

Australian and New Zealand College of Anaesthetists

ABN 82 055 042 852

Faculty of Intensive Care
Faculty of Pain Medicine



Bulletin

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

Inside...

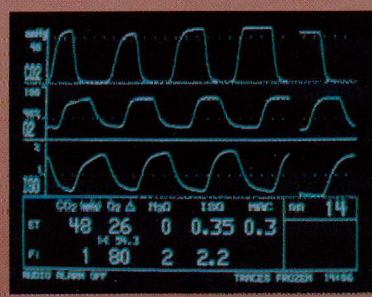
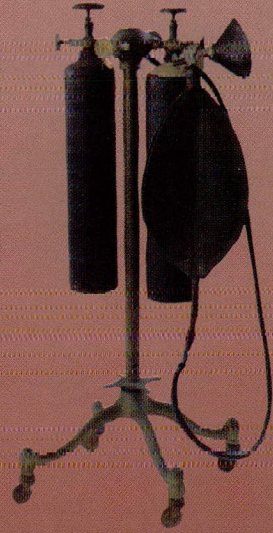
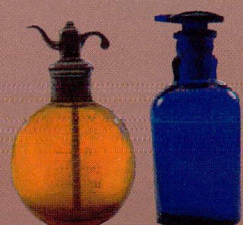
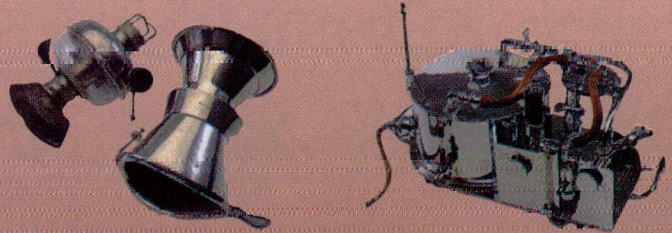
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Clinical Review
- Chair in paediatric anaesthesia
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President's Message

Teik Oh

In the last issue, I referred to our College mission to serve our communities by fostering safe and quality care in our disciplines. The College's training, education, and QA programs are viewed overseas with much respect. Quality programs in anaesthesia, such as critical incident monitoring and risk management, are second to none. The quality of our education and professional practice in Australia and New Zealand shows up in our delivery of care. Quite simply, we are among the world's safest countries in anaesthesia care. Such safe and quality care comes from a strong commitment by all anaesthetists - much from work of Fellows for the College, all unpaid of course.

Fellows then, are likely to be dismayed and outraged by the recent statement by the National Competition Council (NCC) that said "The College of Anaesthesia (sic) severely limits the number of trainees, who can train them and where they can be trained." The NCC's paper "Reforming the Professions" attacked doctors, lawyers and other professionals for alleged anti-competitive practices. This body (not to be confused with the Australian Competition and Consumers Commission, ACCC) was set up by the Australian Federal Government to monitor the States in their reforms of competition laws. What was it doing attacking professional service providers? If role boundaries are stretched, so too is credibility. And when astonishing allegations are made without verification, credibility is replaced by incredulity.

Bureaucrats in their pursuit of the Holy Grail of competition should not overlook safety and quality in medical care. Our College is about standards - standards in education and standards in professional practice. We are not in the business to determine fees, negotiate awards, or manipulate workforce numbers. Our Fellows are educators and advocates of high professional standards. Education is "the

means of developing our greatest abilities, because in each of us there is a private hope and dream which, fulfilled, can be translated into benefit for everyone and greater strength for our nation" (J. F. Kennedy). Our education tree has many robust branches, eg: training, professional development, research, public education, and quality assurance. Nonetheless, despite our achievements, there is still much to do. We want to found a Unit of Education and appoint a Director of Education. We want to review training assessment and indeed the training program. We want to establish self-development courses and Internet learning modules. We want to produce evidence-based guidelines on Preoperative Care and more. We want to introduce simulation-based learning and assessments. We want to improve MOPS and other QA programs. We want to publish better and more professional documents for patients, hospitals, health professionals, and ourselves.

The NCC claims that restrictive practices by the College have led to fat incomes for anaesthetists and a shortage of specialist anaesthetists. However, a substantial number of Fellows work in public hospitals and receive fixed salaries that fall far short of the NCC's stated earnings. I emphasise again that earnings and meeting manpower targets are not businesses of the College. Nonetheless, we are training enough anaesthetists each year to satisfy the demand identified by the Australian Medical Workforce Advisory Committee. The number of anaesthetists in rural Australia is not necessarily a bleak figure either. According to the College database, 19 per cent of Australian Fellows practice in rural and remote regions. The College recognises that its commitments do not end at city boundaries, and continues to strive to promote safe and quality care in rural communities. Council recently approved new policies

regarding overseas-trained specialists (OTS) and areas-of-need (AON) that were developed following discussions with the Australian Medical Council (AMC), the Commonwealth Department of Health and Aged Care, State Medical Boards, and other Australasian Colleges. The College's objectives were to identify OTS "equivalent" to FANZCA specialists and to fast-track suitable OTS into AON posts while maintaining high standards of practice. Council will also further explore initiatives to increase professional development and

education facilities to rural colleagues. The College strives to continually improve safety and quality care in the city and in the country. That is our core business.



A group of Australians having enjoyed the Concert in Notre Dame, Montreal during the World Congress.



Participants and partners at the Conference of International Reciprocating Boards of Education (CIREBA) hosted by the American Board of Anesthesiology in Boston USA, June 2000.

Left to right: Nicholas Collins RCA, Joan Sheales ANZCA, Frank Hughes and Butch Thomas ABA, Michael James and Clive Daniel CASA, Noel Sheales and Teik Oh ANZCA.

Front: Wendy Cogger and Leo Strunin RCA, Carlos McDowell RCAI, Miriam and Bruce Cullen ABA, Lala Oh ANZCA.

Absent: William Blunnie.



Law Report

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

Is the family trust dead?

For several decades, the family trust (discretionary trust) has been a useful part of business structure strategies, tax planning, asset protection and estate planning.

Some regard such entities as mere devices for tax minimisation. However, for many in Australia, the family trust is a standard part of effective business structure strategies. Whilst family trusts have some advantage in relation to tax, they have been a useful part in establishing ownership structures which provide great flexibility for asset protection and the future divestment of assets for retirement and estate planning. The use of a corporate trustee also provides limited liability and provides some flexibility for return of capital and longevity, surviving after the death of individuals involved.

Three major changes may affect the relevance of family trusts:

- the limitation of the capital tax gains reductions only to those assets owned by individuals (and not those held in corporate or trust structures);
- proposals to tax trusts on the same basis as companies, at the company tax rate;
- proposals to tax income earned through trusts or companies, where the majority of the income is earned from personal exertion from one source.

Whilst the precise details of this legislation are not yet known, it is clear that they will have an affect on the use of trusts in the future.

Certainly these changes will mean that family trusts will not be as attractive as a business structure for new enterprises.

However, what is not necessarily affected by these proposed changes is the advantage of trusts for:

- being able to split income between a range of beneficiaries, who may not be paying tax at the top marginal rate;
- asset protection;
- longevity, where the assets held within the trust are part of an entity which will last beyond the lives of the individuals involved.

One advantage arising from the changes is the ability for trusts to retain earnings, without paying a penalty rate of tax. This means trusts will no longer have to distribute all of their income in a year.

However, even without these changes, there are a number of issues which are often forgotten by some tax planners and advisers when using a trust, including:

- 1 the need to review and update trust deeds, where they may be several years old;
- 2 the need to review accumulated loan accounts within trusts;
- 3 the need to review the tax position of a trust, where income losses are held;
- 4 the need to review income streams, where the majority of the income to the trust may be derived from one source.

These changes in tax laws will mean that family trusts/discretionary trusts do not have the advantages that they once held. However, there are still advantages which will meet particular circumstances, suggesting that the family trust is not yet dead.

The legal lessons – Clinical Review

The Privy Council was the final Court of Appeal for the Phipps case. Mr Phipps had appealed from a decision of the New Zealand Appeal Court that had decided unanimously in favour of the RACS .

In the end, the Privy Council largely upheld the Appeal Court decision. The body of the report, with its clinical decisions and comments in relation to Mr Phipps' practice was confirmed. A chapter on recommendations (which had recommended, amongst other things, retraining for Mr Phipps in certain areas of practice) was to be deleted from the report. The Privy Council noted that Mr Phipps' appeal had, therefore, 'substantially failed'.

Since the original Phipps review was undertaken, the RACS has established far more formal procedures in both Australia and New Zealand for these types of reviews. It is acknowledged that a review by one's peers, in these more formal settings, requires careful preparation, careful consideration and due regard to proper process.

Whether in New Zealand or Australia, it is now clearly established law that a review of this nature must have regard to 'natural justice' or procedural fairness, in the way that it is carried out. That is, the person being reviewed needs to have details of all allegations or adverse material made against them, a proper opportunity to respond to the allegations, sufficient time to prepare and review by experts or a committee that is free of bias or prejudice.

These are not necessarily new concepts. What is new, is the clear revelation that these requirements apply to Colleges in these cases.

At the cornerstone of these processes are:

- Establishment of clear terms of reference for the review.

- Ensuring that the reviewers only deal with material that is relevant to the terms of reference, and do not stray beyond them.
- A clear statement of the allegations, or adverse material, held by the reviewers – which are put to the person concerned.
- The person reviewed will have an opportunity, with sufficient time, to deal with the allegations and information, and prepare a response.
- A draft report will be submitted to the person reviewed for final comment before the report is made public.

In addition, the College will only undertake such a review at the request of third parties (hospitals, government departments, other authorities), where the College is fully indemnified for all claims that may arise as a result of the process. A standard deed of indemnity has been prepared for these cases, and it is important that, before the review is commenced, a deed of indemnity is in place ensuring that the College has adequate coverage. In addition, the College maintains its own professional indemnity insurances and public liability insurances.

The Phipps case also reminds us of the role of the media. These matters can become public (either by the person reviewed or by the third parties involved). Media perception and media reporting can be erroneous, sensational and damaging to reputations. Appropriate thought to handling of media enquiries should be undertaken carefully.

Finally, it should be noted that a review by the College of a Fellows' practice is simply that. It is a report prepared that offers opinions based on factual information available to the reviewers. It is not, and is not intended to be, a process by which Fellows are disciplined, their employment challenged, or their accreditation withdrawn. These are separate processes that need to have separate consideration from the review itself. However, it should be noted that the review document or conclusions may nonetheless be used as evidence as part of, or to inform, these other processes.

Admission to Fellowship by Examination

JUNE TO AUGUST 2000

Sudeep Ganapathy	APANA	NSW	Greta Mary	PALMER	Vic
Amjed	AZIZ	NSW	John Egan	PEARSON	NZ
Christina Hermann	BÖHRINGER	NSW	Angela Gay	PLAYOUST	NSW
John Russell	BRADSHAW	NSW	Dayalan	RAMASAMY	Vic
Antoinette Mary	BRENNAN	Vic	Craig Anthony	SMITH	WA
Charles Middleton	DUCAT	NZ	Raymond Bow-Kwong	TAM	Vic
Nicholas John	EBLEN	SA	Jeremy John	WALLACE	Tas
Sai Yan	FONG	WA	Darryl Edward	WASHBOURNE	Qld
Andrew Ian	GARDNER	WA	Timothy George	WEBB	Vic
Paul Gerard	HERREEN	SA	Daryl Lindsay	WILLIAMS	Vic
Peter William	HOWE	Vic	June	YEO KHEE SIM	HK
Sunil Kumar	KAFLE	SA			
Christopher Peter Henry	KALINOWSKI	NZ	By Examination through OTD System:		
Doris Tung Ching	LAM	HK	Michele Ann	MOORE	NZ
Bruce Richard	PAIX	SA	Palvannan	SIVALINGAM	NZ



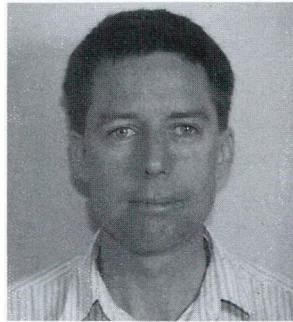
Dr Philip Ragg (R) congratulating Dr Mike Lambros, winner of the ASM 2000 Formal Project Prize.



Dr Adam Tucker, (VIC) receives the Gilbert Brown Prize from Professor Michael Cousins, at the recent ASM 2000 in Melbourne.

Hornabrook Prize Announcement

The Day Care Anaesthesia Special Interest Group Executive congratulates



Dr Brian Anderson

**Starship Children's Hospital,
Auckland, New Zealand**

awarding him the Hornabrook Prize for 1999 for his presentation of original research "**The dose-effect relationship for morphine and vomiting after day-stay**

tonsillectomy in children" at the CECANZ Meeting at Wellington in 1999.

The Hornabrook Prize is awarded for research related to Day Care Anaesthesia taking into consideration originality, significance, design, presentation and effort. The aim of this prize is to promote original research in the field of day care anaesthesia in Australia and New Zealand and particularly to foster research by recent Fellows and trainees.

DECLARED QUALITY ASSURANCE ACTIVITY TO WHICH PART VC OF THE *HEALTH INSURANCE ACT 1973* APPLIES

Item	Title of quality assurance activity	Description of quality assurance activity
7	Australian and New Zealand College of Anaesthetists (ANZCA) Professional Practice Review	The Activity is a study of the incidence or causes of conditions or circumstances that may affect the quality of health services. The purpose of this Activity is to review anaesthetists' practice to ensure the best possible standard of practice. The services to be studied are services in respect of which payments have been or may be made under Part II of the Act (i.e. Medicare Benefits). The persons managing the Activity are Professor Teik Ewe Oh, MD (Qld), FRCP, FRACP, FRCA, FANZCA and Mrs Joan Sheales, Registrar and Chief Executive Officer, Australian and New Zealand College of Anaesthetists (ANZCA). The persons are authorised to engage in the Activity by ANZCA which is an association of health professionals. The Activity is of a kind that has been engaged in previously in Australia. The Activity is a national project involving persons who provide health services in all States and Territories. The application of Part VC of the Act will encourage the full participation in the Activity by the persons who provide health services, to a greater extent than in the previous activity. Non-identifying information will be published by the College as part of its general reporting of activities to its Fellows. This information will also be provided to the Minister for Health and Aged Care.

IMPROVEMENTS IN ANAESTHETIC CODING

July 2000



In response to requests from the Australian and New Zealand College of Anaesthetists and the Consultative Council on Anaesthetic Mortality and Morbidity, The National Centre for Classification in Health (NCCCH) has recently revised the current Australian Coding Standard (ACS) 0031 *Anaesthesia*. This standard will take effect from 1 July 2000 for all hospital and day procedure centre inpatient episodes of care.

Currently, anaesthetics are not captured in the hospital inpatient morbidity collection except in certain circumstances (e.g. children undergoing CT scan) and for pain management procedures. The revised standard now instructs clinical coders to assign codes for anaesthetic administration. It also provides guidance on coding multiple anaesthetics and the correct sequencing of codes.

The improvements to the standard have been undertaken in order to provide accurate and timely data on anaesthetic procedures performed in Australia. This data may then be utilised in studies such as mortality and morbidity review, resource allocation, research projects and continuous quality improvement.

Documentation guidelines

The concept of coding anaesthetics introduces a major change in the clinical coding process. The abstraction of information from the clinical record will now involve careful review of anaesthetic charts by the clinical coder.



To facilitate this process, the following points should be noted:

- Documentation of **all** types of anaesthetic (including sedation) administered during a procedure, e.g. general anaesthetic in conjunction with an epidural, is essential.
- Complete and accurate documentation of the **type** and **route** of anaesthetic administered is crucial in order for the correct code to be assigned.
- It is important to distinguish between injection and infusion in the administration of regional anaesthesia.

Missing or incomplete documentation will make the coding process more difficult, which in turn, may have detrimental effects on coding quality.

The health information manager and/or clinical coders in your institution will be able to provide you with a complete copy of ACS 0031 *Anaesthesia*. You may also wish to view the section on anaesthetic procedures in ICD-10-AM (Volume 3, pages 7-9, 68, 187 & 304).

Any issues arising from the use of this new standard will inform further refinements for the third edition of ICD-10-AM, due for release in July 2002.

A collaborative effort between clinical coders and anaesthetists will ensure vastly improved coded data on anaesthetic administration in the future.



Simulation and Skills Training

SPECIAL INTEREST GROUP

At the June Council Meeting, the formation of a Special Interest Group in Simulation and Skills Training was approved.

The role of this SIG is: to discuss academic issues; formulation of training syllabuses of Simulation and Skills Training courses; maintenance of standards, quality improvements and assurance, research and teaching etc. It is not the intention of this group to take over the current role of The Australasian Association of Simulation & Skills Centres. Other roles and responsibilities will be discussed by the Executive Members of the SIG.

An interim Executive has been established, Chaired by Dr Brendan Flanagan. Membership of this SIG is open to

Fellows, members of the ASA and NZSA. Fellows of other Colleges, practitioners and allied health professionals are encouraged to participate as Associate Members.

Fellows with a special interest in this area should register such interest either by telephone, fax, letter or e-mail to:

Ms Helen Morris
ANZCA Continuing Education
630 St Kilda Road Melbourne Vic 3004
Telephone: 03 9510 6299
Facsimile: 03 9510 6786
E-mail: helen@anzca.edu.au

BRENDAN FLANAGAN
CHAIR



Citation – Professor GA 'Don' Harrison

ROLL OF HONOUR AUSTRALIAN RESUSCITATION COUNCIL
PRESENTED ON 7 JULY 2000

In the disciplines of resuscitation, anaesthetics and intensive care the name of Don Harrison is widely recognised as a leader in the field. His distinguished career in medicine and anaesthetics has led to the award of many academic, professional and civil awards at the highest level including a Medal in the Order of Australia. As well as his vocational role in anaesthetics and intensive care, Don has devoted considerable amounts of his time to resuscitation in all of its facets; practical aspects, teaching, organization, equipment assessment and preparation of educational material were all encompassed in his endeavours.

Don was a participant in the 1975 seminar, which led to the formation of the Australian Resuscitation Council in 1976. It seems a long delay before he became a Council representative in 1987, but he was busy in his association with Surf Lifesaving and in hospital resuscitation promotion. Although late to the ARC he became Chairman after two years and served for four years. He also served as Chairman of the Advanced Life Support Committee for three years.

Under his guidance many initiatives were implemented. The three most influential were Advanced Life Support, International liaison and the Spark of Life meetings. Each of these were important landmarks which increased both the scope of activity and the public and international profile of the Council.

Don resigned as Chairman in 1993 to concentrate on educational aspects of the Council's activities and the introduction of early access to defibrillation. This latter interest was an extension of his equipment interests. For many years he tested resuscitation equipment in his laboratory on behalf of the Council thus contributing to the standard of equipment in this country. His role as Chairman of the relevant committee of the Standards Association of Australia made him pre-eminent in this field.

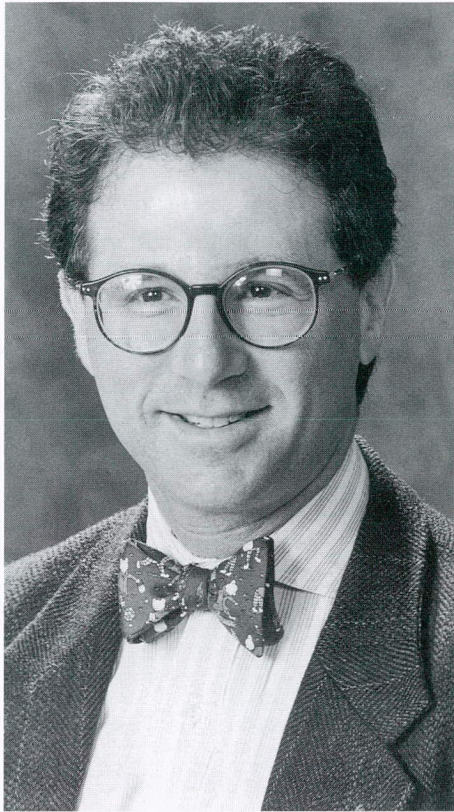
Arguably Don's greatest contribution was in the application of his expertise in education to the documents of the Council. As editor of the Oxygen Skills Manual and the Adult Advanced Life Support Skills Manual, he in fact wrote these landmark documents which combine practical experience, commonsense and educational principles.

No one has contributed more to resuscitation in Australia and to the Australian Resuscitation Council and it is fitting that his name be added to the Roll of Honour.

Vic Callanan



Sir Llewellyn Edwards, AC, Chancellor, The University of Queensland presenting Professor Tess Cramond, AO, OBE with Doctor of Medicine honoris causa, University of Queensland.



Chair in paediatric anaesthesia to investigate pharmacology of anaesthetics and related drugs in children

TORONTO - Canada's first endowed chair in paediatric anaesthesia - and one of very few in the world - has been established at The Hospital for Sick Children (HSC) with a significant gift from the Electromedical Systems Division of Siemens Medical Engineering Group.

Dr Jerrold Lerman, an internationally recognised clinician and scientist, was appointed the inaugural holder of the Siemens Chair in Paediatric Anaesthesia at The Hospital for Sick Children. Dr Lerman is a staff anaesthesiologist at Sick Kids, a Project Director in HSC's Research Institute, and a professor of Anaesthesia at the University of Toronto.

'The Siemens Chair in Paediatric Anaesthesia is important, as it provides long-term financial funding for research in the area of anaesthesia for children,' said Dr Larry Roy, Anaesthetist-in-Chief, The Hospital for Sick Children. 'New anaesthetic agents developed over the past decade allow infants and children to undergo anaesthesia and surgery much more easily. The partnership between Siemens and HSC's Department of Anaesthesia will do much to further expand our knowledge of the use and effects of anaesthesia for children.'

'The bestowal of a chair by Siemens is recognition to the hospital of the esteem in which it is held by Siemens, for its significant endeavours and innovative research in this

specific area of developing medicine. HSC is a strategically important site because of its worldwide renown and because of the large number of procedures performed there each year,' says Siegfried Russwurm, President and CEO of Siemens-Elema AB in Sweden.'

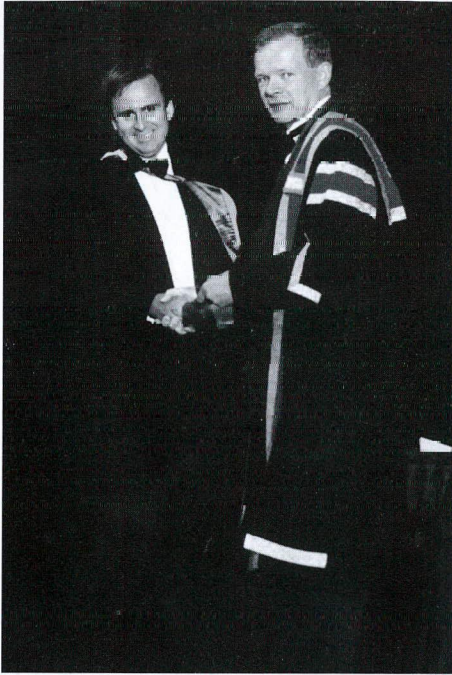
Sick Kids is one of few centres that conducts the kind of drug testing of anaesthetic agents on infants and children that is necessary from a regulatory point of view. Development of a new drug can cost up to \$1 billion, so it is crucial that potential paediatric ramifications are brought forward through research and testing during the development stage.

'Crucial information can be gathered through research and testing of new drugs while they are in the development stage,' said Dr Lerman. 'Sick Kids and its Department of Anaesthesia have a history of providing research that will be educational and that will help children. This Chair will allow us the first opportunity to see how new drugs behave in infants and children and to determine appropriate therapeutic dosages for those drugs.'

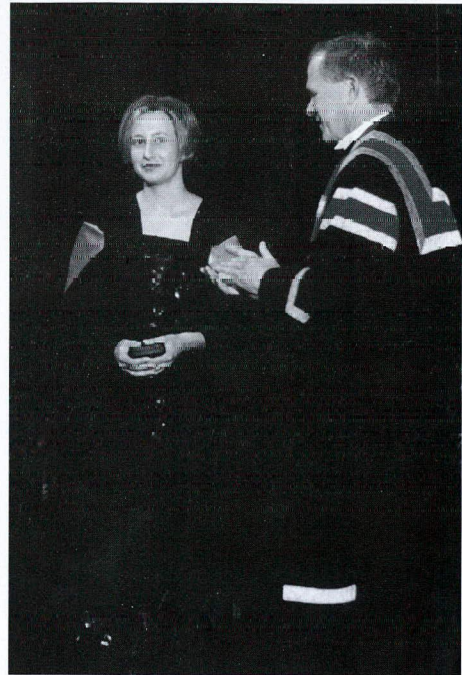
The Electromedical Systems Division of Siemens Medical Engineering Group is a world leader in the provision of life support, anaesthesia, electrocardiography and patient monitoring products, which can be integrated into a comprehensive, continuous care system throughout the hospital. The Siemens Medical Engineering Group stands for innovation, service, and complete medical solutions. It covers the entire spectrum of imaging technologies for diagnosis and therapy, electromedicine and hearing instruments, up to IT-solutions to optimise the workflow and raise the efficiency in clinics and medical practice. Siemens Medical Engineering Group reached an order volume of 4.14 billion Euro and a turnover of 4.09 billion Euro in the fiscal year 1998/99 and has around 19,000 employees throughout the world.

Examination Prize Winners

Renton Prize

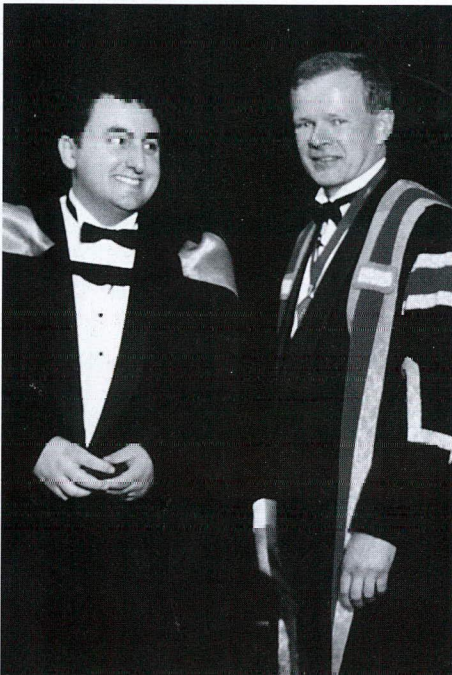


Dr Tyrone Crofts, Victoria, April 1999.

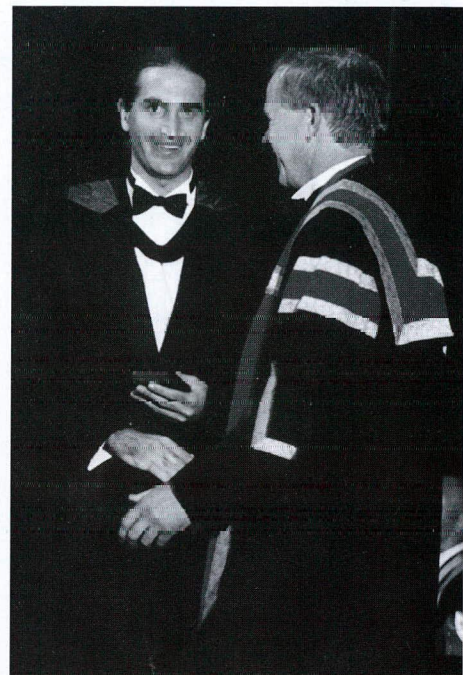


Dr Nicole Healy, Queensland, September 1999.

Cecil Gray Prize



Dr Anthony Coorey, Queensland, May 1999.



Dr Darren Wolfers, New South Wales, April 2000.

Retiring Examiners

with Dr Neville Gibbs, Chairman of Primary Examination Committee.



Drs Jim Love (L) and Peter Lillie (R).



Professor Duncan Blake.



Dr Ted McArdle.



PRIMARY EXAMINATION COURT - AUGUST 2000

Front L - R Drs Kate Leslie, Renald Portelli, Neville Gibbs (Chairman), Patricia Goonetilleke, Rob Henning

Back L - R Drs Malcolm Futter, Tony Plowman, Alan McKenzie, Bob Wong, Prof Tony Gin, Jim Love, Peter Lillie

Final Fellowship Examination

JULY/AUGUST 2000

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

The Viva Examination in anaesthesia and medicine was held at the Australian Institute of Management and the Alfred Hospital, Melbourne.

Ninety-two (92) candidates presented in Melbourne and sixty-three (63) were approved.

The successful candidates were:

K D Arthur	NZ	S A Dobell	VIC	P J Hodges	NSW	M J Middlemiss	NZ
C G Bernard	NSW	P S Doran	NZ	J R Hollard	NSW	J Morris	VIC
M J Bremner	WA	C H Fernandez-	NSW	C D Holmes	NSW	D D E Moses	QLD
S G Buntain	QLD	Cornejo		A W Hooton	NSW	A P Needham	NSW
M J Caporn	QLD	J M Graham	VIC	J M K Hu	NSW	C B Oh	VIC
A M Carll	NZ	H D Gray	NZ	A V Jaumees	NSW	M J Perry	NSW
Chan Kai Lai, A	HKG	A J Hackland	SA	C S H Johnstone	NSW	L Pfitzner	NSW
D W Collins	NSW	T S Hampton	SA	S L Keel	NZ	G E Power	QLD
B E Cuff	NSW	J G Hardman	QLD	J W-Y Kuh	WA	D J Provan	QLD
A Davis	NSW	S M Harrison	NSW	J T-E Lai	NZ	J M Rothwell	NSW
				J S Lain	NSW	Soh Chai Rick	SING
				Lam Wang-leuk D	HKG	J M Somerville	WA
				M K L Lee	NZ	T M Stephen	NSW
				M J Lennon	NZ	D E W Terry	VIC
				F W Lombard	NZ	C J Thomas	QLD
				N D W Lovelock	NSW	M R Thompson	WA
				B Y R Lowe	NZ	C Vernier	NSW
				A Mann	VIC	M L Wakefield	QLD
				E M Mathieson	VIC	D S B Watson	NZ
				C L McCalman	NZ	C M Wood	SA
				M I R McGill	NZ	J D Woodfine	NZ
				R P McKinnon	SA	B Yee	NZ

Final Examination



Final Examination Court – August 2000

Front L-R Drs Michael Jones, Roman Kluger, Glenda Rudkin, Megan Gray, David Scott (Chairman), Penny Biscoe, Leona Wilson, Michael Paech

Centre L-R Dr Keith Cronin, Assoc Prof Peter Klineberg, Drs Phillipa Hore, Tim Costello, Rob Beavis, Ed Loughman, Andrew Puddy, Graham Sharpe, Kersi Taraporewalla

Back L-R Drs Peter Dawson, Tony Weeks, Wally Thompson, Michal Kluger, Professor Tony Gin, Drs Peter Moran, Pat Moran, Craig Morgan, Geoff Mullins.



*Former ANZCA President Dr Richard Walsh with Dr Rod Westhorpe
ASA President greeted by Her Majesty Queen Elizabeth II at the
opening of CTEC. Right Dr Brent Donovan Director of CTEC.*



Dr Patricia Mackay and Prof Ian Mackay following presentation to Dr Mackay of the Australian and New Zealand College of Anaesthetists Medal during the College Ceremony at the Melbourne ASM.



ANZCA IT Developments

Mike Martyn Chairman IT Committee

Since its formation last year (previously named the Computer Committee) the ANZCA information Technology Committee has been extremely active. Members of the Committee (Joe Novella, Mark Finnis, Terry Little, Dick Willis and Joan Sheales) are to be commended on their endeavour over the last year. Special thanks must go to Karen Monette (Administrative Officer IT) who maintains and constantly improves the College Computer systems, website, ANZCA Web News and supports this active Committee. At the May Council Meeting Leona Wilson also joined the committee to give both an Education and New Zealand perspective.

ENABLING IT COMMUNICATION

The most important initiatives this last year resulted from an IT workshop held in February at the College. We included staff from Med-E-Serv who publish our website and an outside consultant, Ms Maureen Henninger (from the University of NSW). The aim was to strategically plan the introduction of new IT functions and to revise the structure of the ANZCA website. A number of resolutions were passed which will have significant implications in enabling electronic communication and education between the College, Fellows, trainees and MOPS registrants.

1. College Database to be published online

The College maintains an electronic database of all Fellows and trainees. It is planned to have relevant material be accessible, with appropriate security, by individual Fellows and trainees in order to check or update contact details and other information. This should save on staff time and also be more convenient for many Fellows. It is also planned to introduce the ability to pay College subscriptions and trainee fees online.

2. Electronic College Mailouts

It is planned that Fellows and trainees will be able to choose to receive the majority of College material

electronically - this could include the College Bulletin, and would have major cost savings.

3. Hospital Accreditation Database to be accessible online

Currently there is a very cumbersome manual system involving large volumes of paper (probably from Tasmanian forests) when hospitals undergo routine inspection for training. It is planned to have the Hospital Database online (with appropriate security) to allow hospital staff to update the material and also for the College visitors to access the material electronically.

4. MOPS Reports be published online and move to data entry online

The MOPS system is currently a disk or paper based system that is collated electronically at the College. Initially it is planned that the individual data, with appropriate security, to be accessed by MOPS registrants. The next step will be to enable individuals to enter their MOPS data online.

5. Library Catalogue Online

The library catalogue is maintained on DB Textworks. The College has purchased DB Webpublisher which will allow the catalogue to be accessed online. The same program could also be used to allow the museum contents to be published online.

6. ANZCA Website restructure

In order to facilitate the above activities and to improve the ability to navigate, the College website has been completely restructured (based on a report from Maureen Henninger). This should be operational at the beginning of September. The structure has been streamlined, education and trainee sections enhanced and the Webgroup section disbanded. Private pages will be accessible by existing passwords (issued by the College to Fellows, trainees and financial MOPS registrants).

REGISTRATIONS FOR PRIVATE ACCESS TO COLLEGE WEBSITE

There were 1,445 registered to access the ANZCA website private areas as of the end of July 2000. There have been 452 registrations this year which indicates a sharp upturn in Fellows and trainees taking up this method of communication. The College regularly sends out ANZCA WebNews to all those registered. If you have not registered please visit www.anzca.edu.au and follow the appropriate process.

STATUS	ORIGIN		
FANZCA	917	Australia	1047
FFICANZCA	83	New Zealand	21
FFPMANZCA	28	S.E. Asia	95
Anaes. Trainee	455	Other	67
IC Trainee	47		
PM Trainee	11		
Non Fellow	16		
Rural GP Anaes.	4		
Staff	31		

ANZCA WEBSITE SIZE AND USAGE

The ANZCA website has increased in size and usage over the last two years with a large increase occurring this year

	July 1998	June 1999	June 2000
Monthly Hits	22,835	37,258	108,349
Monthly Data	91.25 MB	171.76MB	520.18MB
Size of Website	3MB	5.4MB	10.5MB

2000 VIRTUAL CONGRESS

Another successful initiative has been the Virtual Congress run in conjunction with the Melbourne ASM This has received a large amount of activity and support.

Date	Hits	Pages
Apr-00	35,890	8,033
May-00	108,716	32,715
Jun-00	42,528	15,240
Jul-00	22,087	7,511

NATIONAL ANAESTHESIA DAY

As a support to National Anaesthesia Day this year a PowerPoint presentation on Anaesthetists and their work is available for download from the ANZCA website. This can be easily modified for use in individual departments or for any presentations such as to schools or clubs. Thanks to all those who contributed photos and to Karen Monette for collating the presentation.

FACULTY AND REGIONAL COMMITTEE WEBSITES

The last year has seen the establishment of separate websites for the Faculty of Intensive Care (overseen by Mark Finnis), Faculty of Pain Medicine (Terry Little) and the Victorian Regional Committee (Joe Novella). These all add to the ability of the various sections of the College to be able to communicate to their relevant constituents.

NEW COLLEGE COMPUTERS

Another initiative that occurred this year was to upgrade all computers in the College with a purchase of 19 computers and a new server with standardisation of software (Office 2000). This upgrade was long overdue and has occurred very smoothly.

VIRUS ALERTS

This year has seen a large number of viruses (in particular macro viruses) circulating. The College has well established virus checking but we encourage all Fellows and trainees to take care and utilise well established practises and virus protection.

HEALTHCONNECT - PATIENT ELECTRONIC HEALTH RECORDS

An interesting Summit involving some 250 people was held in Adelaide in August to further a collaborative approach in establishing nationwide Electronic Health Records. The Australian Health Ministers at their AHMAC meeting in Wellington in July endorsed the report of the National Electronic Health Records Taskforce which recommended this approach. There is considerable support from consumer forums, state and federal governments and GPs as well as good leadership in developing this initiative so there is a more probable chance of success than many other public funded IT projects. The College will be involved through the CMPC. The establishment of such electronic health records could have considerable advantage to anaesthesia, intensive care and pain medicine.

IT IS YOUR COLLEGE - WE NEED YOU!

The main aims of the IT Committee is to enhance electronic communication between the College and its constituents and to make the working of the College more effective and efficient. We need your support, suggestions and criticisms in order to help direct our attention and endeavour. Please contact us!

Obituary

DR CECIL STANLEY JONES

South Africa - FFARACS 1964, FANZCA 1992

'Buck' Jones was born in England on 27 June 1919. He grew up in Natal, South Africa where his father was an educationalist. Following medical studies at the University of Cape Town, he practised at Addington Hospital in Durban from 1942 to 1947, where he decided on a career in Anaesthetics. He obtained a trainee appointment at the Mayo Clinic in USA where he obtained an MS degree in Anaesthesiology from the University of Minnesota.

In 1952 he was appointed Head of the Department of Anaesthetics at Groote Schuur Hospital, the teaching hospital of the University of Cape Town. At that time there was no organised teaching in Anaesthesia which was a rather neglected subject in the medical curriculum. Buck's first task was to try to put this right and it led to many confrontations with the entrenched specialties. He succeeded in laying the foundation of what was to become a major Anaesthetic Department. In 1958 he was awarded the Cecil John Adams Travelling Fellowship during which he did a survey of anaesthetic problems in South Africa. In 1961 he resigned his appointment and emigrated to Australia to the University of New South Wales. In 1968 he returned to South Africa to private practise in the country town of Worcester. Buck Jones will be remembered here for his efforts in laying the foundations on which the academic department of Anaesthetics of the University of Cape Town has developed.

Buck died suddenly on 9 September 1999.

Arthur Bull



2000



ADMISSION TO FELLOWSHIP

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

Simon John Erickson, WA (endorsed in Paediatric Intensive Care)
Peter Stanley Kruger, QLD
Adam Purdon, NSW



Drs Ron Trubuhovich and Felicity Hawker at the Annual Meeting of the Faculty. Drs Trubuhovich and Cooper retired from the Board after a term of six years.



Dr Felicity Hawker presents Dr Alan Duncan with a gift of thanks for his term as Dean from 1997 to 2000.

Items of Interest

FROM THE JUNE 2000 BOARD MEETING

EDUCATION AND TRAINING

S3 Accreditation

The Board reviewed its criteria for S3 classifications regarding Accreditation of Training in Intensive Care Units. The Board wishes to reiterate the purpose of the establishment of the S3 classification. Units accredited as S3 are to enable trainees to gain specific clinical experience on rotation from a C24 Hospital, which cannot be obtained from the 'parent' unit. The level of teaching and supervision may not be compromised. Full details of the criteria are published separately in this Bulletin.

Review of the In-Training Assessment Process

A review of the Faculty's in-training assessment process, and Policy Document IC-11 'In-Training Assessment of Trainees in Intensive Care' will be undertaken. The review will endeavour to accentuate the formative nature of the process. It is envisaged that trainees, rather than Supervisors and Regional Education Officers, will be responsible for the return of assessment forms. This assessment will be the form used to document all training. Promulgation of any changes will be notified with the revision of the current policy document. Any comments or suggestions should be directed to the Education Officer, care of the Faculty office.

Care of the Critical Ill Surgical Patient (CCrISP) Course

This course has recently been established by the Royal Australasian College of Surgeons and is aimed at providing intensive care skills to the basic surgical trainee. The Board considered the course appropriate for doctors in Postgraduate Year 1 or 2, rather than Faculty trainees.

Joint Specialist Advisory Committee - Intensive Care

This Committee continues to provide supervision of all individual intensive care training, and to endeavour to streamline policy towards a single training program in intensive care. The RACP have recently agreed in principle with the policy of site accreditation.

A New Zealand Joint Specialist Advisory Committee in Intensive Care (NZJSAC-IC) has been established, with its main responsibility being assessment of specialist recognition on behalf of the New Zealand Medical Council. Oversight may also be included in its terms of reference.

Policy evolving from the JSAC-IC Committee of particular importance:

- **The role of the 'Senior Registrar' in Intensive Care Training**

The Joint Specialist Advisory Committee - Intensive Care has developed a statement recommending that where possible, trainees should occupy a training position at the 'senior registrar' level for a minimum of six months. The statement is published in this edition of the Bulletin.

- **Role of the Supervisor of Training**

The Board is currently reviewing the policy document on Supervisors of Training and is endeavouring to provide more details on their role and desirable qualities and attributes. Workshops for Supervisors will be arranged where possible.

- **Formal Project Requirements**

These requirements have been revised and are published in the Faculty section of this Bulletin. Amendments include that publication of scientific papers submitted as projects will not guarantee acceptance. It is also expected that the Supervisor of Training will critically review the final manuscript of projects to ensure suitability for submission.

Survey on Training

A survey of trainees and recent graduates seeking feedback on supervision and training programs was undertaken in 1999. The results have been collated and were considered by JSAC-IC. The variability of responses indicated that the quality of training is very much reliant on the individual supervisor and the nature of the Unit. Further information is published elsewhere in the Bulletin.

Dates for Examinations 2001

The dates for the Fellowship Examinations for 2001 were diarised and are detailed elsewhere in the Bulletin.

PROFESSIONAL AFFAIRS

Criteria for Recognition as a Specialist in Adult Intensive Care

These criteria have been revised and are published elsewhere in the Bulletin. They have been developed by the JSAC-IC to assist in assessing applications for specialist recognition.

A Joint Faculty of Intensive Care Medicine

The Board noted that further development of a proposal for the establishment of Joint Faculty of Intensive Care Medicine between ANZCA and the RACP is awaiting endorsement from RACP Council.

FINANCE

A Separate Subscription for Faculty Fellows

The Board noted the resolutions of May Council regarding the introduction of a separate subscription for Faculty Fellows. The Board agreed that the level of subscription for the 2002 year should be struck at the same rate as the College Subscription.

CONTINUING EDUCATION

Annual Scientific Meetings

In line with College policy, the Board resolved that overseas visitors will be offered a travel allowance of \$A8,000 plus the usual daily living allowance when participating in CME and Scientific Meetings.

INTERNAL AFFAIRS

Election of Board of Faculty

Following the resignation of Drs Jamie Cooper and Ron Trubuhovich from the Board, an election was held with

the following re-constitution of the Board:

Elected:	F.H. Hawker	Dean
	N.T. Matthews	Vice-Dean and Censor
	J.H. Havill	Education Officer
	P.D. Thomas	Treasurer
	R.P. Lee	Chairman, Examinations
	R.J. Barnett	ASM Officer, Communications Officer
	G.F. Bishop	MOPS Officer and Assistant Education Officer
	A.W. Duncan	
Co-opted:	T.E. Oh	President, ANZCA
	R. Raper	RACP Adult Medicine Representative
	J. Gillis	RACP Paediatric Medicine Representative

Honours and Appointments

The Board extended its congratulations to Dr Andrew Bersten on receipt of the Young Tall Poppy of South Australia Award for Scientific Achievement.

Faculty Website

The structure and content of the Website are currently being reviewed. Comments and suggestions are most welcome.

S3 Accreditation

At the June 2000 meeting, the Board considered the requirements for Units applying for S3 Classification, ie 3 months of core training in specific circumstances. The Board's intent for S3 accreditation is that such Units provide specific and valuable clinical experience for trainees with appropriate levels of supervision and teaching, and are part of organised rotations from C24 training programs.

The Board discussed the following problems:

1. The described intent of the S3 classification is not clear.
2. There are lesser requirements for supervision of Trainees in S3 units compared with C12 and C24 units.
3. Applications for accreditation as S3 are being sought to fulfil clinical needs and not for reasons of benefit to Trainees.
4. It is recognised but not stipulated that S3 units are unsuitable to fulfil the compulsory component of intensive care exposure for trainees of other specialist training bodies.

The intent of the S3 classification is to provide a rotation from a C24 Unit which provides a "parenting" role, and which is to the benefit and opportunity of Trainees. Approval for training should be granted as S3 when the unit provides specific and complementary clinical experience that is not available in the Unit organising the rotation, and when the clinical experience is thought to be special and valuable for Trainees. Examples of such clinical exposure include retrieval services, rural intensive care units and cardiac intensive care units.

Faculty Policy Document IC-3 does not require the same level of supervision for Trainees in S3 units as in C12 or C24

units. This is acceptable when the clinical experience in the S3 unit is of particular and unique benefit, for example retrieval and rural units. For these rotations, there is more flexibility with regard to supervision and training requirements. However, for other Units applying for S3 accreditation, then the intent should be that supervision and teaching are more comprehensive.

In granting an S3 accreditation:

1. A "parent" C24 unit should supervise and organise the rotation.
2. The "parent" C24 unit should provide a proposal for consideration by the Board. Such a proposal should highlight the benefit of the rotation to Trainees, and the supervision, teaching and specific clinical exposure provided.
3. In part, to help ensure acceptable supervision of Trainees, the S3 unit should have
 - a Director who is JSAC-IC recognised and
 - an appropriately qualified specialist rostered to supervise the Unit and only the unit at all times

Other criteria as outlined in Faculty Policy Document IC-3 will also need to be fulfilled.

It should be noted that S3 units are not suitable to fulfil the compulsory component of intensive care exposure to trainees of other specialist training bodies (eg ANZCA, ACEM).

Neil Matthews
Censor



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

RECOGNITION AS A SPECIALIST IN ADULT INTENSIVE CARE

Introduction

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

The criteria set out below were developed by JSAC-IC 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 a Specialist in Intensive Care. It is not intended that they should affect any specialist recognition granted prior to 1995. They are not used to maintain a specialist register by JSAC-IC. Fulfilment of the criteria below does not confer eligibility for Fellowship of the Faculty of Intensive Care, ANZCA or the Royal Australasian College of Physicians.

Criteria

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

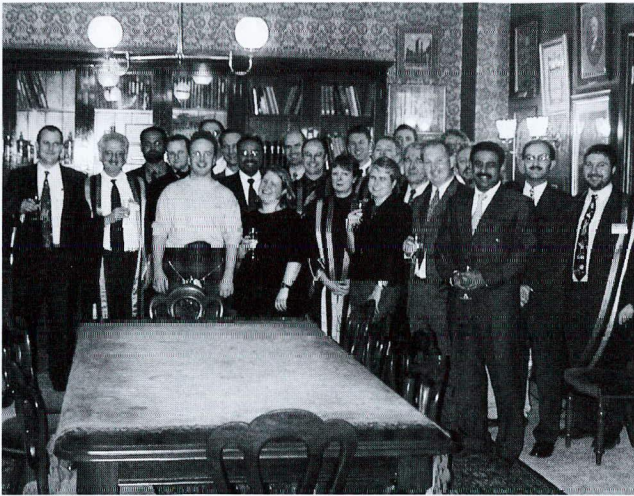
Persons with specialist qualifications from outside of Australasia must have completed training equivalent in duration, structure and content, assessments and supervision to that required by the Australasian intensive care training bodies.

Note: Under Australian Medical Council 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 may be required. It is usual for overseas training specialists to be awarded Fellowship when they meet the requirements of the relevant College.

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

3. For persons who commenced specialist training before 1989 or specific training in Intensive Care before 1995 and who have the qualifications FANZCA or FRACP specialist recognition will be supported by JSAC-IC when the applicant has:
 - (a) spent two years in a training capacity in 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 must be equivalent in duration and content to that required by the Australasian intensive care training bodies.

June 2000



The Court of Examiners and successful candidates of the General Fellowship Examination, held at the Royal Melbourne Hospital in late August.



From left, Drs Peter Morley, Martin Rowley, Jim Tibballs, Tony O'Connell, Steve Keeley and Richard Lee congratulate Dr Fiona Miles on her success at the recent Fellowship Examination in Paediatric Intensive Care. The Examination was conducted at the Royal Children's Hospital in Melbourne.



Court of Examiners for the August General Fellowship Examination. From left: Drs Peter Morley, Martin Rowley, Al Vedig, Felicity Hawker, Les Galler, John Myburgh, Steve Edlin, Richard Lee, Rob Young and Graeme Hart



Successful candidates of the August General Fellowship Examination. Rear: Drs John Foy, John Fraser, Sean Newell, Peter Scott, Naresh Ramakrishnan, Michael Davis, Andrew McKee; Foreground: Drs Amod Karnik, Penny Stewart, Emma Merry, Ram Sistla, Amjed Aziz, Ian Seppelt

The role of 'Senior Registrar' in Intensive Care Training

The Joint Specialist Advisory Committee for Intensive Care (JSAC-IC) of the RACP and the FIC, ANZCA is charged with overseeing training in intensive care. In regulating this process, the JSAC-IC has recently endorsed moves away from the approval and accreditation of training programs and posts to accreditation of training sites with clear definition of the extent of training which may be undertaken at individual sites.

Continuing review has indicated that there remains considerable variation in the training experienced by trainees. Some trainees may spend all of their core training in a 'shiftwork' environment with a substantial out-of-hours component entailing less supervision and limited longitudinal responsibility for patient care. Other training sites include a 'senior registrar' role which entails a greater in-hours component with increased teaching and supervision together with more continuous responsibility for patient care than shiftwork enables.

There is no evidence that this sort of variation in training experience affects the quality of the graduate. However, the 'senior registrar' model more clearly reflects the usual

pattern of consultant level intensive care practice in Australia and New Zealand. Thus the JSAC-IC recommends that all trainees undertake as part of core training a continuous period of at least 6 months in a 'senior registrar' capacity.

The following features characterise the 'senior registrar' role:

- Longitudinal responsibility for patient care for more than a single shift. This implies an 'on-call' commitment.
- Supervision of more junior doctors in the management of critically ill patients.
- Supervision by an intensive care specialist in such a way as to enable the trainee to exercise initiative and take responsibility for patient care in an appropriate fashion based on the acuity of illness of the patient and the skill level of the trainee.

Ray Raper (FRACP)

Chairman

Joint Specialist Advisory Committee – Intensive Care

Survey of Trainees and Recent Graduates

The following is a summary of feedback from a Survey sent to Trainees and recent Graduates seeking feedback on supervision and training programs.

Summary

There was no difference in responses from Trainees and recent Graduates.

1. Standard of information from Faculty/College

- no negative comments
- 2.7% unsatisfactory, 20.7% excellent

2. Teaching

- informal better than formal
- standard of teaching varies between Units
- several Units where Trainees very unhappy with amount and standard

3. Supervision

- standard of supervision varies between Units
- in hours supervision better than out of hours

4. Supervisors of Training

- no negative comments
- excellent rapport
- good knowledge of Faculty/College procedures
- less satisfaction with feedback on performance and guidance for examinations

Outcomes

1. Trainees providing feedback to Faculty/College and having an input into the quality of their training
2. Establishes a benchmark
3. Need to improve
 - formal teaching in Units
 - teaching and supervision where believed to be unsatisfactory
 - formal feedback and guidance from Supervisors of Training

Results from Survey

Mailed: 251

Returned: 116 (46.2%)

Provided additional comments: 52 (44.8%)

Demographic Data

Trainees	44 (39.6%)
Recent graduates	67 (60.4%)
No response	5

	Unsatisfactory (none/poor)	Excellent
Information provided by Faculty/College	2.7%	20.7%
Teaching		
• tutorial	32%	6.3%
• ward round	17.4%	22.0%
• informal	11.0%	21.1%
• exam preparation	27.8%	20.6%
• time allowed for study	19.3%	20.2%
Supervision		
• in hours	1.8%	40.0%
• out of hours	6.4%	17.8%
• availability of help for non-clinical problems	15.2%	13.3%
Range of clinical experience & exposure	0%	14.7%
Supervisors of Training		
• rapport	2.9%	40%
• feedback on performance	12.8%	24.8%
• knowledge of procedures/policy	6.9%	26.5%
• help with examination preparation	22.3%	21.4%
• program guidance	15.5%	21.4%
Didn't know Supervisor of Training: 6/111 (5.4%)		

Faculty of Intensive Care

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

POLICY DOCUMENTS

- IC-1 (1997) Minimum Standards for Intensive Care Units *Bulletin Aug 94, pg 44*
- IC-2 (1994) The Duties of an Intensive Care Specialist in Hospitals with Approved Training Posts *Bulletin Aug 94, pg 49*
- 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 (1995) Ensuring Quality Care - Guidelines for Departments of Intensive Care *Bulletin Mar 95, pg 32*
- IC-9 (1997) Statement on Ethics and Patients' Rights and Responsibilities *Bulletin Nov 97, pg68*
- IC-10 (1996) Minimum Standards for Transport of the Critically Ill *Bulletin Mar 96, pg42*
- 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*

Award of the GA (Don) Harrison Medal

Immediate past Dean, Dr Alan Duncan, was recently in the UK to present the GA (Don) Harrison Medal to Dr Mark Hayden, for his performance in the Fellowship Examination in Paediatric Intensive Care in 1999. Dr Hayden is the first Fellow to receive the Faculty's endorsement in Paediatric Intensive Care. Dr Hayden is about to take up an appointment as Senior Registrar in Paediatric Intensive Care at the Hospital for Sick Children, Great Ormond Street, London.





Dean's Message

Michael J Cousins, AM

Recognition of Pain Medicine as a Specialty

Now that our training program and examination system are well established, the time has come to apply for recognition of Pain Medicine as a specialty. Recently representatives of the Faculty and of the Australian Pain Society have held discussions regarding this important step. After wide ranging discussion, it has been agreed that the best course would be for the Faculty and the APS to make separate submissions, in order to reinforce the broad range of support for specialty recognition. The Faculty will particularly emphasise its unique role as a training and education body, its representation of five specialist bodies and its secure future as a component of a major specialist college with substantial educational and other resources at its disposal. It was agreed that the definition of a Pain Medicine Consultant is "A consultant in Pain Medicine is a Physician who holds the Diploma of Fellowship of the Faculty of Pain Medicine".

Continuing Education for Fellows

As is the case in all specialties, there is an increasing emphasis on developing methods for continuing education that will be accessible and useful for Fellows. The Education Committee is particularly keen to see that the needs of our Fellows are served, while at the same time providing a very high quality training program for our Trainees. Fellows should be aware that the 'Guide to Study', currently being developed, may be of significant interest and assistance to Fellows for CME purposes. The Education Committee will also be investigating the development of web based educational modules which could be of assistance to Trainees and Fellows alike.

Finances and the Faculty

From the inception of our Faculty, it has been agreed that we should attain financial independence within ANZCA as soon as possible. In other words we must strive to "pay our own way". However the initial Board was keen to keep the annual dues as low as possible during the early phase of development of the Faculty. A recent review of our finances with our Treasurer, has made it quite clear that it will be necessary to increase the annual dues if we are to meet our financial responsibilities within ANZCA. ANZCA has already been extremely generous to the new Faculty in providing administrative support, office space and equipment and other resources within ANZCA. Shortly the Faculty will have the services of a professional educationist working in a proposed education centre. The Faculty also has access to an excellent library with a librarian who will assist Fellows in obtaining literature materials. Of even greater significance is the wonderful new purpose designed ANZCA building which will be completed later this year and provides for excellent new space for the Faculty. Very few new specialties have had the great advantages afforded by these resources at such an early stage. I will be writing to every Fellow to outline the changes to annual dues and I hope that you will be understanding of the need to make a reasonable financial contribution to the costs of keeping our specialty training, examination and other programs at the highest standard.

2001 CSM - Hong Kong

I would particularly draw Fellows' and Trainees' attention to the 2001 Scientific Meeting of our Faculty which will be held in Hong Kong. This is an unusual opportunity for us to network with our colleagues in the Asia/Pacific region and a particularly interesting and innovative program has been

planned. The Faculty Foundation Visitor is an outstanding individual in the form of Professor Troels Jensen who has wide ranging interests which are detailed in the highlights of the Board meeting. There will also be some unusual aspects of the meeting which will include a scientific appraisal of some areas of Pain Medicine that are unique to the culture and practices of the Eastern part of the world. I would encourage as many Fellows as possible to attend this meeting.



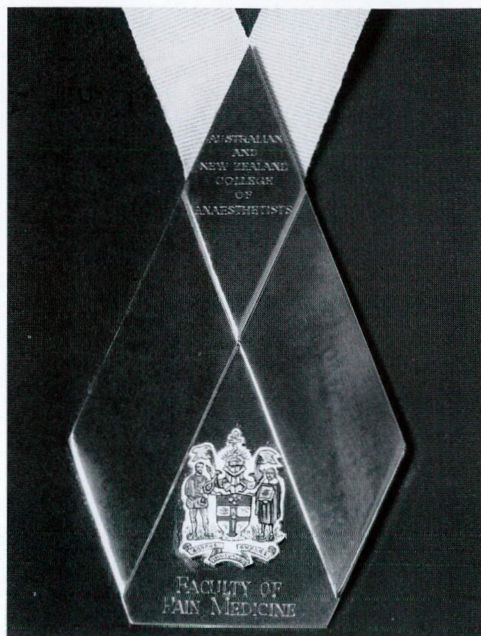
CSM Hong Kong

The Faculty Scientific Convenor for this meeting is the RACS representative to the Board, Mr Leigh Atkinson, who is currently developing a very interesting Pain Medicine program.

The Faculty Foundation Visitor is Professor Troels Jensen, a neurologist from Aarhus University, Denmark. Professor Jensen's interests include: Neuropathic pain: mechanisms, assessment and treatment; Post-amputation pain: mechanisms and treatment; Post-stroke pain: mechanisms and treatment; Sodium channel blockers in central pain; "Whiplash injury"; Neuropathic pain and spinal cord injury; Opioids and chronic non cancer pain.

FELLOWSHIP EXAMINATION DATES FOR 2000

Closing date for registration:	September 1, 2000
Examination dates:	October 25, 26 and 27, 2000
Venue:	Royal Adelaide Hospital



The Dean's Medal

Donated by RACS to the Faculty. This Badge of Office is a five-sided gilt medal, representing the five specialties which make up the Faculty of Pain Medicine. The Badge of Office was presented by Mr Bruce Barraclough PRACS during the College Ceremony at the recent AGM.

ELECTED TO FELLOWSHIP

The following have been elected to Fellowship of the Faculty of Pain Medicine

Mark	AWERBUCH	SA	FRCP
Stephanie	DAVIES	WA	FANZCA
Geoffrey	GEE	WA	FANZCA
Nigel	JONES	SA	FRACS
Kay	LANE	Qld	FANZCA
Ray	NEWCOMBE	ACT	FRACS
Ivan	YAKSICH	Qld	FRACS

PROFESSIONAL DOCUMENTS

Faculty of Pain Medicine

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

PROFESSIONAL DOCUMENTS

PM2 (2000) Requirements for Multidisciplinary Pain Centres Offering Training in Pain Medicine *Bulletin Sept 2000, pg 46*

Highlights from Board Meeting

HELD ON JULY 13, 2000

Admission to Fellowship by Examination

The following were admitted to Fellowship by examination:

Anne CHAN, SA FANZCA
Geoffrey NEEDHAM, NSW FAFRM (RACP)

Education

The Guide to Study is well underway and should be completed by the end of July. This will be available to Trainees registering for the training program from 2001, as well as to Fellows of the Faculty for the purpose of continuing education.

The Education Committee will commence developing Objectives of Training in the near future.

The Committee reaffirmed that Log Books are now not an assessment tool, but as an aid to training and will be used as a method of feedback between Trainees and Supervisors. Log Books will also be part of the accreditation procedure for the training centre.

Examination

The Chairman, Examination Committee reported that plans are progressing for the examination to be held in October 2000. There has been strong interest from individuals to present for this examination.

The Examination Committee, at its meeting in August, will be reviewing applications received from Fellows of all participating Colleges to be appointed to the Panel of Examiners. This report will be presented to the next meeting of the Board.

Treatise Material

The Board agreed that treatise material is part of the training requirements and will come under the umbrella of the Examination Committee.

Pre-examination Short Course

A pre-examination short course has been developed and is to be held from August 18 to 20 at Royal North Shore Hospital.

Hospital Accreditation

HAC has completed reviews of the Pain Management Centres at Auckland Hospital, Royal Brisbane Hospital and Flinders Medical Centre. The Board has approved these units for training programs, subject to a number of areas being addressed.

Forthcoming reviews are the Pain Management Centres at The Geelong Hospital and Royal Adelaide Hospital.

Regulations

The Faculty Regulations were developed before the Faculty was up and running and the Board has realised that there are areas which either require revision to suit the Faculty or are not relevant. Considerable revision of the Regulations has been undertaken and they will continue to be reviewed over the next few months.

Policy Documents

PM2 (2000) Requirements for Multidisciplinary Pain Centres Offering Training in Pain Medicine

The Board resolved that Faculty Policy Document PM2 (2000) *Requirements for Multidisciplinary Pain Centres Offering Training in Pain Medicine* be promulgated (see attached).

Guidelines for Acute Pain Management

At the request of Council, the Board agreed to this document being a joint College and Faculty document and that it be numbered PS41 (2000).

TE15 (to be renumbered PM1) Guidelines for Trainees and Departments Seeking College Approval for Training in Pain Medicine

This document is currently under revision.

Recognition of Pain Medicine as a Specialty

Representatives of the Faculty and of the Australian Pain Society have held discussions regarding recognition of Pain Medicine as a specialty. Separate submissions are being prepared and will be forwarded to the Australian Medical Council.

Agreement has been reached on the definition of a Pain Medicine consultant as: "A consultant in Pain Medicine is a physician who holds the Diploma of Fellowship of the Faculty of Pain Medicine".

Chapter of Palliative Medicine, RACP

Foundation Fellows have now been inducted and these include the Dean, Vice Dean and a number of Fellows of the Faculty.

Representation on ANZCA Committees

The following Fellows of the Faculty have been appointed to these Committees:

Education	Education Officer (M Cohen)
General Examinations	Chairman, Examination Committee (P Briscoe)
Primary Examination	Chairman, Examination Committee (P Briscoe)
CE&QA	B Kinloch
Constitution Review	Dean (M Cousins)
Workforce	Education Officer (M Cohen)
Board of Anaesthesia, Intensive Care	Dean (M Cousins)
Pain Medicine Foundation	
Communications	C R Goucke
Information Technology	T Little
ASM Scientific Program	R L Atkinson
ASM	P Macintyre
House	G Rice
Research	C R Goucke
ACECC	M Paech
Library	T Little

Faculty of Pain Medicine

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

REQUIREMENTS FOR MULTIDISCIPLINARY PAIN CENTRES OFFERING TRAINING IN PAIN MEDICINE

1. INTRODUCTION

- 1.1 These guidelines establish the minimum standards for Multidisciplinary Pain Centres offering training for the **Diploma of Fellowship in Pain Medicine** of the Australian and New Zealand College of Anaesthetists.
- 1.2 A Multidisciplinary Pain Centre is a healthcare delivery facility staffed by medical practitioners of at least three (3) specialties, and from other allied health professions. These individuals specialise in the diagnosis and management of patients with chronic pain and/or patients with acute pain and/or patients with cancer pain, referred to generically as patients with pain.
- 1.3 The staff of a Multidisciplinary Pain Centre must be able to assess and treat the physical, psychosocial, medical, vocational and social aspects of patients with pain.
- 1.4 A number of allied healthcare disciplines must be represented on the staff of a Multidisciplinary Pain Centre. Such disciplines include nursing, occupational therapy, physiotherapy, clinical psychology, social work, vocational counselling and others appropriate to the population being served.
- 1.5 A session is a notional period of 4.0 hours devoted exclusively to Pain Medicine.

2. ADMINISTRATIVE STRUCTURE AND STAFFING

- 2.1 The Centre should be recognised by the Hospital Management for funding purposes.
- 2.2 All staff in the Centre must be accredited by the Hospital for the duties and procedures they perform.
- 2.3 The Centre should have a Medical Director with a minimum of four (4) sessions weekly.
- 2.4 The following disciplines form a part of staffing.
- 2.4.1 **Anaesthesia:** there must be a minimum of eight sessions weekly by specialist staff.
- 2.4.2 **Psychiatry:** regularly scheduled specialist clinical sessions are essential.
- 2.4.3 **Rehabilitation Medicine:** regularly scheduled specialist clinical sessions are essential.

2.4.4 **Rheumatology, oncology, neurology, neurosurgery, orthopaedic surgery, palliative medicine, drug and alcohol and other appropriate medical specialties:** regular clinical input is highly desirable from these medical specialties.

2.4.5 **Nursing staff:** there must be senior registered nursing staff exclusively attached for a minimum of ten sessions weekly.

2.4.6 Regular clinical input for these disciplines is highly desirable:

2.4.6.1 **Clinical Psychologist**

2.4.6.2 **Physiotherapist/Physical Therapist**

2.4.6.3 **Occupational Therapy**

2.4.6.4 **Social Work**

2.4.6.5 Allied Health disciplines such as Rehabilitation/Occupational Counselling, Dietetics and others may be associated with the Centre.

2.5 Centres must establish and maintain regular direct contact with the patient's General Practitioner.

2.6 The Unit should offer a range of expertise in the following areas:

2.6.1 Review of prior medical records

2.6.2 History taking and physical examination relevant to Pain Medicine

2.6.3 Psychological assessment and treatment

2.6.4 Referral for external medical consultation

2.6.5 Medical management

2.6.6 Physical therapy

2.6.7 Other appropriate services, including:

2.6.7.1 Cognitive behavioural programs

2.6.7.2 Relaxation techniques

2.6.7.3 Biofeedback

2.6.7.4 Work hardening/exercise physiology

2.6.8 Pain Management therapies

2.6.9 Vocational assessment and counselling

2.7 Regularly scheduled staff education sessions are essential

- 2.8 Involvement in undergraduate and post graduate medical, nursing and allied health education is highly desirable.
- 2.9 Regularly scheduled Quality Improvement/Peer Review activities are essential.
- 2.10 An active research program related to Pain Medicine is highly desirable.
- 2.11 A comprehensive patient record system is essential. A computerised data review system for diagnosis treatment is highly desirable.
- 2.12 Documentation of treatment protocols and procedures for patients together with a statement of their rights and responsibilities is essential.
- 2.13 At least one full-time equivalent of secretarial assistance to the Centre is essential.
- 2.14 Allocation of RMOs is highly desirable.
- 3. PHYSICAL FACILITIES**
- 3.1 Appropriate consulting and examination rooms are essential.
- 3.2 Access to procedure rooms with adequate equipment and staffing is essential. Staffing will include nurses, technicians and radiographers as required.
- 3.2.1 Anaesthesia and resuscitation equipment must comply with ANZCA College Policy Document TI *Recommended Minimum Facilities for Safe Anaesthetic Practice in Operating Suites*.
- 3.2.2 Recovery facilities and procedures must comply with ANZCA College Policy Document P4 *Guidelines for the Care of Patients Recovering from Anaesthesia*.
- 3.3 Suitable office space for permanent staff and trainees is essential. See ANZCA College Policy Document EI *Guidelines for Hospitals seeking College Approval of Posts for the First Four Years of Vocational Training in Anaesthesia*.
- 3.4 Access to in-patient beds.
- 3.4.1 Access to in-patient beds is mandatory.
- 3.4.2 In-patient beds designated to the Multi disciplinary Pain Centre are highly desirable.
- 3.5 Access to an adequate library with major pain medicine books and access to bibliographic databases for journal publications are mandatory.
- 4. CLINICAL WORKLOAD AND STANDARDS**
- 4.1 Numbers of new patients per annum:
- 4.1.1 **Acute perioperative/Trauma:** a minimum of **200** new patients per annum per trainee.
- 4.1.2 **Chronic non-cancer pain and cancer pain:** a minimum of **300** new patients per annum per trainee.
- 4.2 **Out-patient medical specialist sessions:** There should be a minimum of five per week.
- 4.3 **Formal interdisciplinary case conferences:** must be held at least once weekly (to draw up a treatment plan in discussion among a number of health professionals who have seen the patient in consultation). Preferably three to five per week will be held.
- 4.4 **Procedural sessions:** A minimum of one procedural session (eg: diagnostic and therapeutic nerve blocks, etc.) per procedural specialist per week.
- 4.5 **In-patient rounds:** There must be a minimum of six day rounds per week to cover all patients under the care of the Pain Centre. There must be medical specialist input to the rounds.
- 4.6 There must be a medical specialist designated to the Pain Centre available 24 hours per day throughout the year. This cover must include scheduled out-of-hours rounds.
- 4.7 **Radiology:** There must be regular review sessions.
- 4.8 **Therapeutic:** Nerve blocks and other invasive treatments should be sufficient to provide adequate exposure for trainees. Non-invasive treatments must also receive appropriate emphasis to ensure candidates become pain medicine specialists rather than pain proceduralists.
- 4.9 **Psychiatry and Psychology therapy sessions:** Sessions must provide adequate exposure for trainees.
- 4.10 **Audit and clinical review sessions:** These must be held at least monthly and include documentation of results.

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.

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

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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*
- TE16 (1998) Requirements for Multidisciplinary Pain Centres Offering Training in Pain Medicine *Bulletin Nov 1998, pg 83*
- 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*
- P4 (1995) Guidelines for the Care of Patients Recovering from Anaesthesia *Bulletin Aug 95, pg 64*
- 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*
- P15 (1995) Guidelines for the Perioperative Care of Patients Selected for Day Care Surgery *Bulletin Aug 95, pg 62*
- 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*
- P18 (1995) Monitoring During Anaesthesia *Bulletin Nov 95, pg 68*
- P19 (1995) Monitored Care by an Anaesthetist *Bulletin Nov 95, pg 60*
- P20 (1996) Responsibilities of the Anaesthetist in the Post-Operative Period *Bulletin Mar 96, pg 52*
- P21 (1996) Sedation for Dental Procedures *Bulletin Mar 97, pg 56*
- P22 (1996) Statement on Patients' Rights and Responsibilities *Bulletin Mar 96, pg 53*
- P24 (1997) Sedation for Endoscopy *Bulletin May 97, pg 78*

- PS26 (1999) Guidelines on Providing Information about the Services of an Anaesthetist *Bulletin Nov 99, pg 63*
- P27 (1994) Standards of Practice for Major Extracorporeal Perfusion *Bulletin Nov 94, pg 46*
- 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*