a Quality Assurance program can be considered as *Planning, Implementation, Review, and Setting Standards*. The steps are repeated continually or at appropriate intervals for on-going Quality Assurance programs.

- 2.1 *Planning* involves careful design and preparation of a project, such as definition of the topic to be evaluated and the data to be collected, and the methods to collect and analyse data.
- 2.2 *Implementation* involves collection and analysis of data, review of results, and determination of the action to be taken, ie. to:
 - 2.2.1 Monitor and evaluate the quality and appropriateness of patient care.

- 2.2.2 Identify areas of deficiency or risk, which is defined as a chance of injury or adverse consequence.

- 2.2.3 Implement changes where necessary and monitor any changes made, including the safe implementation of new methods of treatment.

- 2.3 *Review* involves monitoring the outcome of changes introduced from implementation to “close the loop”. Showing the outcome or impact of a Quality Assurance program on health care is an important component of the program.

- 2.4 *Setting Standards* involves incorporation of the improvements achieved into new official regulations, guidelines, or standards.

3. QUALITY ASSURANCE PROGRAMS

A number of activities can be undertaken as Quality Assurance programs.

- 3.1 *Evaluation of Departmental Structure and Performance:* The overall performance and resources of a Unit are compared with accepted criteria (eg. FICANZCA or AMWAC guidelines) and those of other equivalent Units in the Region. Specific areas include:
 - 3.1.1 Staff:
 - 3.1.1.1 Numbers and qualifications, including senior, junior, nursing, technical and secretarial staff.
 - 3.1.1.2 Appointment criteria and procedures, and allocation of duties and levels of supervision.
 - 3.1.1.3 Workload and conditions of work.
 - 3.1.1.4 Staff well-being as assessed by health, morale and occupational safety record.
 - 3.1.2 Physical facilities:
 - 3.1.2.1 The working space for all clinical and non-clinical activities.
 - 3.1.2.2 Equipment, including compliance with standards, preventive and other maintenance and replacement.
 - 3.1.3 Financial aspects of the Unit, including:
 - 3.1.3.1 Budgets.
 - 3.1.3.2 Expenditure.

- 3.1.4 Unit teaching programs.
- 3.1.5 Unit research activities.
- 3.2 *Evaluation of Patient Management Activities.* Topics to be evaluated include:
 - 3.2.1 Criteria for admission to the Intensive Care Unit, including severity of illness and diagnostic groups, and monitoring of patients refused admission.
 - 3.2.2 Patient management during Intensive Care stay, including:
 - 3.2.2.1 Diagnostic methods utilised (eg. clinical, laboratory, imaging).
 - 3.2.2.2 Indications for specific therapies.
 - 3.2.2.3 Record keeping.
 - 3.2.3 Performance against agreed clinical indicators eg. (ACHS).
 - 3.2.3.1 Risk adjusted morbidity and mortality.
- 3.3 *Evaluation of the Individual performance of Intensive Care Staff.* Specific areas include:
 - 3.3.1 Patient management.
 - 3.3.2 Continuing education and teaching.
 - 3.3.3 Health, morale and safety.
 - 3.3.4 Research.
- 3.4 *Critical Incident Monitoring.* Critical incidents are voluntary reports by staff on events that led to, or could have led to an adverse outcome in patients or staff members. A program should analyse the causes, contributing and mitigating factors, and outcome of critical incidents. Strategies for improvement should be recommended. An evaluation of outcome from the implementation of changes is expected.
- 3.5 *Peer Reviews.* Areas that can be reviewed include communication with patients and relatives, patient assessment, monitoring and investigations used, record keeping, and patient follow up and outcome. The principal methods are:
 - 3.5.1 Mortality and morbidity meetings.
 - 3.5.2 Reviews of randomly selected cases.
 - 3.5.3 Practice peer review as outlined in the Faculty MOPS Program Manual.
- 3.6 *Patient / Relative Surveys.* A program can survey satisfaction with communication, managing relatives, anxiety alleviation, informed consent, pain management and procedures performed. Issues such as confidentiality and patient anonymity should be addressed.

4. AUDIT OF QUALITY ASSURANCE PROGRAMS

All Units should review their Quality Assurance programs from time to time. Programs should be consistent with the size and capabilities of the Unit. The Unit should ensure that remedial steps are taken whenever problems are identified and that continued review should follow.

5. QUALITY ASSURANCE COORDINATOR

- 5.1 The Unit should appoint a Quality Assurance Coordinator normally for a period of two years, with eligibility for re-appointment. Appropriate time and secretarial and other support should be allocated to this Coordinator.
- 5.2 The Quality Assurance Coordinator should ensure that these Faculty guidelines are implemented within the limits of the size of the Unit.

These guidelines should be interpreted in conjunction with the following Policy Documents of the Faculty of Intensive Care, Australian and New Zealand College of Anaesthetists:

- IC-1 "Minimum Standards for Intensive Care Units"
- IC-2 "The Duties of an Intensive Care Specialist in Hospitals Accredited for Training in Intensive Care"
- IC-3 "Guidelines for Intensive Care Units seeking Faculty Accreditation of Training in Intensive Care"

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 1995

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Dean's Message

Michael J Cousins, AM

Recognition of Pain Medicine as a Specialty

The President, Professor Teik Oh and I visited the Federal Minister for Health and Aged Care, Dr. Michael Wooldridge on 3rd November, 2000. The Minister was informed of the Faculty's intention to apply as soon as possible for recognition of Pain Medicine as a Specialty. The Minister was most interested to hear of the involvement of five specialty bodies in a single training program and examination process. He acknowledged the important step of increased professionalism in this much neglected area of medicine.

Manpower and Pain Medicine

At the meeting with the Federal Minister, we also discussed the very large shortfall in training positions and specialist manpower in Pain Medicine. The Minister agreed that it would be necessary to move rapidly towards obtaining an AMWAC study on the manpower needs in Pain Medicine at a Trainee and Specialist level. An appropriate pathway for achieving a manpower study was developed, in consultation with the Minister.

Finances and the Faculty

As discussed in my last Dean's Message, the Faculty needs to move towards meeting the costs of its operation, which have been borne by ANZCA during the developmental years. In order to achieve this aim, the Board has approved an increase in the Faculty Subscriptions to \$550.00 plus GST for 2001 and to \$700 plus GST for 2002. I should emphasise again the substantial resources provided to the Faculty by its parent body ANZCA as outlined in my previous Dean's Message. At the same time, the Faculty is mindful of the requirement for most of its Fellows to pay subscriptions to their primary specialty body.

Educational Initiatives

I would particularly like to draw to the attention of Fellows the excellent work of the Education Committee in developing the 'Guide to Study' and 'Reading List'. Although this has been an effort from a number of individuals, A/Prof Milton Cohen and

Dr Suellen Walker have expended great effort in achieving the current stage of development of these documents. The Reading List is to be circulated to Fellows in the near future with the purpose of asking for input to finalise this document.

2000 Examination at Royal Adelaide Hospital

At the time of writing, I can now report that 18 of the 21 candidates were successful at the second examination. The Court of Examiners represented all of the participating specialist bodies of Anaesthesia, Surgery, Medicine, Psychiatry and Rehabilitation Medicine. The Court of Examiners was unanimous that the examination process was of a very high calibre. Feedback from the examination candidates indicated that they appreciated the examination as a very rigorous and thorough evaluation. The Faculty is most grateful to the Royal Adelaide Hospital for hosting such a successful examination venue and particular thanks are due to the Chairman, Examination Committee, Dr. Penny Briscoe and Margaret Benjamin for a great deal of hard work in achieving the success of this second examination.

Research

I previously made Fellows aware of the ANZCA Foundation which funds research in areas of relevance to the College and its two Faculties. All Fellows of the Faculty are eligible to apply for research funding in the form of research projects or research fellowships. Details of the application process is provided elsewhere in this Bulletin.

I would like to take this opportunity to wish all Fellows and their families a restful and enjoyable forthcoming holiday season and a productive and fulfilling New Year.

Highlights from the Board Meeting

HELD ON OCTOBER 12, 2000

Admission to Fellowship by Examination

The following were admitted to Fellowship by examination:

John HENSHAW Tas FANZCA
William HOWARD Vic FANZCA

Admission to Fellowship by Election

The following were admitted to Fellowship by election:

Gary CLOTHIER SA FAFRM (RACP)
Michael COOPER NSW FANZCA
Julia FLEMING VIC FANZCA
Dianne PACEY NSW FAFRM (RACP)
Philip SIDDALL NSW MBBS, PhD
Melissa VINEY VIC FANZCA

Guidelines for Eligibility to Present for Examination

Amendments to the Guidelines to Present for Examination have been approved.

1. From 2001 onwards admission to the examination without formal training in Pain Medicine will cease.
2. Candidates for the 2001 and 2002 examination will be required to have undergone¹ at least one year of training in an approved multidisciplinary pain medicine centre. One further year of relevant experience is required which may consist of prior experience², subject to approval by the Censor.
3. From 2003 onwards, candidates presenting to the examination must have been enrolled prospectively for a program of two years of approved Pain Medicine training in keeping with the Administrative Instructions.
4. All candidates for the 2001 examination and after will be required to submit a treatise.
5. Requirements to be met by candidates who fail the 2000 examination will be determined on a case by case basis.

¹ to allow for retrospective accreditation for time spent in an approved multidisciplinary pain medicine centre.

² to indicate that completion of that year is a pre-requisite for sitting for the examination. Retrospective accreditation of other experience should be permitted, subject to approval by the Censor.

Finance

The Board agreed that the Annual Subscription fee for 2002 be \$700 plus GST (see Dean's message).

Education

The 'Guide to Study' and 'Reading List' have been circulated to members of the Education Committee for feedback and are

now close to completion. It is the intention of the Education Committee to make these documents available to Fellows as well as Trainees. The Board congratulated the Chairman of the Education Committee, Milton Cohen and also Suellen Walker for their major contributions in preparing the 'Guide to Study' and 'Reading List'. The Reading List is to be circulated to Fellows with the purpose of asking for their input prior to finalising this document.

The Education Committee will now move on to the development of an 'Objectives of Training' document, which will be cross referenced with the 'Guide to Study'. This will be a challenging task and the Chairman of the Education Committee would like to hear from Fellows who may be interested in contributing to this task.

Another important future objective of the Education Committee is the development of web based education, both for Trainees and also for Fellows.

NHMRC Acute Pain Management: Scientific Evidence

The Faculty, in conjunction with the SIG on Acute Pain Management, ANZCA will jointly undertake the task of revising this NHMRC document. Dr. Pam Macintyre has been appointed to Chair this Working Party and will be producing a document which will be suitable for approval by the NHMRC. This is seen as being a very important activity both for the Faculty and ANZCA, since the initial document was received extremely well and is viewed as having made an important contribution to the management of acute pain.

Examination

The Chairman of the Examination Committee, Dr. P. Briscoe advised that there were 21 candidates for the second examination, to be held at the Royal Adelaide Hospital from 25th to 27th October. The format for the first examination was carried through to the second examination.

Feedback to unsuccessful candidates will henceforth be by letter to the candidate indicating whether they have passed or failed each of the four sections of the examination. Also those candidates with a particularly poor performance in one or other sections of the examination will receive information under the heading "bad fail" for such sections.

From 2001 onwards, Observers at the examination will be introduced. Initially new examiners will be given preference but it will also be possible for Fellows to apply to act as an Observer.

The 2001 examination will be held at the Sir Charles Gairdner Hospital, Perth in October/November, with the precise date to be notified in the near future.

Pre-examination Short Course

This was held on 18-20th August, 2000 at Royal North Shore Hospital. A substantial number of candidates for the examination attended this course and reported that it had been extremely helpful. Dr. Suellen Walker was congratulated by the Board in organising an excellent course. From 2001 onwards, the Education and Examination Committees will take responsibility for the organisation of the short courses.

Hospital Accreditation

The Hospital Accreditation Committee has recently completed reviews of the training program at the Royal Adelaide Hospital, South Australia and the Geelong Hospital, Victoria.

Training Program

The Prospectus and Training Manual have now been revised and were approved in their new format by the Board. The Prospectus will be circulated to all participating Colleges and Faculty with the aim of providing information to prospective Trainees.

Professional Documents

PMI Guidelines for Trainees and Departments Seeking Faculty Approval for Posts in Pain Medicine. This document has been revised and it is agreed that it is now close to final format. Fellows are encouraged to view this document on the Faculty website and to provide input to the Faculty Executive Officer as soon as possible. It is planned that the document will be approved in its final form at the next meeting of the Board.

PS41 Guidelines on Acute Pain Management. The Board adopted this document as a joint College and Faculty document.

Supervisors of Training in Pain Medicine. The Education Committee is drafting a new Faculty Professional document on Supervisors of Training in Pain Medicine which will outline the responsibility of such individuals.

Paediatric Pain Medicine Practitioners

Dr. John Collins from the New Children's Hospital, NSW has accepted an invitation from the Board to Chair the Paediatric Pain Working Party whilst Dr. Suellen Walker is overseas for twelve months.

Dr. Walker has completed a report to the Board on Paediatric Pain Medicine which results from a survey of 14 institutions in Australia and New Zealand with a response rate of 13 out of 14 institutions. This report will provide a sound basis for moving ahead with the development of Paediatric Pain Medicine. The Board noted that there are already joint paediatric and adult pain medicine units, with a training position at the New Children's Hospital/Westmead Hospital, NSW and the Prince of Wales Hospital/Children's Hospital, NSW. The Board also noted that a wide ranging review of

paediatric pain management services at the Royal Children's Hospital, Melbourne, had been carried out with the participation of Dr. Suellen Walker.

Palliative Medicine

The Joint Working Party of the Faculty and Chapter of Palliative Medicine (RACP) was proceeding under the Chairmanship of Dr. Paul Glare. A discussion document has been developed entitled "Guidelines for Dual Training in Pain Medicine and Palliative Medicine". It is hoped that discussions will proceed in defining a workable pathway for individuals who wish to obtain dual qualification in Palliative Medicine and Pain Medicine. The Board and Chapter of Palliative Medicine have already developed a modus operandi for Faculty Trainees to rotate to Palliative Medicine Units and vice versa.

Recognition of Pain Medicine as a Specialty

The Dean advised that the President and he would be meeting with the Federal Minister for Health and Aged Care, Dr. Michael Wooldridge on 3rd November, 2000 to discuss the recognition of Pain Medicine as a Specialty. This visit was preceded by a letter from the Dean asking for the Minister's support of an application which will be made in the near future to the Australian Medical Council.

The Faculty has now received a letter from the AMC which provides draft documentation describing the process of application for specialty recognition. A specialist recognition taskforce has been established: M Cousins (Chair), C R Goucke, R L Atkinson and B Kinloch. It was noted that ANZCA has requested review by the AMC at an early stage to achieve accreditation as soon as possible in 2001. This process is likely to assist the Faculty in its application for specialist recognition.

Australasian Faculty of Occupational Medicine RACP Forum on Determination of Permanent Disability in Relation to Compensable Injury.

M. Cohen represented the Faculty at this Forum which comprised doctors, lawyers and insurance representatives. A written report is being prepared and will be available to interested Fellows.

Development of White Papers

The Faculty is in the process of developing White Papers on major areas of treatment, using an evidenced based approach. It has been decided to appoint small taskforces, each with a task of developing a white paper on one treatment area.

Dorsal Column Stimulation

The Board has expressed its concern to the Department of Health and Aged Care about the proposal to remove Dorsal Column Stimulation from the MBS Schedule 5. It appeared that this may jeopardise the use of this treatment modality

with important implications for the training of Fellows. It has subsequently been learned that it is planned to move this item to Appendix C and the Faculty has requested representation on the Working Party to discuss this issue.

Expert Committee for Surgical Implanted Prostheses

The Board has written to the Department of Health and Aged Care nominating Mr R L Atkinson and Dr J Ditton as representatives to this Committee.

CSM May 5-9, 2001, Hong Kong

The program for this meeting is progressing well. It is planned to hold a Faculty Dinner on Friday 4th May, immediately prior

to the meeting. Professor Troels Jensen will be the official Faculty Overseas Speaker and the Hong Kong College of Anaesthesiologists has also invited Professor Michael Ashburn from the University of Utah Pain Management Centre as a guest speaker.

ASM May 11-15, 2002, Brisbane

Plans are underway for the program for this meeting.

Examination for the Diploma of Fellowship of the Faculty of Pain Medicine

**OCTOBER 25-27 2000
ROYAL ADELAIDE HOSPITAL**

The structure for the examination was:

Written Examination

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

Short Cases

Three stations of 10 minutes each with patients with acute, chronic and cancer pain respectively. Two examiners assessed candidates at each station.

Long Case

One hour history taking and physical examination. 20 minutes to prepare material followed by a 30 minute viva with two examiners.

Structured Vivas

Five stations of 10 minutes. Three stations focussed on acute, chronic and cancer pain respectively. The fourth station was focussed on medical imaging and the fifth station was an actor role-playing an ethical consultancy issue. There were two examiners at each station.

The examination was criterion based, with an overall pass required in at least two sections and more than 50 marks out of 100 overall.

18 of the 21 candidates met the above criteria and were awarded a pass by the Court of Examiners. Each candidate was presented to the Dean, Professor Michael Cousins AM and the Chairman, Court of Examiners, Dr Penny Briscoe. Following the presentation, successful candidates met for a brief social function with the Court of Examiners.

Faculty of Pain Medicine

ABN 82 055 042 852

PROFESSIONAL DOCUMENTS

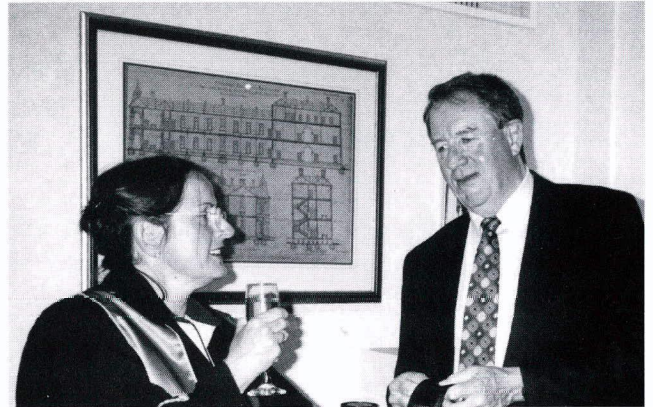
- PM2 (2000) Requirements for Multidisciplinary Pain Centres Offering Training in Pain Medicine *Bulletin Aug 2000, pg 46*
PS38 (1999) Statement Relating to the Relief of Pain and Suffering and End of Life Decisions *Bulletin June 99, pg 93*
PS40 (2000) Guidelines for the Relationship Between Fellows and the Healthcare Industry *Bulletin Mar 2000, pg 55*
PS41 (2000) Guidelines on Acute Pain Management *Bulletin Nov 2000, pg 80*



Successful Candidates

Back L to R: *Drs Tony Weaver, Tony Davies, Chris Reid, Paul Gray, Martin Carter, Steven Faux, Bryce Clubb, Greta Palmer, Brendan Moore, Diarmuid McCoy, Paul Wrigley*

Front L to R: *Drs Malcolm Hogg, Suyin Tan, Linda Huggins, Lucia Rodrigues, Alan Howell, Lorna Fox*



Successful Candidates meeting with Examiners at Social Function following Examination



Court of Examiners

Back L to R: *Drs John Corry FAFRM (RACP), Bruce Rounsefell FANZCA, A/Prof Peter Reilly FRACS, Drs David Jones FANZCA, Frank New FRANZCP, Pam Macintyre FANZCA, A/Prof Milton Cohen FRACP, Drs Richard Chye FRACP, Ray Garrick FRACP, George Mendelson FRANZCP*

Front L to R: *Prof Nigel Jones FRACS, Dr Penny Briscoe FANZCA (Chair, Court of Examiners), Prof Michael Cousins AM (Dean) FANZCA, Prof Tess Cramond FANZCA, Drs David Gronow FANZCA, Matthew Crawford FANZCA*

Obituaries

Dr Grant James Freear

South Australia – FANZCA 1999

The recent sudden death of Grant Freear at the age of 39 years was a devastating loss for his family and for his many friends and colleagues.

Born in Wellington, New Zealand, Grant was educated at Upper Hutt College and the University of Otago. He graduated with BSc in 1982 and with MBChB in 1986. His early postgraduate years were spent in Christchurch and Auckland. He commenced training in anaesthesia at Christchurch Hospital in 1990 before moving to Waikato Hospital for a further three years. In early 1995 he moved to Adelaide with his wife and young family. During his Provisional Fellowship Year at the Royal Adelaide Hospital in 1998, Grant demonstrated the qualities that were to make him an invaluable and respected Staff Specialist, a position to which he was appointed in January 1999.

Grant's clinical work included both anaesthesia and hyperbaric medicine. He was a skilled and meticulous clinical anaesthetist who had an uncanny ability to manage calmly and efficiently the most difficult of cases and the most unexpected of complications. His work in hyperbaric medicine was of a similar standard; his passing has been a particularly large loss for this small unit.

Aside from clinical work, Grant was an anaesthetist who consistently contributed much more than his share to the other activities of the Department. He was an excellent teacher who was always in demand from the trainees for extra tutorials and trial vivas. Training in CPR for operating theatre staff was nearly all done by Grant. He managed many of the QA activities of the Department. His computing skills were of such a standard that he was often the reference person for all manner of computing problems and he became the main Department tutor for Powerpoint presentations. Shortly before his death, he managed a major upgrade of departmental audiovisual equipment. In all his activities, Grant gave generously and cheerfully of his time, effort and knowledge.

The RAH anaesthetists have lost a respected colleague and friend. For Grant's wife Jill and children Olivia and Josh, their loss is immeasurable. The sincere condolences of the whole anaesthesia community are extended to them.

Richard Willis

Dr Daniel Brodie Hogg

Queensland – FFARACS 1963, FANZCA 1992

Saturday 21 October Dan Hogg died peacefully at home after losing a long battle with cancer. On that day anaesthesia in this country lost one of its elder statesmen.

Dan was born at Toowoomba on 17 April 1930. His early life was spent on his parents' farm at Brookstead on the Darling Downs. He was educated at the Brookstead Primary School and subsequently went as a boarder to the Toowoomba Grammar School for his secondary education. He matriculated to the University of Queensland in 1947.

Having decided on a career in medicine, he moved to Emmanuel College in Brisbane in 1948. He graduated in 1953.

His next four years were spent at the Brisbane General Hospital as it was known then – two years as a resident and two years as a surgical registrar. It is interesting that a number of the city's leading surgeons worked as his resident during this period. As was the custom in those days, he then left Australia to complete his training and his exams in the UK.

On arrival in London in 1958, he sat for and passed the surgical primary examination. As fate would have it, he then switched to anaesthesia and spent the next three years as an anaesthetic registrar at the London Hospital, returning to Brisbane in 1962 to commence private practice with the late Dr Roger Bennett. He accepted an appointment as a Visiting Anaesthetist at the Princess Alexandra Hospital in 1964. He worked continuously in both these sectors till his retirement at the end of 1995.

There were many facets to Dan Hogg. As an anaesthetist he had it all. An extensive theoretical knowledge, and the practical experience and the common sense to apply it appropriately. He had the ability to think clearly and act decisively under pressure. He had the humour and tolerance to work in harmony with his colleagues. Perhaps most importantly of all, he had the genuine concern for the well-being of his patients.

He spent an enormous amount of time and effort teaching his younger colleagues. Many of us practicing in Queensland today owe much to this man.

It is little wonder that he earned and received the widespread respect and affection not only of his anaesthetic colleagues, but of the medical fraternity as a whole.

Medicine aside, his interests and hobbies were mostly cultural: the theatre, music, ballet, art and opera. He read and travelled extensively. His knowledge in these areas was phenomenal.

As might be expected, this truly humble and cultured man attracted a large number of close friends from all countries, and from all walks of life.

The last five years of his life have been difficult for him. He endured his ill health with great patience and courage. At all times he was optimistic and full of praise and gratitude for the care and attention he received from those looking after him.

He will be greatly missed.

Kenneth Williams

National Anaesthesia Day 2000

REPORT ON QUESTIONNAIRES

127 Questionnaires sent out

78 Returned

Type of Activity

Display in hospital foyers	62	79%
Display in shopping centre/mall	1	1%
Other activities	26	33%

Activity - other, detail

- Pamphlets given to pre-admission patients.
- Talk for all staff about quality and anaesthesia.
- Direct contact with patients.
- Open day in school holidays for family, using Patient Simulator, poster displays and interactive displays.
- Coincided with a science festival at the town hall so our display was up for 2 weeks.
- Trip to 2 schools (30 minutes each with five classes of 7-8 year olds, showing monitors, IV and anaesthetics).
- Talk for school students.
- Media event - launch of video 'Doctor behind the mask; a day in the life of an anaesthetist'.
- Public information night.

Props Employed

Old/new equipment display	23	29%
Posters	68	87%
Leaflets	67	86%
Stickers	55	70%
Static Displays	12	15%
Other:	9	11%

Use of Media Kit

Publicity	Sought	Achieved
Newspaper	18	13
Radio	10	6
Television	9	5
Public Meetings	8	8

Media - Comments

- Very useful hints and guidelines for those who do not know how to approach media.
- Key messages were used.
- The posters and materials supplied were used very effectively to promote Anaesthesia week within the hospital.

Use of Public Relations Department 27 35%

Community Response

- Children took stickers and displayed them.
- Extra leaflets have been put in pre-admission clinic to give

to people undergoing anaesthesia in the near future.

- Noticeable response from people coming in for operations. Saw it in the paper or on TV.
- Had an old anaesthetic machine set up in the foyer, good response from the public.
- Several e-mails and letters of thanks subsequently.
- Patients said it was good to have the information.
- Fascination by patients' visitors - education of their visitors.
- Good verbal responses from public in hospital foyer, and staff who noticed displays.
- Two groups of ten students attended a demonstration in their school holidays.
- Interest shown by public and staff of hospital, one or two members discovered that anaesthetists were doctors.
- Public talk on 10th July - 150 attended, 45 question & answers, went very well.

Suggestions/Comments

- Suggest the College have a national awareness programme via media a week before the day.
- It would be good if leaflets & a few stickers could be handed out to anaesthetists working mainly in private, many did not appear to know about National Anaesthesia Day and expressed an interest to be informed.
- Simple message: general 'national' but something 'locally specific'. We made a small video of a day in the life of an anaesthetist. (Will be used in preadmission clinic.) Media loved it.
- This year's theme was better, more specific, less gushy than last year's theme.
- at 30 minute intervals two theatre anaesthetic nurses each took up to three hospital staff and gave them an insight into theatre (and more particularly) what an anaesthetist does.
- One senior staff member was amazed to learn that after a muscle relaxant the anaesthetist has to assist the patient to breathe!
- The public as a whole are quite unfamiliar with what anaesthetists do, and we are pleased that this day helps raise public awareness.

Australian and New Zealand College of Anaesthetists

ABN 82 055 042 852

RECOMMENDATIONS FOR THE POST-ANAESTHESIA RECOVERY ROOM

1. INTRODUCTION

A well-planned, well-equipped, well-staffed and well-managed post-anaesthesia recovery area is essential for the safe early management of patients who have recently undergone a surgical or other procedure, irrespective of the type of anaesthesia or sedation used.

2. GENERAL PRINCIPLES

- 2.1 Recovery from anaesthesia should take place under supervision in an area designated for the purpose.
- 2.2 This area should be close to where the anaesthesia or sedation has been administered.
- 2.3 The staff working in this area must be trained for their role and able to contact supervising medical staff promptly when the need arises.
- 2.4 In some situations (for example, paediatric hospitals) minor variations in these recommendations may be appropriate.

3. DESIGN FEATURES FOR THE RECOVERY AREA

- 3.1 The area should be part of the operating or procedural suite with easy access for management of emergencies by both theatre medical staff and staff in street clothes from outside the theatre suite. Provision should be made for rapid evacuation of patients from the area in an emergency.
- 3.2 Ventilation of the area should be of operating theatre standard.
- 3.3 Space allocated per bed/trolley should be at least 9 square metres. There must be easy access to the patient's head.
- 3.4 The number of bed/trolley spaces must be sufficient for expected peak loads and there should be at least 1.5 spaces available per operating room.
- 3.5 The layout of bed spaces should allow staff to have an uninterrupted view of several patients at once.
- 3.6 Each bed space must be provided with:
 - 3.6.1 an oxygen outlet
 - 3.6.2 medical suction complying with relevant national standards

- 3.6.3 two general power outlets
- 3.6.4 appropriate lighting and wall colour to allow accurate assessment of skin colour
- 3.6.5 emergency lighting
- 3.6.6 appropriate facilities for mounting and operating any necessary equipment and for the patient's chart.

- 3.7 Space must be provided for a nursing station, utility room and storage for drugs, equipment and linen.
- 3.8 There must be appropriate facilities for scrubbing up for procedures.
- 3.9 There should be a wall clock with a sweep second hand or analogue display clearly visible from each bed space.
- 3.10 Communication facilities should include:
 - 3.10.1 an emergency call system to areas where specialist staff are available.
 - 3.10.2 a telephone with access to the hospital paging system.
- 3.11 There must be access for portable X-Ray equipment. Appropriate power outlets and viewing box must be available
- 3.12 An emergency power supply must be available in the area.

4. EQUIPMENT AND DRUGS

- 4.1 Each bed space should be provided with:
 - 4.1.1 oxygen flowmeter and patient oxygen delivery systems
 - 4.1.2 suction equipment including a receiver, appropriate hand pieces and a range of suction catheters
 - 4.1.3 pulse oximeter
 - 4.1.4 facilities for blood pressure measurement including cuffs suitable for all patients
 - 4.1.5 stethoscope
 - 4.1.6 means of measuring body temperature
- 4.2 Within the recovery area there must be:
 - 4.2.1 means for manual ventilation with oxygen in a ratio of one unit per two bed spaces, but with a minimum of two such devices

- 4.2.2 equipment and drugs for airway management and endotracheal intubation
- 4.2.3 emergency and other drugs
- 4.2.4 a range of intravenous equipment and fluids and a means of warming those fluids
- 4.2.5 drugs for acute pain management
- 4.2.6 a range of syringes and needles
- 4.2.7 patient warming devices
- 4.2.8 devices for measuring expired carbon dioxide
- 4.3 There should be easy access to:
 - 4.3.1 12 lead electrocardiograph
 - 4.3.2 defibrillator
 - 4.3.3 neuromuscular function monitor
 - 4.3.4 rigid bronchoscope with sucker and grasping forceps
 - 4.3.5 warming cupboard
 - 4.3.6 refrigerator for drugs and blood
 - 4.3.7 procedure light
 - 4.3.8 basic surgical tray
 - 4.3.9 blood gas and electrolyte measurement
 - 4.3.10 diagnostic imaging services
 - 4.3.11 apparatus for mechanical ventilation of the lungs
 - 4.3.12 monitors for direct arterial and venous pressure monitoring
 - 4.3.13 chest drains
- 4.4 The recovery trolley/bed must:
 - 4.4.1 have a firm base and mattress
 - 4.4.2 tilt from one or both ends both head up and head down at least 15 degrees
 - 4.4.3 be easy to manoeuvre
 - 4.4.4 have efficient and accessible brakes
 - 4.4.5 provide for sitting the patient up
 - 4.4.6 have secure side rails which must be able to be dropped below the base or be easily removed
 - 4.4.7 have an I.V. pole
 - 4.4.8 have provision for mounting monitoring equipment, apparatus for delivering oxygen, patient ventilation equipment, underwater seal drains and suction apparatus during transport of patients.

5. STAFFING

- 5.1 Staff trained in the care of patients recovering from anaesthesia must be present at all times.
- 5.2 A registered nurse trained in recovery area care should be in charge.
- 5.3 Trainee nurses and registered nurses who are not experienced in the care of patients recovering from anaesthesia must be supervised.
- 5.4 The ratio of registered nurses to patients needs to be flexible so as to provide no less than one nurse to

three patients, and one nurse to each patient who has not recovered protective reflexes or consciousness.

6. MANAGEMENT AND SUPERVISION

- 6.1 Written protocols for management should be established. The Director of Anaesthesia should be responsible for the medical aspects of these policies.
- 6.2 A written routine for checking the equipment and drugs must be established.
- 6.3 When an anaesthetised patient is being transferred from one trolley/bed to another, a minimum of three people must assist with lifting. An anaesthetist must be present to have prime responsibility for the patient's head, neck and airway.
- 6.4 A designated anaesthetist should be contactable in the event that the responsible anaesthetist is unavailable. In larger hospitals, recovery duties should be the designated anaesthetist's primary duty
- 6.5 Observations should be recorded at appropriate intervals and should include state of consciousness, oxygen saturation, respiratory rate, pulse rate, blood pressure and temperature.
- 6.6 All patients should remain until they are considered safe to be discharged from the recovery area according to established criteria.
- 6.7 The anaesthetist responsible for the patient should:
 - 6.7.1 accompany the patient until transfer to recovery area staff is completed
 - 6.7.2 provide written and verbal instructions to the recovery area staff
 - 6.7.3 specify the type of apparatus and the flow rate to be used for oxygen therapy
 - 6.7.4 remain in the vicinity until the patient is safe to be left in the care of recovery area staff
 - 6.7.5 supervise the recovery period and authorise the patient's discharge from the recovery area. It is recognised that in some circumstances it may be necessary for the anaesthetist previously responsible for the patient to delegate these duties to a trained recovery area nurse or to another anaesthetist who should be fully informed of the clinical state of the patient.
- 6.8 The practitioner responsible for the patient's overall care should be available to consult with the anaesthetist in the recovery period if necessary and, in appropriate circumstances, authorise the discharge of the patient.

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Professional Documents Under Review

In line with College Policy, the following professional documents are due for review in 2001:

- E1 *Guidelines for Hospitals seeking College Approval of Posts for the First Four Years Vocational Training in Anaesthesia*
- E13 *Guidelines for the Provisional Fellowship Year*
- EX1 *Examination Candidates Suffering from Illness, Accident or Disability*
- P2 *Privileges in Anaesthesia*
- P6 *Minimum Requirements for the Anaesthesia Record*
- P16 *Standards of Practice of a Specialist Anaesthetist*
- PS12 *Statement on Smoking as Related to the Perioperative Period*
- P20 *Responsibilities of the Anaesthetist in the Post-Operative Period*
- P22 *Statement on Patients' Rights and Responsibilities*

Australian and New Zealand College of Anaesthetists

ABN 82 055 042 852

RECOMMENDATIONS FOR THE PERIOPERATIVE CARE OF PATIENTS SELECTED FOR DAY CARE SURGERY

Day Care Surgery means that the patient will ordinarily be discharged from the hospital or unit later on the day of the procedure. Anaesthesia for the procedure may require general, regional or local anaesthesia, sedative techniques or a combination of techniques.

SELECTION GUIDELINES

In all cases, the ultimate decision as to the suitability of a patient for day care surgery is that of the procedural anaesthetist. The decision as to the type of anaesthesia must remain in the province of the anaesthetist and will be based on surgical requirements, patient considerations, the experience of the anaesthetist and the facilities of the day care surgical unit.

1. Procedures suitable for day care surgery must entail:

- 1.1 A minimal risk of post-operative haemorrhage.
- 1.2 A minimal risk of post-operative airway compromise.
- 1.3 Post operative pain controllable by outpatient management techniques.
- 1.4 No special post-operative nursing requirements that cannot be met by hospital in the home or district nurse facilities.
- 1.5 A rapid return to normal fluid and food intake.
- 1.6 Early commencement of procedures for which a long recovery period is likely.

2. Patient requirements for day care surgery include:

- 2.1 A willingness to have the procedure performed, together with an understanding of the process and an ability to follow discharge instructions.
- 2.2 The patient's place of residence for post-surgery care being within one hour's travelling time from appropriate post-operative medical attention.
- 2.3 Physical status of ASA I or II. Medically stable ASA III or IV patients may be accepted for day care surgery following consultation with the anaesthetist concerned.
- 2.4 Normal term infants of over six weeks of age or ex-premature infants (less than 37 weeks gestation) of more than 52 weeks post-conceptual age. Younger children may be accepted in units with particular

paediatric experience after prior consultation with the involved anaesthetist. Longer post-operative observation may be necessary.

3. Social requirements for day care surgery include:

- 3.1 A responsible person able to transport the patient home in a suitable vehicle. A train or bus is usually not suitable.
- 3.2 A responsible person staying at least overnight following discharge from the unit. This person must be physically and mentally able to make decisions for the patient's welfare when necessary.
- 3.3 Ensuring that the patient and/or responsible person understands the requirements for post-anaesthetic care and intends to comply with these requirements particularly with regard to public safety.
- 3.4 The patient remaining within one hour of appropriate medical attention until the morning following discharge.
- 3.5 The patient having ready access to a telephone in the post-operative dwelling.
- 3.6 The patient having advice as to when to resume activities such as driving and decision making.

4. PATIENT PREPARATION

- 4.1 College Professional Document PS7 *Recommendations on The Pre-Anaesthesia Consultation* describes the essential nature of this consultation for all patients who are to receive anaesthesia.
- 4.2 College Professional Documents PS22 *Statement on Patients' Rights and Responsibilities* and PS26 *Guidelines on Providing Information about the Services of an Anaesthetist* are both relevant to preparation for day stay surgery.
- 4.3 Patient assessment can be assisted by:
 - 4.3.1 A standardised patient health/anaesthesia questionnaire.
 - 4.3.2 Prior referral of the patient by the surgeon to the anaesthetist in cases of doubt as to the suitability for day case surgery.
 - 4.3.3 Preliminary nurse assessment according to guidelines approved by an anaesthetist.

4.3.4 Anaesthesia consultation and preparation prior to the day of surgery, preferably by the involved anaesthetist.

4.4 The patient should be provided with information in an understandable written format which must include:

4.4.1 General information about the procedures to be followed in the day care unit.

4.4.2 Instructions for fasting according to the following guidelines unless otherwise specifically prescribed by the anaesthetist or where other institution guidelines apply:

4.4.2.1 Limited solid food may be taken up to six hours prior to anaesthesia.

4.4.2.2 Unsweetened clear fluids totalling not more than 200 ml per hour in adults may be taken up to two hours prior to anaesthesia. Body fluid depletion due to excessive fasting should be avoided.

4.4.2.3 For infants, breast milk may be given up to four hours prior to anaesthesia.

4.4.2.4 Only medications or water ordered by the anaesthetist should be taken less than three hours prior to anaesthesia.

4.4.2.5 An H₂-receptor antagonist should be considered for patients with an increased risk of gastric regurgitation.

4.4.3 A discharge planning questionnaire.

6.4 Minimal nausea, vomiting or dizziness.

6.5 Adequate hydration and likelihood of maintenance with oral fluids.

6.6 Minimal bleeding or wound drainage.

6.7 Patients at significant risk of urinary retention (central neural blockade, pelvic and other surgery) must have passed urine.

6.8 A responsible adult to take the patient home. For some patients it may be important to have an adult escort as well as the vehicle driver.

6.9 Discharge should be authorised by an appropriate staff member after discharge criteria have been satisfied.

6.10 Written and verbal instructions for all relevant aspects of post-anaesthetic and surgical care must be given to the patient and the accompanying adult. A contact place and telephone number for emergency medical care must be included.

6.11 Suitable analgesia should be provided for at least the first day after discharge with clear written instructions on how and when it should be used. Advice on any other regular medication is also necessary.

6.12 A telephone enquiry as to the patient's well-being on the following day should be made whenever possible.

If the patient is to be transferred to an inpatient facility, the anaesthetist and/or the surgeon will be responsible for the patient until care has been transferred to another appropriate medical officer.

5. RECOVERY FROM ANAESTHESIA

5.1 College Professional Document PS4 *Recommendations for the Post-Anaesthesia Recovery Room* establishes requirements for the facilities and staffing of recovery areas. This document is fully applicable to day care units.

5.2 An area must be provided with comfortable reclining seating for patients during the second stage of recovery prior to discharge home. This area must be adequately supervised by nursing staff and should also have ready access to resuscitation equipment, including oxygen and suction. Patients must not leave this area unaccompanied.

6. DISCHARGE OF THE PATIENT FROM THE DAY CARE UNIT

The discharge area should have ready access to wheel chairs, a parking area and ambulance facilities so as to minimise walking for the post-operative patient and to aid transfer of the patient to inpatient hospital care when this is necessary.

The following criteria apply to patients being discharged home:

6.1 Stable vital signs for at least one hour.

6.2 Correct orientation as to time, place and relevant people.

6.3 Adequate pain control.

7. QUALITY ASSURANCE

Each day care unit must have an established system for audit of the outcomes related to anaesthesia care, and include these outcomes in quality assurance and peer review processes.

RELATED DOCUMENTS

- PS4 *Recommendations for the Post-Anaesthesia Recovery Room*
- PS7 *Recommendations on the Pre-Anaesthesia Consultation*
- PS22 *Statement on Patients' Rights and Responsibilities*
- PS26 *Guidelines on Providing Information about the Services of an Anaesthetist*

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Australian and New Zealand College of Anaesthetists

ABN 82 055 042 852

RECOMMENDATIONS ON MONITORING DURING ANAESTHESIA

INTRODUCTION

Monitoring of fundamental physiological variables during anaesthesia is essential. Clinical judgement will determine how long this monitoring should be continued following completion of anaesthesia.

The Health Care Facility in which the procedure is being performed is responsible for provision of equipment for anaesthesia and monitoring on the advice of one or more designated specialist anaesthetists, and for effective maintenance of this equipment (see College Professional Document *Recommendations on Minimum Facilities for Safe Anaesthetic Practice in Operating Suites* (T1)).

Some or all of the recommendations in this document may need to be exceeded depending on the physical status of the patient, the type and complexity of the surgery to be performed as well as the requirements of anaesthesia.

The described monitoring must always be used in conjunction with careful clinical observation by the anaesthetist as there are circumstances in which equipment may not detect unfavourable clinical developments.

The following recommendations refer to patients undergoing general anaesthesia or major regional anaesthesia for diagnostic or therapeutic procedures and should be interpreted in conjunction with other Professional Documents published by the Australian and New Zealand College of Anaesthetists.

1. PERSONNEL

Clinical monitoring by a vigilant anaesthetist is the basis of safe patient care during anaesthesia. This should be supplemented by appropriate devices to assist the anaesthetist.

A medical practitioner whose sole responsibility is the provision of anaesthetic care for that patient must be constantly present from induction of anaesthesia until safe transfer to Recovery Room staff or Intensive Care Unit has been accomplished. This medical practitioner must be

appropriately trained in Anaesthesia, or be a Trainee Anaesthetist supervised in accordance with College Professional Document *Policy on Supervision of Clinical Experience for Trainees in Anaesthesia* (TE3).

In exceptional circumstances brief absences of the person primarily responsible for the anaesthetic may be unavoidable. In such circumstances that person may temporarily delegate observation of the patient to an appropriately qualified person who is judged to be competent for the task. Permanent handover of responsibility must be to an anaesthetist who is able to accept continued responsibility for the care of the patient (see College Professional Document *Guidelines on the Handover of Responsibility during an Anaesthetic* (PS10)).

The individual anaesthetist is responsible for monitoring the patient and should ensure that appropriate monitoring equipment is available. Some procedures necessitate special monitoring (e.g. MRI scanning) or remote monitoring to reduce hazard to staff (e.g. radiological procedures) (see College Professional Document *Recommendations on Minimum Facilities for Safe Anaesthetic Practice Outside Operating Suites* (T2)).

2. PATIENT MONITORING

2.1 Circulation

The circulation must be monitored at frequent and clinically appropriate intervals by detection of the arterial pulse and measurement of arterial blood pressure by indirect or direct means.

2.2 Ventilation

Ventilation must be monitored continuously by both direct and indirect means.

2.3 Oxygenation

Oximetric values must be interpreted in conjunction with clinical observation of the patient. Adequate lighting must be available to aid with assessment of patient colour.

3. EQUIPMENT

3.1 *Oxygen Supply Failure Alarm*

An automatically activated device to monitor oxygen supply pressure and to warn of low pressure must be fitted to the anaesthesia delivery system. This device should shut off the nitrous oxide supply and be capable of maintaining oxygen flow for a limited period (see College Professional Document *Recommendations on Minimum Facilities for Safe Anaesthetic Practice in Operating Suites* (T1)).

3.2 *Oxygen Analyser*

A device incorporating an audible signal to warn of low oxygen concentrations, correctly fitted in the breathing system, must be in continuous operation for every patient when an anaesthesia delivery system is in use.

3.3 *Pulse Oximeter*

Pulse oximetry provides evidence of the level of oxygen saturation of the haemoglobin of arterial blood and identifies arterial pulsation at the site of application. A pulse oximeter must be in use for every anaesthetised patient.

3.4 *Breathing System Disconnection or Ventilator Failure Alarm*

When an automatic ventilator is in use, a monitor capable of warning promptly of a breathing system disconnection or ventilator failure must be in continuous operation. This must be automatically activated.

3.5 *Electrocardiograph*

Equipment to monitor and continually display the electrocardiograph must be available for every anaesthetised patient.

3.6 *Temperature Monitor*

Equipment to monitor temperature continuously must be available for every anaesthetised patient.

3.7 *Carbon Dioxide Monitor*

A monitor of carbon dioxide level in inhaled and exhaled gases must be in use for every patient under general anaesthesia.

3.8 *Neuromuscular Function Monitor*

Equipment to monitor neuromuscular function must be available for every patient in whom neuromuscular blockade has been induced.

3.9 *Volatile Anaesthetic Agent Monitor*

Equipment to monitor the concentration of inhaled anaesthetics must be in use for every patient undergoing general anaesthesia from an anaesthesia delivery system where volatile anaesthetic agents are available. Automatic agent identification should be available on new monitors.

3.10 *Other Equipment*

When clinically indicated, equipment to monitor other physiological variables such as cardiac output or spirometry should be available.

RELATED DOCUMENTS

- T1 *Recommendations on Minimum Facilities for Safe Anaesthetic Practice in Operating Suites*
- T2 *Recommendations on Minimum Facilities for Safe Anaesthetic Practice Outside Operating Suites*
- TE3 *Policy on Supervision of Clinical Experience for Trainees in Anaesthesia*
- PS10 *Guidelines on the Handover of Responsibility During an Anaesthetic*

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Australian and New Zealand College of Anaesthetists

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and Faculty of Pain Medicine

GUIDELINES ON ACUTE PAIN MANAGEMENT

1. INTRODUCTION

- 1.1 Effective treatment of acute pain is a fundamental component of quality patient care.¹
- 1.2 Education and practical experience in acute pain management are essential components of training programs for Fellowships of ANZCA and FPMANZCA.

2. PRINCIPLES OF ACUTE PAIN MANAGEMENT

- 2.1 Adverse physiological and psychological effects may result from unrelieved severe acute pain.¹
- 2.2 Effective treatment of post-operative pain may reduce the incidence of post-operative morbidity (e.g. epidural analgesia has been shown to reduce postoperative pulmonary complications – Level I evidence, NHMRC Statement of evidence No 6.)¹
- 2.3 More aggressive and/or pre-emptive treatment of post-operative pain may reduce the incidence of chronic pain. (Level II evidence, NHMRC Statement of evidence No 3.)¹
- 2.4 Effective management of acute pain requires tailoring of treatment regimens to the individual patient.¹
- 2.5 Effective management of acute pain depends on education and training of all staff, and involvement and education of the patient and their carers.¹
- 2.6 Effective management of acute pain depends on formal protocols and guidelines covering acute pain management which are relevant to each institution; and formal quality assurance programs to regularly evaluate the effectiveness of acute pain management.¹
- 2.7 The following groups of patients have special needs that require particular attention:
 - 2.7.1 Children
 - 2.7.2 Obstetric patients
 - 2.7.3 Elderly patients
 - 2.7.4 Patients with cognitive or sensory impairment
 - 2.7.5 Patients with pre-existing or chronic pain

2.7.6 Patients at risk of developing chronic pain

2.7.7 Patients with cancer or HIV/AIDS

2.7.8 Patients dependent on opioids or other drugs/substances

3. EDUCATION

- 3.1 Education regarding acute pain management should be part of the medical undergraduate core curriculum. Knowledge should be supplemented at the postgraduate level for all medical and other staff.
- 3.2 Nursing staff has a key role in the management of acute pain. Appropriate ongoing education and accreditation of relevant nursing staff are essential.
- 3.3 Patient attitudes and beliefs have been shown to modify pain perceptions and analgesic requirements, and patient and carer education can therefore positively influence the outcome of acute pain management.¹
 - 3.3.1 A discussion regarding analgesia, its role in recovery and rehabilitation, and options available (pharmacological and non-pharmacological), is an essential component of an acute pain management consultation.
 - 3.3.2 Availability of appropriate reading material will enhance patient and carer understanding and expectations of available pharmacological and non-pharmacological therapies.

4. ASSESSMENT OF ANALGESIC EFFICACY AND ADVERSE EFFECTS

- 4.1 Tailoring of treatment regimens to the individual patient requires that regular assessments of adequacy of analgesia and any adverse effects of analgesic drugs or techniques are performed and documented.
- 4.2 Proper assessment and control of pain requires patient involvement, and measurement using self-reporting techniques, and frequent assessment and reassessment of pain intensity and effect of any intervention.¹

- 4.3 Pain should be assessed both at rest and during activity. In addition to patient comfort, pain relief should be assessed with respect to adequate function including physical therapy requirements and mobilisation.¹
- 4.4 Unexpected levels of pain, or pain that suddenly increases, may signal the development of a new medical, surgical or psychiatric diagnosis.¹
- 4.5 The most common side effects of opioid analgesic drugs are nausea and vomiting, pruritus and sedation. The presence and severity of these and other drug-related side effects should be documented and appropriate treatment given or appropriate adjustments made to the analgesic technique as required. Response to treatment interventions should also be recorded.
- 4.6 Respiratory depression is an uncommon consequence of opioid administration. It can generally be avoided by careful titration and individualisation of opioid dose.¹ A decrease in respiratory rate has been found to be an unreliable indicator of the presence or absence of respiratory depression. Sedation is a better indicator and sedation scores should be recorded in all patients receiving opioids for acute pain management.¹

5. PHARMACOLOGICAL THERAPIES

- 5.1 Drugs that may be used include opioids, non-steroidal anti-inflammatory drugs and local anaesthetics, as well as adjuvant agents such as antidepressants, anticonvulsants and membrane stabilisers.
- 5.2 In order to obtain the best therapeutic effect while minimising side effects, many analgesic drugs require careful titration and individualisation of dose regimens. When opioids are used, this requires appropriate initial doses (in the adult patient this should be based on patient age), dose intervals appropriate to the route of administration, and regular monitoring of pain and sedation scores, respiratory rate, and occurrence of other side effects.¹
- 5.3 Multimodal analgesia (i.e. the concurrent use of different classes of analgesics) improves the effectiveness of acute pain management. (Level II evidence, NHMRC Statement of evidence No 2.)¹
- 5.4 Drug administration can be by oral, subcutaneous, intramuscular, intravenous, epidural, intrathecal, inhalational, rectal, transdermal or transmucosal routes.
- 5.5 Some specialised analgesia delivery techniques require greater medical and nursing knowledge and expertise, as well as some complex equipment and the use of established protocols and guidelines. The anaesthetist initiating these forms of analgesia may delegate the management of the techniques to another medical

practitioner or registered nurse or to a pain service, provided that these personnel have received appropriate training and provided the anaesthetist is satisfied with the competence of the person(s) to whom management has been delegated. Such techniques include:

5.5.1 *Patient-controlled analgesia*

- 5.5.1.1 Patient-controlled analgesia provides greater patient satisfaction compared with conventional routes of opioid administration.¹
- 5.5.1.2 Patient-controlled analgesia allows patients to more easily overcome the wide interpatient variation in opioid requirements, and to rapidly titrate the amount of opioid delivered according to increases and decreases in pain stimulus and/or any opioid related side effects.
- 5.5.1.3 Patient-controlled analgesia may be more effective when supervised by an Acute Pain Service.¹

5.5.2 *Epidural and Intrathecal analgesia*

- 5.5.2.1 Postoperative epidural analgesia can significantly reduce the incidence of pulmonary complications. (Level I evidence NHMRC Statement of evidence No 6.)¹
- 5.5.2.2 Large audits have shown that epidural analgesia, coordinated by an acute pain service and managed in general hospital wards with regular review and using appropriate protocols and monitoring, can be as safe as traditional analgesic techniques. (Level III evidence NHMRC Statement of evidence No 7.)¹
- 5.5.2.3 Epidural and intrathecal analgesia remain the responsibility of the anaesthetist instituting the technique. The anaesthetist may delegate the management of these techniques to other personnel as outlined above.

5.5.3 *Other regional analgesic procedures*

- 5.5.3.1 Regional analgesia remains the responsibility of the anaesthetist instituting the technique, or their delegate.

5.5.4 *Continuous infusions of opioids, local anaesthetics, ketamine and other drugs*

- 5.6 Other drugs may be required for the treatment of any analgesia-related side effects; or other symptoms.

6. NON-PHARMACOLOGICAL THERAPIES

- 6.1 Non-pharmacological therapies must be considered as complementary to pharmacological therapies.
- 6.2 Cognitive/behavioural therapies (e.g. relaxation and distraction) increase tolerance to pain but may require training prior to admission (e.g. antenatal classes).
- 6.3 Physical therapies (eg. massage, heat, acupuncture, and transcutaneous electrical nerve stimulation) may be useful as an adjunct to analgesia.¹

7. ACUTE PAIN SERVICES

- 7.1 A multidisciplinary approach to the management of acute pain, such as with an acute pain service, can lead to improved pain relief and patient outcomes.¹
- 7.2 Such an approach is recommended for all patients, especially those with complex medical or psychological pathology.
- 7.3 Features of such a service should include:
 - 7.3.1 Staffing by medical personnel, particularly anaesthetists and nurses with special expertise in acute pain management.
 - 7.3.2 Close liaison with physiotherapists, psychologists and other paramedical personnel.
 - 7.3.3 Close collaboration with surgical and other specialties involved in the patient's overall acute perioperative care.
 - 7.3.4 Development of specific policies, protocols and guidelines for treatment and monitoring.
 - 7.3.5 Review of all patients under the care of the service at least once daily, and liaison with appropriate medical and nursing staff.
 - 7.3.6 Provision of a consultation service for patients with acute or acute-on-chronic pain problems.
 - 7.3.7 Provision of an after-hours service with appropriate consultant involvement.
 - 7.3.8 Involvement with management plans for analgesia after discharge, where appropriate.
 - 7.3.9 Research.
 - 7.3.10 Education of medical, nursing and other staff and students.

8. QUALITY ASSURANCE

- 8.1 Regular audits of acute pain management should be instituted to assess continuing effectiveness of any treatment and incidence of side effects and adverse effects.
- 8.2 It is recommended that a record is made of patient demographics, analgesic drugs, techniques used, pain reports and any adverse effects that occur, including those listed in 4.5 and 4.6 above and any other significant complication.

Reference

¹ Acute Pain Management: Scientific Evidence, National Health and Medical Research Council, Canberra, 1999

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

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

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

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

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- 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*
- PS33 (1999) Recommended Minimum Facilities for Safe Anaesthetic Practice for Electro-Convulsive Therapy (ECT) *Bulletin Nov 99, pg 64*
- 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*

PROFESSIONAL DOCUMENTS

E = Educational P = Professional T = Technical

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

- E1 (1996) Guidelines for Hospitals seeking College Approval of Posts for the First Four Years of Vocational Training in Anaesthesia *Bulletin Nov 96, pg 64*
- TE3 (1999) Supervision of Clinical Experience for Trainees in Anaesthesia *Bulletin Nov 99, pg 67*
- TE4 (1997) Duties of Regional Education Officers in Anaesthesia *Bulletin Nov 97, pg 88*
- TE5 (1997) Supervisors of Training in Anaesthesia *Bulletin Nov 97, pg 89*
- TE6 (2000) Guidelines on the Duties of an Anaesthetist *Bulletin July 2000, pg 86*
- TE7 (1999) Secretarial and Support Services to Departments of Anaesthesia *Bulletin Nov 99, pg 69*
- TE9 (1999) Quality Assurance *Bulletin June 99, pg 94*
- TE11 (1999) Formal Project Guidelines *Bulletin Mar 99, pg 70*
- E13 (1996) Guidelines for the Provisional Fellowship Year *Bulletin Nov 96, pg 66*
- E14 (1994) Guidelines for the In-Training Assessment of Trainees in Anaesthesia *Bulletin Aug 94, pg 62*
- TE17 (1999) Advisors of Candidates for Anaesthesia Training *Bulletin Nov 99, pg 66*
- EX1 (1996) Examination Candidates Suffering from Illness, Accident or Disability *Bulletin Nov 96, pg 70*
- T1 (1995) Recommended Minimum Facilities for Safe Anaesthetic Practice in Operating Suites *Bulletin Nov 95, pg 52*
- T3 (1995) Recommended Minimum Facilities for Safe Anaesthetic Practice in Organ Imaging Facilities *Bulletin Nov 95, pg 56*
- T5 (1995) Recommended Minimum Facilities for Safe Anaesthetic Practice in Dental Surgeries *Bulletin Nov 95, pg 65*
- T6 (1995) Recommended Minimum Facilities for Safe Anaesthetic Practice in Delivery Suites *Bulletin Nov 95, pg 61*
- 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 00, pg 72*
- P6 (1996) Minimum Requirements for the Anaesthesia Record *Bulletin Mar 96, pg 48*
- PS7 (1998) The Pre-Anaesthesia Consultation *Bulletin Mar 98, pg 73*
- PS8 (1998) The Assistant for the Anaesthetist *Bulletin Mar 98, pg 75*
- P9 (1996) Sedation for Diagnostic and Surgical Procedures *Bulletin Nov 96, pg 73*
- PS10 (1999) Handover of Responsibility During an Anaesthetic *Bulletin Nov 99, pg 62*
- P11 (1991) Management of Cardiopulmonary Bypass *Bulletin May 91, pg 43*
- PS12 (1996) Statement on Smoking as Related to the Perioperative Period *Bulletin Nov 97, pg 78*
- PS14 (1998) Guidelines for the Conduct of Major Regional Analgesia in Obstetrics *Bulletin Nov 98, pg 81*
- PS15 (2000) Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery *Bulletin Nov 00, pg 75*
- P16 (1994) The Standards of Practice of a Specialist Anaesthetist *Bulletin Nov 94, pg 45*
- PS17 (1997) Endoscopy of the Airways *Bulletin Nov 97, pg 80*
- PS18 (2000) Recommendations on Monitoring During Anaesthesia *Bulletin Nov 00, pg 78*
- P19 (1995) Monitored Care by an Anaesthetist *Bulletin Nov 95, pg 60*
- P20 (1996) Responsibilities of the Anaesthetist in the Post-Operative Period *Bulletin Mar 96, pg 52*
- P21 (1996) Sedation for Dental Procedures *Bulletin Mar 97, pg 56*
- P22 (1996) Statement on Patients' Rights and Responsibilities *Bulletin Mar 96, pg 53*
- P24 (1997) Sedation for Endoscopy *Bulletin May 97, pg 78*
- PS26 (1999) Guidelines on Providing Information about the Services of an Anaesthetist *Bulletin Nov 99, pg 63*

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